Glenfield Care Limited

Flora Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 29 February 2016 and was unannounced.

Flora Lodge provides care and accommodation for up to 14 people. The service specialises in supporting younger adults and older people with mental health needs, learning disabilities, and autistic spectrum disorders. The premises are situated in a residential area close to the centre of Leicester.

The service had a registered manager. This 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.

The people using the service told us liked living at the Flora Lodge. The service had a friendly and relaxed atmosphere and people appeared content. They got on well with the staff who were kind and caring.

Although there were sufficient numbers of staff on duty to meet people's needs during the day, this was not the case at night. We told the provider to take action to address this which they did as a matter of priority.

Records showed that not all of the staff had been safely recruited. This was because the provider had failed to carry out the necessary pre-employment checks or appropriate risk assessments to determine their suitability to work with the people using the service.

Staff protected people from risk while at the same time supporting and respecting their freedom. However records showed staff did not always have the information they needed to keep people safe. In addition, unsuitable storage facilities and poor record keeping meant that people were not protected from the risk of the unsafe management of medicines.

People told us they felt safe living at Flora Lodge and would tell staff if anything was wrong. Staff knew how to protect people from abuse. However the provider's safeguarding policy and complaints procedure were both out of date and contained misleading information.

Staff had some understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards but did not have the information they needed ensure people's human rights were being protected.

All the staff we met were enthusiastic about their roles and doing their best to understand of the needs of the people they supported. However not all had been trained in the areas considered essential for people working with those with mental health needs and learning disabilities.

People told us they liked the food provided and had plenty of choice. Staff knew people's likes and dislikes and tried to encourage people to eat healthily. Improvements were needed to the way people's dietary

needs were assessed and planned for.

Most of the staff had worked at the service for several years which had enabled them to build up close therapeutic relationship with the people using the service. We saw that people interacted well with staff and had no hesitation in approaching them if they needed assistance. Staff were knowledgeable about people's ongoing healthcare needs and supported them to access healthcare services.

Staff treated people with dignity and respected their privacy. They routinely involved people in making decisions about their. However there was no evidence that people using the service were formally involved in their own care planning. In addition, some daily records included observations that were written in a disrespectful way.

People told us the care and support provided was responsive and helped them to cope with their mental health needs and other issues. Staff encouraged people to develop the skills they needed to live more independent lives. People told us they had improved while using the service and become more independent.

Although the staff on duty were aware of people's needs the knowledge they had was not always reflected in people's care records. In addition care records were not personalised and contained little evidence of people's likes and dislikes and how they wanted their care and support provided.

Staff encouraged people to participate in activities within the service and in the local community. People using the service told us they took part in a range of activities including being members of a community gardening programme, swimming, shopping, pottery, discos, walks, and playing board games.

There was no effective system or process in place to assess, monitor and improve the quality and safety of the services provided. The provider's audits, where they existed, were ineffective as they had not identified areas of the service in need of improvement.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were not enough staff on duty at nights to keep people safe and meet their needs.

Not all the staff employed had been safely recruited.

The risks to people's health and safety had not been properly assessed.

People were not protected from the risk of the unsafe management of medicines.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provider had not acted in accordance with the MCA with regard to people's consent to the care provided.

Not all the staff employed had had the training they needed to provide effective care.

People were satisfied with the food provided and staff encouraged them to eat healthily. Some improvements were needed to assessments of people needs relating to their nutrition and hydration.

Staff supported people to access to healthcare services and receive ongoing healthcare support.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The staff were caring and had developed good relationships with the people using the service.

There was no evidence of people being formally involved in making decisions about their care and support.

Some care notes were written in a disrespectful manner.

Is the service responsive?

Requires Improvement

People told us the care and support provided was responsive to their needs.

Care plans were not personalised and contained little evidence of people's likes and dislikes and how they wanted their care and support provided.

Staff encouraged people to participate in activities within the service and in the local community.

The provider's complaints procedure was out of date and in need of improvement.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

People told us liked living at Flora Lodge and the atmosphere was friendly and relaxed.

There was no effective system or process in place to assess, monitor and improve the quality and safety of the services provided.

Some areas of the service in need of improvement had not been identified or addressed.

Flora Lodge

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 was planned to check 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.'

This inspection took place on 29 February 2016 and was unannounced.

The inspection team consisted on an inspection and a specialist advisor. A specialise advisor is a person with professional expertise in care and nursing. Our specialist advisor for this inspection had expertise in the care of people with mental health needs.

Prior to the inspection we reviewed the provider's statement of purpose and the notifications we had been sent. A statement of purpose is a document which includes a standard required set of information about a service. Notifications are changes, events or incidents that providers must tell us about.

We also contacted local authority commissioners who are responsible for funding some of the people using the service and asked them for their views about the service.

During the inspection we spoke with seven people using the service. We also spoke with the registered manager, two senior carers, two support workers, and, by telephone, the provider.

We looked at records relating to all aspects of the service including care, staffing and quality assurance. We also looked in detail at six people's care records.

Requires Improvement

Is the service safe?

Our findings

During our inspection, which took place during the day, there were sufficient numbers of staff on duty to meet people's needs. We saw that when people needed assistance staff were able to provide this promptly. Staff also had the time to talk and do activities with people, for example accompanying them when they went out into the local community. One person using the service said, "There's always someone around."

However when we looked at record we identified there were insufficient numbers of staff on duty at night. This was because one person using the service was temporarily on 24 hour one-to-one care. However there was only one member of staff on duty at night. This meant there were no staff assigned to support the other 12 people using the service.

We asked staff how this situation was being managed. They told us they stayed with the person needing one-to-one care and if they had to support anyone else in the service they took this person with them. They also said that they took this person with them when they did the 10pm medicines round.

This had the potential to put people as risk as it meant that the majority of people using the service had no routine support at night. It also meant that the person receiving one-to-one support, who had limited mobility, had to accompany staff around the premises when medicines were administered and at other times. This could put them at risk of falls and could not be seen to be safe.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were not enough staff on duty at night to keep people safe and meet their needs.

After we became aware of this situation we contacted the provider by telephone from the service to report our concerns. Following a discussion the provider agreed to increase staffing levels at night. By the end of our inspection senior staff had organised for this to be done. The provider told us the extra staffing at night would continue for as long as one-to-one staffing was needed for one person at night.

We looked staffing records to see how the provider had determined the suitability of staff employed at the service. The law requires providers to keep certain information with regard to the persons they employ. We found that in two instances the provider had not done this. The first staff member's file had no photograph, no proof of identity, and no satisfactory evidence of conduct in previous related employment. The second staff member's file had no proof of identity, no satisfactory evidence of conduct in previous related employment, and no employment history.

In addition there was no evidence that pre-employment checks had been reviewed in order to decide on a staff member's suitability for a position at the service and the provider had not taken into account potential risk nor carried out appropriate risk assessments. This meant that the provider had failed to carry out satisfactory pre-employment checks to determine the suitability of staff to work with the people using the service which meant we could not be sure people were safe.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider could not demonstrate that fit and proper persons had been employed to work in the service.

During our inspection we saw staff protecting people from risk while at the same time supporting and respecting their freedom. For example we saw staff accompanying one person around the premises as they were not safe to do this on their own, and discreetly observing people using the kitchen to make sure they were safe. The staff we talked with understood the type of risks people using the service might be subject to and how to minimise these.

However records showed staff did not always have the information they needed to keep people safe. For example, from viewing daily records and questioning staff, we found that one person using the service was at significant risk of physical injury and mental distress. Staff understood this and some measures had been put in place to minimise the risks. However the person's risk assessments and care plans had not been updated to reflect the current risks to the person. This meant that staff had nothing in writing to follow in terms of providing safe care to this person.

We also found there had been a number of incidents involving another person related to continence issues and behaviour that challenges. Although these were noted in daily records no risk assessments or care plans had been put in place to address this. There was no analysis as to the cause of these incidents or evidence of advice being sought from other health or social care professionals as to how to support the person in question. This meant that again staff had nothing in writing to assist them in supporting this person and we could not be sure that the care provided was safe or appropriate.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not assessed the risks to people's health and safety nor were they doing all that was reasonably practicable to mitigate such risks.

We talked with people about how they received their medicines. People said they were satisfied with how this was done. One person told us, "My medication is four times a day. The staff come round." We observed some people being given their medicines and staff did this safely, allowing people to take their time and have their medicines in the way they wanted them.

We found that improvements were needed to the way medicines were administered, recorded and stored. Staff had arranged for one person, who self-medicated, to keep their medicines in a removable plastic container in their room. This was a safety issue as the medicines could easily be removed from the premises and non-authorised people had access to them. When we brought this to the attention of the staff on duty they immediately arranged for the person's medicines to be moved a lockable wall-mounted cabinet which was also in the room.

One person using the service had been prescribed a medicine that requires them to have regular blood tests to ensure the medicine was working safely. We looked at blood testing records and found there were gaps in these so it was not clear whether the person in question had had their blood tested or not. We asked staff about these omissions and were told, "The resident sometimes takes himself to have his bloods done." While this is understood staff must still monitor this medicine and the accompanying blood tests to ensure the person in question is having their medicine safely.

A number of people using the service had been prescribed PRN (as required) medicines, for example analgesics for pain relief. Some people were able to ask for these medicines. For example one person

requested their PRN medicine during our inspection. Prior to administering it staff asked the person why they needed it to make sure it was being taken appropriately. However other people, due to fluctuating mental health needs and other mental capacity issues, might not always be able to request their PRN medicines. However, as there were no PRN protocols for staff to follow, it was unclear how staff were meant to know when to administer some people's PRN medicines.

This is also a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not protected from the risk of the unsafe management of medicines.

People told us they felt safe living at Flora Lodge. One person said, "It's alright her, it's a safe place to live and I feel ok." Another person commented, "I'm comfortable and feel at home here."

All the staff we spoke with could tell us how they would recognise potential signs of abuse. They also knew what to do if they had concerns about the well-being of any of the people who used the service. One staff member told us, "I would follow the policy and procedure, tell the manager, and if then nothing was done tell the owner, and if that didn't work go to social services."

Improvements were needed to the provider's safeguarding policy as it contained out of date information. It advised staff to report safeguarding concerns to CQC. Although CQC does need to be informed, the lead authority for safeguarding is social services but this was not mentioned in the policy. Nor were the police who also have a role if a criminal act is suspected.

Although the staff on duty did understand the role of social services and the police in safeguarding investigations the provider's policy on this told them something different. This could be confusing for staff and lead to delays if the policy was followed. We asked the provider to update the policy.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Records showed that one person using the service was subject to a DoLS authorisation due to deterioration in their health which had affected their mental capacity. But other people using the service had not been assessed with regard to certain decisions. For example, staff told us four people were unable to leave the premises unaccompanied due to safety concerns. However there were no records to show how this restriction had been agreed on, nor any evidence of best interests meetings being held, or of advice being sought from the local DoLS team as to whether this was appropriate or lawful.

Staff had some understanding of the Mental Capacity Act and Deprivation of Liberty Safeguarding but did not have the information they needed ensure that the human rights of all the people using the service were being protected. This was because mental capacity assessments had not been carried out as required.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not acted in accordance with the MCA with regard to people's consent to the care provided.

All the staff were met were enthusiastic about their roles and doing their best to understand of the needs of the people they supported. During our inspection they cared for people effectively and we saw examples of good practice as staff were effective in the way they met people's needs.

Records showed that some staff had had recent training, for example in 'safe handling of medicines') and 'mental health awareness'. Staff told us they had found these distance learning courses, provided by a local college, useful for their work.

However records showed there were gaps in the provider's training programme and not all staff had been trained in the areas considered essential to people working with those with mental health needs and learning disabilities.

For example one member of staff, despite being employed in a service specialising in the care of people with these needs, had had no training in either areas with the exception of a course in 'challenging behaviour'. Another staff member was aware of safeguarding process but records showed they had not been trained in

this.

Records also showed that some people using the service were living with conditions such as epilepsy and dementia. Yet only one staff member had been trained in the former, and three in the latter.

These gaps in training meant that some staff members might not have the skills and knowledge they needed to carry out their roles and responsibilities effectively. We discussed this with the registered manager who agreed to review the training programme and take action to ensure all staff had the training they required.

People told us they liked the food provided. One person told us, "All the staff are brilliant at cooking." During our inspection a staff member prepared a home-cooked lunch with using fresh produce. Some people using the service called into the kitchen to find out what for lunch. Others sat in the adjoining dining room socialising with each and drinking tea while waiting for their meal. This made for a homely, family atmosphere.

People told us they had plenty of choice as to what they ate. One person told us, "There's set meals but if you don't like it them you can have something else." Another person commented, "If you don't like something just have something different." People told us they could have a cooked breakfast if they wanted. One person said they had made a cake the previous day with staff which they enjoyed.

Staff knew people likes and dislikes with regard to their diet and told us they tried to encourage people to eat healthily. However there was limited information in care records about people's needs with regard to their nutrition and hydration and most people had not been assessed with regard to their dietary requirements. We discussed this with the registered manager who agreed to review people's needs in this area to ensure staff were aware of these so they could provide appropriate support.

One person told us how staff supported them to access healthcare services. They told us that staff used to take them in the car or on the bus to their hospital appointments, but they could now go on their own. They told us they were pleased staff had supported them to manage their own healthcare in this way.

Staff were able to explain how people's ongoing healthcare needs were met and how they would support people to access healthcare if they needed to. One member of staff told us, "If there are signs or symptoms of a resident not being well, I contact the GP or in an emergency I would not hesitate to ring 999."

During our inspection we saw staff assessing whether or not a person using the service needed to see their GP due to a healthcare issue. Staff decided they did need to do this and made them an appointment for that day. This was an example of staff ensuring a person's healthcare needs were met.

Requires Improvement

Is the service caring?

Our findings

The staff were caring and we observed they had developed good relationships with the people using the service. We saw them reminding people that Flora Lodge was their home and staff were there to provide them with support. One person told us, "I feel happy here and staff are good to me."

Staff told us they liked working at the service because of the amount of involvement they had with the people using the service. One staff member told us, "We get to spend time with the residents and take them out." Another staff member commented, "My favourite thing about working here is that we really get to know the people who live here." We heard that one member of staff had given up their day off during a holiday period so they could take some of the people using the service to a party. They told us, "I didn't want them to miss out."

The people using the service were also caring towards each other. One person had been helping staff to support someone who was unwell by keeping them company and playing board games with them. Another person was seen assisting another person to get a cup of tea.

Most of the staff had worked at the service for several years which had enabled them to build up close therapeutic relationship with the people using the service. We saw that people interacted well with staff and had no hesitation in approaching them if they needed assistance.

Staff sat with people, talked with them about their interests, and prompted them to express how they were feeling. This was evidence of staff having developed therapeutic relationships with the people using the service. The therapeutic relationship is central to providing care to people with mental health needs and can help to promote awareness and trust, and enrich people's quality of life.

During our inspection we saw staff involving people in making decisions about their care and support and offering them choices. For example, people were asked about their wishes with regard to personal care, meals and activities. Staff always sought people's agreement before any care was provided.

Staff told us people were involved in care planning and review. We discussed this with some people using the service and they had no recall of being involved in the process. One person said, "I don't think I have."

We looked at three care records and could find no evidence of people's involvement. The records included sections where the people using the service had to opportunity to sign their name to agree to their care but these were blank.

We discussed this with the registered manager who agree to improve the process where people using the service were involved in care planning and review and ensure there were records in place to show this was being done.

During our inspection we saw that staff treated people with dignity and respected their privacy. For example,

staff did not enter people's rooms without asking their permission first and were always polite and courteous when they spoke with them.

However some daily records were written in a disrespectful way. For example one person was referred to as 'grumpy' and another as being 'in a very unpleasant mood'. These are value judgements and could be seen as offensive to people who may be experiencing symptoms related to their mental health needs or learning disabilities. We discussed this with the registered manager said the derogatory comments may have been the result of staff not knowing how to write about people respectfully. She agreed to address this as a training issue.

Requires Improvement

Is the service responsive?

Our findings

The service was not consistently responsive.

People told us the care and support provided was responsive had helped them to cope with their mental health needs and other issues. One person told us, "The staff help me to get better." Another person commented, "I've improved since I've been here."

We saw that staff had encouraged people to develop the skills they needed to live more independent lives. For example, one person told us that since coming to the service they gained the confidence to use public transport and go out into the local community unaccompanied. Another person had acquired the skills needed to self-medicate, access healthcare services themselves, and shop, cook, and do their own laundry. These examples showed how some people had benefited from using the service.

Staff had a good understanding of how best to communicate with the people they supported and knew the signs to look out for if a person was unwell. For example, one staff member told us how a person's demeanour might change if they wanted to be left alone and staff understood and respected this. However they also knew the signs that this person gave when they wanted staff to talk with them. During the inspection we saw staff use a range of methods to communicate with people and give them a sense that they mattered and belonged.

We reviewed six sets of care records. They were not personalised and contained little evidence of people's likes and dislikes and how they wanted their care and support provided. This meant that staff did not have the written information they needed to provide individualised care to people using the service.

Although the staff on duty were aware of people's needs the knowledge they had was not in people's care records. This could put people at risk of poor care if, for example, extraordinary circumstance led to staff who did not know the people using the service having to support them. We discussed this with the registered manager who agreed to develop more personalised care plans for people including how they wanted their care and support provided during a typical day.

Staff encouraged people to participate in activities within the service and in the local community. We asked one staff member about one person's weekly activity programme. They were able to tell us, without hesitation, every activity this person took part in which including both recreational and educational activities. This demonstrated their knowledge of what this person liked to do and how the activities in question promoted the person's independence and enabled them to live a full life.

People using the service told us they took part in a range of activities including being members of a community gardening programme, swimming, shopping, pottery, discos, walks, and playing board games. One person showed us the puzzles they were doing in their room and told us they enjoyed these. In the afternoon of our inspection some people using the service and staff watched a music programme on

television and talked about it together.

People told us that if they had a complaint they would tell the registered manager or any other member of staff. One person said, "I'd tell the staff and they would sort it out because they always help me if there's a problem."

The provider's complaints procedure was out of date. It referred to the Commission for Social Care Inspection, an organisation that no longer exists, having been replaced by the CQC. It also referred to outdated legislation. It made no reference to the local authority's role in dealing with complaints or the ombudsmen, nor to any advocacy organisations that could assist a person using the service to make a complaint. This meant that people would not be able to follow this procedure if they wanted to make a complaint. We discussed this with the registered manager who agreed to re-write the complaints procedure as a matter of priority.

Requires Improvement

Is the service well-led?

Our findings

People told us liked living at the Flora Lodge. One person said they thought it was a good place to live because there were no restrictions on them. They said us, "It's open here – all the doors are open." Another person commented, "It's like home. The staff are like family. I can come and go as I like but if I need help the staff are always here. It works for me."

The service had a friendly and relaxed atmosphere and people appeared content. Some people were relatively independent and came and went during the day. When staff saw them they checked if they needed any support but otherwise enabled them to choose how they spent their time. Other people needed more support from staff and this was provided both in the service and out in the local community.

Staff told us they felt there was an open culture amongst the staff team and said the registered manager and provider supported them. One member of staff said, "I know I can go to them whenever I want." Another member of staff told us they felt they could discuss the service with the manager and provider and they would be listened to if they did this.

The registered manager told us the provider was supportive and open to ideas on how to develop the service. She said the provider visited the service once a week to work alongside staff and spend time with the people using the service, on occasions taking them out to a café. Staff said both the registered manager and the provider got on well with the people they supported and treated them like family.

We looked at the results of the provider 2015 quality assurance survey. Records showed that a total of seven questionnaires had been completed and returned. These were undated so we could not confirm when they had been filled in. The questionnaires showed that people were generally satisfied with the service and some positive comments were made, for example "I like it here." There was no evidence of staff, relatives, or other stakeholders being asked for their views.

When we looked at how well-led the service was. We found there was no effective system or process in place to assess, monitor and improve the quality and safety of the services provided. This meant that some shortfalls had not been identified or addressed.

For example, records showed that the registered manager reviewed care plans monthly. We looked at one person's care plans and saw they had been reviewed 12 times between March 2015 and February 2016. With the exception of once, when the person's medicines had been amended, every review had stated 'no changes'. However daily records showed that there had been changes in the person's needs over this time relating to behaviour that challenges us, but care plans had not been updated to show these.

A second person's care plans had also been reviewed regularly but had not been updated despite recent significant events in the person's life and changes to their physical and mental health needs. This showed that the system of care plan review was ineffective meaning that staff did not have the up-to-date information they needed to provide good quality person-centred care to the people using the service.

In addition the care plans reviews had not identified they were undated and unsigned so it was unclear when they were written and by who. Nor had the reviews identified that on occasions disrespectful language had been used to describe the demeanour of some of the people using the service.

The provider's policies and procedures had been audited and reviewed in 2015. However this audit had not identified that both the provider's safeguarding policy and complaints procedure were out of date and contained incorrect information.

We also found that recent events at the service had not always been well-managed. For example, when we inspected there was only one member of staff on duty at nights. However there was no formal plan, instructions, or risk assessment for staff to follow with regard to lone working at night. This meant staff were not being supported to manage the situation in a safe manner.

Some areas of the premises were in need of improvement. We found that two automatic door closers needed replacing as did the intumescent strips on some of the doors. This meant there was an increased fire risk at the service. We also found that one person's bedroom sink was blocked and full of stale water that could not drain away and had been like that for a few days. In addition some areas of the premises were in need of re-decoration or refurbishment in order to create a more homely and therapeutic environment for the people using the service.

We concluded that the provider's audits, where they existed, were ineffective as they had not identified areas of the service in need of improvement.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have an effective system in place to assess, monitor and improve the quality and safety of the service provided.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not acted in accordance with the Mental Capacity Act with regard to people consenting to the care provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not assessed the risks to people's health and safety nor were they doing all that was reasonably practicable to mitigate such risks. People were not protected from the risk of the unsafe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have an effective system in place to assess, monitor and improve the quality and safety of the service provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff on duty at night to keep people safe and meet their needs.