Mauricare Limited

Aston Manor

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

We carried out this inspection on 4 and 6 November 2015. The inspection was unannounced.

Aston Manor is a nursing home currently providing care for up to a maximum of 32 older people. The service has two floors and provides care and support for people with nursing and residential needs including people who are living with dementia. On the day of our visit there were 31 people living at the home.

The service had a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff were confident to report safeguarding concerns, although not all staff had a clear understanding of the safeguarding procedures to follow other than reporting to the manager.

Medications took a long time to administer and as a result, people were at risk of not receiving their medication on time. There were unclear practises regarding giving people medicines covertly.

Summary of findings

Staff were not deployed effectively or with the right skills to meet people's needs. One to one support for some people was not managed or reviewed to meet the needs of individuals.

Risk assessments and care plans were not adequate or detailed enough to ensure people's safety or for staff to provide individual care.

Cleaning procedures were not always effective and there were strong offensive odours within parts of the home.

The registered manager was aware of the requirements of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

People reported they enjoyed the food, although we found mealtimes were not organised well and people's weight loss was not managed effectively. People with diabetes did not receive sufficient support for their dietary needs.

People had little access to meaningful activities. Some resources were available but these were not always relevant to people's interests.

Complaints were recorded and responded to and people knew how to complain if they wished to.

Some processes were in place for auditing the quality of service provision but these were not always robust.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, the location will be inspected again within six months.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staff were not all clear about the procedure to follow to ensure people were safeguarded from abuse.

Staff deployment did not ensure people's needs were met. One to one support for people was poorly managed.

Individual risks to people were not adequately assessed.

Medication was not administered in a timely manner.

Cleaning was not always effective and there were strong odours in places.

Is the service effective?

Inadequate

The service was not effective.

Staff lacked the necessary skills to support people's particular needs.

The registered manager was aware of the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards.

Mealtimes were disorganised; some people were just finishing their breakfast when it was time for lunch. People's food and fluid intake was not effectively monitored to ensure their health needs were met.

Is the service caring?

Inadequate

The service was not caring.

There were inconsistencies in the way staff interacted with people; some staff were kind and patient and at other times we saw staff ignored people.

Staff did not always demonstrate high regard for people's dignity.

Is the service responsive?

Inadequate

The service was not responsive

There was a lack of person centred care.

People were bored and there were limited opportunities for them to engage in meaningful activities.

Complaints and concerns were recorded appropriately.

Is the service well-led?

Inadequate

The service was not well led.

Some processes were in place for auditing the quality of service provision but these were not robust.

Summary of findings

Staff lacked direction in their work and there was no visible leadership in the home.

Aston Manor

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We had previously inspected this service in October 2014, soon after it was registered. We did not give a rating at that inspection as it was too early to rate.

This inspection took place on 4 and 6 November 2015 and was unannounced. The inspection team consisted of three adult social care inspectors.

Before the inspection we reviewed the information we held about the service. This included looking at any concerns we had received about the service and any statutory notifications we had received from the service. We had received some concerns from the local authority following their contract monitoring visit, that people's needs were not being met in a number of ways.

We used different methods to help us understand the experiences of people who lived in the home. We spoke with nine people who were living in the home and four visiting relatives. We also spoke with six members of staff including the registered manager and the cook.

We looked in detail at six people's care records and observed care in the communal areas of the home. We looked at four staff recruitment files and staff training records. We also looked at records relating to the management of the service including policies and procedures. We looked round the building and saw people's bedrooms, bathrooms and communal areas.

Inadequate

Is the service safe?

Our findings

We asked people if they felt safe in the home. One person said "Why wouldn't I be safe here?". Another person said: "I suppose I am safe, I feel safe". One person said: "Oh aye, the staff make sure you're safe, that's one good thing about this place".

We asked visitors if they felt their family members were safe in the home. They said: "Yes we have no concerns about safety". Another visitor said they felt the home was safe for their family member. One relative said their family member had not been at the home very long but they felt there were no concerns about safety. One relative told us "the place is clean. The laundry is second to none".

We looked at the record of accidents and incidents and we saw these were recorded on the computer within each person's record. Information about accidents and falls were summarised but there was no record or analysis of other incidents, such as safeguarding incidents or challenging behaviour to identify when incidents may need further investigation or identify what action had been taken.

Staff we spoke with were not always aware of individual risks to people and so people were not always supported safely. We saw on one occasion a member of staff used an inappropriate moving and handling technique to assist a person. On another occasion we saw staff offered a walking frame to a person and when we asked whether this equipment was for the person, staff said they were not sure. We noted one person was particularly unsteady on their feet and appeared to be overbalancing, yet staff were not alert to this risk. We saw this person had a conflicting risk assessment in place for their mobility as in one section it stated 'no mobility issues, yet in another section it stated 'poor mobility'. We saw on two occasions, people walked without the appropriate footwear; one person had only one slipper on and staff did not intervene to ensure the person walked safely around the home.

We looked at risk assessments in people's care records and saw these were scant, not relevant or personalised and contained inaccurate information. For example there was a risk assessment for some people about a trip to the zoo with regard to the potential hazard of being bitten by an animal. This was not relevant because people had not been or planned to go to the zoo. Furthermore, we saw the contents of some risk assessments had been copied and pasted onto other people's records as they contained incorrect names. More critical risk assessments, such as for people's mobility or nutrition, were not completed.

The above examples illustrate the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 12(2)(a)(b) because risks were not fully assessed and mitigated.

We spoke with staff who told us they would be confident to report any concerns to the manager if they were worried about a person's well-being. One member of staff knew the signs of abuse and said they would always report to the manager, or to other relevant agencies if necessary, but not all staff knew who to report concerns to other than the manager. Staff said they would report any poor practice if they witnessed this, to ensure people in the home were safe. However staff did not always recognise that verbal abuse between people was an issue that would need reporting.

We looked at recruitment files for two members of staff. We saw that files contained evidence that checks had been completed prior to employment. However, we saw no evidence that one of the new members of staff had completed induction and the manager was unable to confirm this.

We saw that staffing levels and deployment of staff at the time of our inspection did not meet people's needs. For example, the communal areas were left unattended for long periods of time because staff were attending to other people in their rooms. We noted people in the communal areas required assistance and on at least three occasions inspectors had to locate staff to support people. We saw many people in the home required two staff to assist with their moving and handling, which meant some people had to wait to be supported whilst staff attended to others.

The above examples illustrate the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 18(1) because there was ineffective deployment of sufficient numbers of competent staff to meet people's needs.

Where staff were deployed to support people whose behaviour challenged the service or others, we found they had little understanding of how to ensure people's safety or the safety of others. Two members of staff told us they had not received any specific training for the individual they

were supporting: "I'd just have to touch wood nothing happened, but I'd use common sense". The manager told us staff had received 'challenging behaviour training' but not detailed training to meet the needs of particular individuals. We noted one member of staff constantly followed one person around the home as they repeatedly walked through the communal areas and garden. We saw from this person's care plan that certain behaviours displayed by others caused them to feel upset; one of these was when people became too physically close. However, staff closely shadowed this person intensely and remained physically close to them. When we spoke with the staff they were unaware of the person's particular needs or how to effectively support them. This meant that staff lacked knowledge of how to support people.

We had noted from one person's care plan they had significant dietary needs, yet when we spoke with the member of staff who supported the person, they were unaware. Staff said they had not read the person's care plan and therefore did not know the person's needs

We looked at the systems that were in place for the receipt, storage and administration of medicines. We saw medicines were stored securely and at an appropriate temperature. We found medicines were only administered by staff that had been appropriately trained. We observed some people being given their medicine during our visit. The agency nurse did not know all of the people they were giving medicine to and asked their names before administering this, although not all people could reliably reply. We saw people were offered their medication on a large tablespoon. We noted the morning medication round was still ongoing at lunchtime, which meant some people may have not had their medicines on time.

We saw the Medication Administration Record (MAR) charts. They included details of the medicine, what it was for, the dosage and how the medicine should be taken. We checked a sample of the medicines available against the amounts recorded as received and administered and found these to be correct.

We found some significant concerns in relation to cleanliness and infection control, and particularly in one communal area. For example, when we arrived one morning we found one landing area had extensive smears of faeces on the carpet, the walls, the furniture and the handrails. There was a covering of litter on the landing floor, which staff told us was where a person had 'shredded their incontinence pad and smeared faeces'. This resulted in highly offensive odours throughout the area. Staff told us this was a regular nightly occurrence and they managed this by cleaning up the following morning. We spoke with one person whose room was adjacent to the landing area. They told us they did not like the smell from the landing and confirmed this happened on a regular basis.

We spoke with the cleaning staff who described how they steam cleaned the carpets each time this happened and gave assurances the area was thoroughly cleaned. The manager told us checks of the premises were made daily to ensure cleaning was carried out to a satisfactory standard. However, when we returned to check the area later we saw there was still faeces on the handrail and the offensive odour remained throughout the day.

We found antibacterial hand gel dispensers throughout the home were empty. We saw one member of domestic staff refill some dispensers, although some still remained empty. We saw cleaning took place throughout the day. Relatives we spoke with said: "The place is always spotless, they're always cleaning".

Staff practise in relation to infection prevention was variable. The staff member responsible for cleaning showed us how they audited areas to be cleaned, including mattresses and individual bedrooms. We saw appropriate supplies of cleaning materials and cleaning staff were knowledgeable about how to minimise the risk of infection through the appropriate use of cleaning cloths and personal protective equipment (PPE). PPE was in plentiful supply and easily accessible to staff. Not all staff practised hand hygiene, for example, we saw staff in the kitchen open the bin with their hand and then handle food.

The above examples illustrate the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 12 (2) (h) because there was ineffective prevention, detection and control of the spread of infection.

Inadequate

Is the service effective?

Our findings

People we spoke with said they thought staff were capable. One relative we spoke with told us: "The staff here know [my family member] and I trust they are sure of what they are doing. I don't have any concerns about the staff's abilities". Another relative sad: "Oh yes they [the staff] have regular training sessions". They told us: "Some new carers need instruction in how to put [my relative] in the chair. Staff know [my relative] well" and "I haven't seen anything bad".

We saw an induction checklist in staff files and the manager told us staff had all received induction. One new member of staff told us they had shadowed more experienced staff until they felt confident in their role and they had been told about key areas, such as fire safety and safeguarding as part of their induction. The manager told us some staff had previously been employed at other local homes that had recently closed. We saw that recruitment procedures had been followed to ensure staff were vetted appropriately. However, the manager said the skills and competencies of some new staff were not checked out when the staff started and she was not aware of the skill mix of the staff team. There was no staff training matrix in place to provide an overview of staff training and there were no systems in place to monitor the competency of staff.

Staff told us they received mandatory training, such as moving and handling. Some staff said they had been offered 'challenging behaviour' training and dementia awareness training. The staff we spoke with said they felt they were offered sufficient training and induction to help them in their role, although the manager could not evidence this in the staff files we looked at.

Staff had not received any training to support the particular needs of individuals, such as those who demonstrated behaviour that challenged the service or others.

There were six people in the home who were identified to us as requiring one to one support. However, it was not clear how this had been determined as there was no evidence of reviews of people's care in their care plans. People's dependency needs varied but again, it was unclear how this was assessed to determine staffing levels. Where agency staff gave one to one support, they exclusively spent their time with the one person and interaction with others was minimal. Where regular staff were assigned to give one to one support, we saw they were frequently pulled away to respond to other people's needs or support their colleagues in assisting people. We observed one person who was not identified as receiving one to one support, but who was very unsteady on their feet and at obvious risk of falling, yet their needs had not been reviewed.

We found that although staff had supervisions, these were not always regular. One member of staff said they had not had a supervision meeting for over six months.

The above examples illustrate the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 18(2)(a) because staff did not all have the knowledge and skills to support people's specific needs.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

We asked staff about their understanding of mental capacity and Deprivation of Liberty Safeguards. Staff had an understanding of mental capacity and how decisions might be made in someone's best interest if they lacked capacity. The manager showed us evidence of where Deprivation of Liberty Safeguards had been authorised for 14 people living in the home.

We saw staff did not always offer people choices or seek their consent with regard to everyday routine decisions. For example, people were not always asked where they wanted to sit or what they would like to eat or drink. We observed staff offered to assist one person whose clothing was wet. When the person refused, staff persisted in trying to persuade the person and this resulted in the person becoming very angry.

We observed breakfast and lunchtimes in Aston Manor. We saw that first thing in the morning before breakfast, some people were awake and dressed. They were seated in the lounge area and there was no evidence anyone had been offered a drink. We asked staff how long people had been up or whether they had been offered a drink and staff were unable to tell us. We spoke with one person who said: "I'd

Is the service effective?

love a cup of tea". Another person said they had 'been up for a few hours' but not given anything to drink. Another person said: "We just have to wait, the staff are busy seeing to everyone else".

We saw some people were offered a choice of breakfast but others were not and staff presented some people with food and drinks without asking what they might like. Staff put plastic aprons on people to protect their clothes, but with no consultation. When food was brought to people it was already plated up and there was no discussion about what or how much they might like. Condiments were not available and on one occasion we saw a person use 'imaginary' condiments before eating their meal.

We spoke with the cook who told us they liaised with care staff to ensure people's dietary needs were met. We saw menus contained varied and nutritional contents. Staff told us the meals had been swapped around to respond to people's appetites and this meant tea time was a lighter meal. However, the organisation of mealtimes was chaotic and staff did not consider people's individual needs. We saw two people had breakfast very late in the morning and staff told us lunch would be served one hour later, with no consideration for those who had recently eaten. Some people had to wait a considerable length of time, around 45 minutes, to be served lunch and they sat at tables waiting.

People were complimentary about the meals. One person said: "They make lovely meals here". Another person said: "The food is nice but I never know what I'm having". Staff told us: "We have a rough idea of who likes what".

Staff supported some people with meals on a one to one basis and these people were assisted to eat before people who could eat independently. When we spoke with staff they were not all clear about who had eaten their meal and who had not. We saw where people had not come into the dining room, staff took their meals to them but there was no order to this. We spoke with the member of staff in charge of the dining room who said it was their task to record each person's food and fluid intake. We saw records were not completed on time, and although the member of staff said they relied on their memory to update the record, this was not an accurate reflection of what people had been given to eat and drink. This meant that people's food and fluid intake was not monitored effectively.

Records showed that some people had lost weight and were at risk of malnutrition. However, staff were not all aware of who was at risk and where people's care plans stated they should be weighed weekly there was no evidence of this being done. We looked at the care plans for six people who were listed on a noticeboard in the staff room as needing weekly weighing. We could find no records to show they had been weighed weekly. We spoke with the manager to ask why people's weekly weights were not being done and she was unable to explain. We found five people were recorded as having lost weight, yet there was no indication of what was being done about this.

We saw a list of special diets displayed discreetly for staff. There was no list of which people were at risk of choking and required thickening agent in their drink and a member of staff we asked said: "We just know who has what". This was not known by staff who were less familiar with people and there was a considerable number of new staff in post. This meant people may have been placed at risk of choking by staff's lack of awareness of appropriate fluid consistency.

We had noted from one person's care plan they had significant dietary needs, yet when we spoke with the member of staff who supported the person, they were unaware. Staff said they had not read the person's care plan. This person's care plan stated they should not be given too much sweet and sugary food. However, when we saw records of the food they had been given we found this was high in sugar content and there was nothing on the record sheet to highlight the person's particular requirements.

The above examples illustrate the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 14 because the nutritional and hydration needs of people were not met.

We saw from people's records that staff sought medical advice and where a GP was needed, they were involved in people's care. One relative told us the staff always consulted their family member's GP and if their family member needed to go to hospital this was arranged.

Inadequate

Is the service caring?

Our findings

People told us the staff were kind and caring. One person said: "The staff work hard and they do care but they are so busy, they're run off their feet". Another person said: "They're grand, they do a good job". Relatives spoke well about the staff and said: "Staff and nurses are wonderful". Relatives described the home as 'a happy place'.

We saw some staff were caring in their approach to people. For example, staff spoke with people kindly and made eye contact when speaking and listening. When supporting one person on a one to one basis we saw one member of staff was patient and attentive and allowed the person time to make their needs known. We observed this member of staff interacted in a way that showed they understood the person's non-verbal signs, such as when they looked tired, and they acknowledged this with kind words. Another member of staff helped a person who was unable to put their slippers on. We heard staff give reassurance to one person who said they did not feel well, and staff brought them a cup of tea.

However, at times we saw people were ignored and staff did not respond to people's requests or signs that they needed support. We saw in the lounge one person clearly indicated they were uncomfortable and although they could not find the exact words to verbalise their needs, it was apparent they needed the toilet. We saw staff did not identify the person's needs for help and the inspector intervened, but by this time the person was incontinent and this situation compromised their dignity.

Some people did not appear well cared for. For example some people wore dirty clothes and some gentlemen had not been shaved. We heard one member of staff referred to a person by the wrong name on more than one occasion.

Staff had some awareness of people's rights to privacy, such as by knocking on people's doors before entering, but people's dignity was not always sufficiently regarded. For example, when staff used the hoist to move one person they attached a blanket to form a screen, but this covered the person's view and face and did little to preserve their dignity. Another person's trousers fell down as they were being assisted but staff did not notice this and the person attempted to preserve their own dignity.

We heard staff speak about people instead of with them, and staff referred to people in ways that were not respectful. For example, staff called people 'the softs' when speaking about those who needed a soft diet, and 'doubles' for those people who needed two staff to support them.

We saw every person had a plastic cup to drink from. We spoke with the manager who said this was because 'people throw the cups' and they regarded plastic cups as being the safest for people to use. The manager was unable to verify that any cups had ever been thrown and it was clear this was not fully considered. This illustrated a lack of understanding of the needs of people who may be living with dementia.

The above examples illustrate the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 10 because people were not treated with dignity and respect.

Staff we spoke with said they enjoyed their work with people and wanted to provide care to a good standard. Some staff acknowledged that they were often too busy with care tasks to chat with people and get to know them.

Inadequate

Is the service responsive?

Our findings

Some people told us staff knew their needs. One person said: "They [the staff] know what I like" . One person said: "They know everything about me, I've been here a long time". One person told us there had been 'a lot of comings and goings' referring to staff turnover and said: "The new ones [staff] don't know me so well but they will". One relative said staff involved them in discussions about their family member's care.

We found through speaking with staff they were aware of some people's life histories and staff referred to this when speaking with people. One person had had many connections with the home throughout their life in various ways and staff knew this. However, we found staff did not use their knowledge of people's histories to inform ideas for meaningful activity. For example, where one person had a keen interest in music they were not supported with this in spite of demonstrating their enjoyment of singing and percussion.

We saw there were some resources and activities, but these were not used to engage people in a meaningful way. For example, there were books and CDs but these were not used. We saw a musician came but people were disinterested and this did not capture people's attention; many people remained passive or asleep during the session.

We saw people remained in their chairs for long periods without any interaction or intervention from staff. Some people appeared bored and agitated whilst others were passively awake or asleep. Where people could speak with us they said there was not enough to do. One person said: "There's not a lot going on except the meals". Another person said there was "nowt to do in here". One relative we spoke with said that since the previous activities staff had left, "Nothing happens anymore".

We spoke with the person responsible for activities and they told us they arranged events such as Christmas events, but that part of their role was also as cook.

Care was not person centred or responsive to people's needs. For example we saw there were 'toilet times' and 'pad rounds' in place as part of the routine for care, which were not based upon individual need. We saw the faith room upstairs was used as a store room and when we spoke with staff they were unaware of people's particular religious or cultural beliefs. This meant that people's rights were not being respected or promoted.

Care records were not fit for purpose. We found computer records and paper core care plans that were incomplete, inaccurate and conflicting. For example, records stated one person was both 'continent' and 'incontinent', 'bedbound' and 'walks constantly'. For one person with one to one staff support, there was no mention of this in the care plan or reference to the person's behaviour which was known to challenge the service or others.

The above examples illustrate the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 9(1) because people's care was not person-centred and in keeping with their needs and preferences.

One person we spoke with told us they would speak with the staff or the manager if they had any complaints but added: "I can't grumble really". One relative we spoke with said they had no cause for complaint and if they did, they were sure the manager would deal promptly with their concerns. Relatives were aware of the complaints policy and the suggestion box on the wall. Another relative said that complaints were 'not always followed up' and it was 'pointless' attending relatives meetings because 'no action is taken'. We looked at the complaints record and found complaints had been recorded and responded to appropriately. The manager said they received many verbal compliments although these were not documented.

Inadequate

Is the service well-led?

Our findings

People and relatives told us they thought the home was managed well, they knew who the manager was and felt they were approachable. One relative we spoke with told us that in comparison to their family member's previous care home, this was 'a five star service'.

We found the manager was not visible in the service and remained in the office for much of the inspection. We discussed this with the manager who told us this was not usual and that they were usually more visible in the home. Some staff we spoke with said the manager spent time in the home, although not all staff confirmed this.

Staff told us they felt supported by the manager to do their role and we saw evidence staff meetings had taken place. However, we saw staff lacked direction and often asked one another what they should be doing. There was a lack of strong leadership evident in the way staff appeared disorganised in their work. At times there were no staff available in the communal areas and at other times staff collected together but with no shared purpose. We heard one member of staff say to another: "I don't know what I'm supposed to be doing". Communication was not effective between staff. For example, the night shift did not inform the day shift how long people had been awake.

There was no evidence that the vision and values of the service were shared and promoted. The manager was aware that the turnover of staff may impact upon the culture within the home, yet there was little oversight of this.

Documentation in relation to premises management was in place although it was not always clear what action had been taken where improvements were needed. For example, the emergency lighting on the lift was stated to 'require attention' in July 2015, yet there was no supporting evidence to show this had been done.

We looked at quality assurance systems in the home and found these were weak. There was evidence of some audit records, such as kitchen audits, with clear actions stated. However, some audits lacked rigour and did not identify areas that needed to be improved, such as care plans audit and the meals time audit. The monthly care plans audit had been ticked as completed in October, yet when we reviewed people's care plans there were significant errors and gaps in information. The medication audit in September 2015 showed actions were required, but there was no further evidence to show what had been done. This raised concerns about the validity of the audits.

There was no oversight of staff competencies or practise in relation to key areas of people's care, such as infection control, weight monitoring, dignity, moving and handling, behaviour support or nursing needs. The daily walk round sheets were not completed daily and there were gaps in records for people's care. We noted the weighing scales had been out of action for two weeks but the manager was unable to explain why.

The above examples illustrate the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 17(2)(a) (b) because systems to assess, monitor and improve the quality and the safety of services provided was not robust. Systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of people were not robustly in place.

We saw questionnaires had been sent to relatives and these had produced positive feedback, although some relatives stated activities were poor. There was evidence the quality assurance feedback had been reviewed and relatives we spoke with said they were often asked their opinion of the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People's care was not person-centred and in keeping with their needs and preferences.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **People were not treated with dignity and respect.**

Regulated activity	Regulation
	Regulation 18 HSCA (RA) Regulations 2014 Staffing **There was ineffective deployment of sufficient numbers of competent staff to meet people's needs.** **Staff did not all have the knowledge and skills to support people's specific needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **The nutritional and hydration needs of people were not monitored or managed effectively.**

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Risks were not securely assessed and mitigated. There was ineffective prevention, detection and control of the spread of infection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems to assess, monitor and improve the quality and the safety of services provided was not robust. Systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of people were not robustly in place.