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Applegarth Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Applegarth Care Home is registered to provide accommodation and personal care for up to 20 older people and people living with dementia. On the day of our visit there were 20 people living in the service.

The service had a registered manager. 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 and associated Regulations about how the service is run. The registered manager was not present during our visit. The proprietor informed us the registered manager had decided not to return back to work after an absence of leave and was working out their notice period. However, a new home manager had recently been employed, who was present throughout our visit. During the registered manager's leave of absence, the deputy manager took over the responsibility of running the service.

We previously inspected the service on the 6 and 8 July 2015. The service received an overall rating of 'good' with 'requires improvement' in the key question, is the service well-led. This was because there was not a registered manager in post, which is a legal requirement.

We found the provider did not make sure managerial staff were appropriately supported and obtained further qualifications that would enable them to perform their job role.

Actions in response to medicines audits were not always promptly addressed. We have made a recommendation for the service to seek current guidance on how to respond promptly to findings from medicines audit.

People did not always receive effective care because there were no assessments in place to assess whether people, specifically those who were unable to communicate, were in pain. We have made a recommendation for the service to seek current guidance in relation to pain protocols for people who find it difficult to communicate.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible; even though there were policies and systems in place to enable them to do this.

Reviews of care were regularly undertaken by staff however; we saw no records of meetings held with people or their relatives as part of these reviews. We have made a recommendation for the service to seek nationally evidence-based guidance for how to carry out reviews of care.

Initial assessments were carried out but were not available in people's care records. We have made a recommendation for the service to seek current guidance on how to make sure initial assessments are easily accessible and available in people's care records. We found the service did not always make sure people

had access to information they needed in a way they could understand.

The service did not maintain accurate, complete and up to date records in respect of people who used the service. The provider was not registered with the Information Commissioner's Office (ICO), as legally required. Quality assurance systems in place were ineffective in identifying when quality and safety was being compromised.

People were protected from abuse and improper treatment because staff knew what action to take when they suspected abuse had happened. Safe recruitment practices were in place. Sufficient staff were employed that made sure people's care and support needs can be met. People were protected against hazards such as falls, slips and trips and risk management plans were in place when people's personal safety had been assessed.

A relative felt staff had the knowledge, skills and experience to carry out their job roles. They commented, "They (staff) are very experienced dealing with dementia."

Staff were appropriately supervised. People were supported to maintain a balanced diet; their nutritional needs were regularly assessed and they had access to health and social care professionals.

Relatives felt staff were caring. Comments included, "I have never once felt any negative attitudes from staff. Staff interacts with her (family member) in an endearing way and they are very respectful." A written compliment from another relative stated, "Thank you for the fantastic care, kindness and patience."

People's privacy and dignity was respected and staff promoted their independence. Staff demonstrated a good knowledge of people's needs and gave examples of how they supported people with their care. Information relating to people's personal data and records relating to the management of the service was kept secure.

Care plans were personalised and contained information about people's likes, dislikes and the people who were important to them. We observed staff carrying out care that was person centred. People's social needs were met. This was because staff were encouraged to interact meaningfully with people and record their interactions. People received consistent, co-ordinated and person-centred care when they moved in between services. There was a system in place to make sure people could make a complaint about their care and treatment.

People and relatives felt the service was well managed. Comments included, "It's a very nice place here" and "I think they are all approachable. I know everyone by name." Staff felt that management were friendly and approachable.

People and those important to them had opportunities to feedback their views about the home and quality of the service they received. Complaints and concerns were taken seriously and used as an opportunity to improve the service.

We found breaches of regulations as a result of this inspection. 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?

Good

The service was safe.

Safe recruitment practices were in place.

Sufficient staff were employed that made sure people's care and support needs can be met.

People were protected against hazards and risk management plans were in place when people's personal safety had been assessed.

Is the service effective?

Requires Improvement

The service was not always effective.

Effective care was not always given to people who were unable to communicate when they were in pain.

People were not always supported to have maximum choice and control of their lives.

People received care from staff who were appropriately inducted; trained and supervised.

People were supported maintain a balanced diet and their nutritional needs were regularly assessed.

People had access to health and social care professionals.

Is the service caring?

Good

The service was caring.

Relatives felt staff were caring.

People's privacy and dignity was respected and staff promoted their independence.

Staff demonstrated a good knowledge of people's needs and gave examples of how they supported people with their care.

Information relating to people's personal data and records relating to the management of the service was kept secure.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There were no assessments in place to assess whether people, specifically those who were unable to communicate, were in pain.

Initial assessments were carried out but were not available in people's care records.

The service did not always make sure people had access to information they needed in a way they could understand.

People received consistent, co-ordinated and person-centred care when they moved in between services.

There was a system in place to make sure people could make a complaint about their care and treatment.

Is the service well-led?

Requires Improvement

The service was not well-led.

The provider did not make sure managerial staff were appropriately supported and obtained further qualifications that would enable them to perform their job role.

The provider was not registered with the Information Commissioner's Office (ICO), as legally required.

Quality assurance systems in place were ineffective in identifying when quality and safety was being compromised.

The service sought feedback from people and took appropriate action in response to them.

Applegarth Care Home

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.

This inspection took place on 26 and 27 September 2017. The inspection team consisted of an inspector and a bank inspector.

Before the inspection we reviewed all the information we held about the service. We looked at notifications the provider was legally required to send us. Notifications are information about certain incidents, events and changes that affect a service or the people using it.

We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at all the information we have collected about the service.

We spoke with a visiting health professional during our visit.

During this inspection we were not able to speak at length with people, due to their dementia. We carried out observations of care practice throughout our visit. We spoke with one person; one relative; one care worker; two senior care workers; activity co-ordinator; deputy manager; home manager; operations manager and the proprietor. We looked at three care records; three staff records; seven medicine administration records and records relating to management of the service.

Good

Is the service safe?

Our findings

We viewed an audit carried out by a pharmacist on 25 February 2017. The provider completed a list of people's medicines found in front of the medicine administration records (MARs). The pharmacist noted this list had not been updated following changes. We viewed the lists and found this practice had still continued as it did not document changes in people's medicines. We recommend the service seek current guidance on how to respond promptly to findings from medicines audit.

People were protected from abuse and improper treatment. This was because staff knew what action to take when suspected abuse had occurred and had attended the relevant training. Comments included, "If a resident tells me a member of staff hit them, I would report this immediately to my manager" and "I have attended safeguarding training and we looked at signs such as changes in people's personality and bruising." A view of staff training records confirmed what the staff member had told us. A safeguarding adults policy was in place which covered amongst others, how staff could prevent abuse from happening and what to do when abuse happened. A staff member commented, "I have access to the safeguarding policy if I need it."

People were protected against hazards such as falls, slips and trips. A relative commented, "When they (staff) moved her it has been with a hoist safely." A staff member supported this by stating they had attended training on how use a hoist. They commented, "We make sure the area is clear (if people are walking around) and check that equipment is in good working order. Any problems are reported to the maintenance staff."

Risks to people's personal safety had been assessed and plans were in place to reduce these risks. For example, we viewed the risk assessment of a person who was assessed as high risk of malnutrition. Care records showed the person's weight and food intake was regularly monitored to ensure the identified risk was reduced. Another person was assessed as high risk of skin breakdown. The service had obtained an air flow pressure relieving mattress from the community nursing service. This air mattress automatically self-adjusted for the weight of the person. Records showed regular checks were carried out on the equipment to ensure it was in working order.

Safe recruitment practices were followed before new staff were employed to work with people. Checks were made to ensure staff were of good character and suitable for their role.

There was sufficient staff to meet people's needs. A relative commented, "Yes, even though they (staff) are always busy, they always have time to offer you coffee or tea." Staff comments included, "Right now we have 20 residents before it was 18. We work well as a team and are able to cope" and "Sometimes it depends on the day. When a person is poorly we could do with extra staff." The deputy manager explained that although the provider assessed the individual dependency levels of people, this was not explicitly linked to staffing levels. However, staffing was constantly reviewed following feedback with staff and due to this the provider had recently agreed to introduce a 'twilight shift'. This was because it had been identified as a time when extra staffing would be required. The deputy manager said that additional staff was also arranged if a person

needed to attend an external appointment such as a hospital visit. Lunch time was another area under consideration by the provider to increase staffing as it may take approximately 30 to 40 minutes to assist someone with their meal. This meant the service had taken appropriate measures to ensure there were enough staff to meet people's care needs.

There were arrangements in place to keep people safe in an emergency and staff understood these and knew where to access the information. Fire instructions in case of fire were located in people's rooms and in communal areas. Records showed fire testing and drills regularly happened.

There were soap dispensers in communal bathroom/toilet areas. The service environment was clean and fresh and cleaning staff were visible throughout the day. Laundry was completed on site in a building away from the main building. Staff were observed wearing personal protection equipment (PPE) appropriately.

Requires Improvement

Is the service effective?

Our findings

Staff spoke with us about a person who suffered from contractures. This is a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints. We found this was not fully reflected in the person's care records. The person was prescribed pain relief medicine on an, as required basis. However, care records did not show how staff assessed the person's pain. We spoke to management about this who agreed to explore pain risk assessments, specifically for people who were not easily able to communicate their needs. We recommend the service seek current guidance in relation to pain protocols for people who find it difficult to communicate.

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 so that they can receive care and treatment when it 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).

We checked whether the service was working within the principals of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Records showed the provider had made DoLS applications for people where they were unable to make specific decisions such as, use of bed safety rails, locked door system, lap belts on wheel chairs. For example, we saw an application submitted for a person who had bed safety rails in use when they were in bed. However, we noted there was no mental capacity assessment to show whether the person could make a decision in regards to having the bed safety rail installed. We saw no record of a best interest meeting that involved the person, their relatives or other health professionals, to look at the least restrictive options. Instead the person's care record only described their cognitive and psychological needs.

In another example, we looked at the care record for a person who was on a pureed diet. Staff told us this decision was made because they had noticed the person was better able to manage this type of modified diet. Care records did not show the rationale for a change in the person's diet and the person or their relative's involvement in making this decision. There were no records to show the provider had sought and obtained further advice from a relevant health professional. The meant people's rights were not protected because the provider did not always act in accordance with the MCA.

This is a breach of Regulation 11 of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014.

A relative felt staff had the knowledge, skills and experience to carry out their job roles. They commented, "They (staff) are very experienced dealing with dementia."

Staff told us they had received induction, training and skills they needed to meet people's needs. Comments included: "I attended 12 weeks of induction which included one week of shadowing. In September I had training which covered infection control and challenging behaviour. I love video learning" and "If you want training they (management) will organise it." We viewed the staff training matrix last updated 15 September 2017 and saw staff received appropriate training which was up to date. This meant people were supported by staff who were appropriately inducted, trained and supervised.

People were supported to eat and drink and to maintain a balanced diet. This was observed during the lunch time period and at various parts of the day. Staff ensured the tables were appropriately set and people were offered a choice of meals and drinks. People ate in a relaxed environment and visual menus were available on each table to support people with their choices. Throughout the day people were offered drinks. Care records showed how staff should support people with their meals and what aids should be used, such as plate guards, to enable a continued level of independence.

People's nutritional needs were assessed. People's weight was regularly monitored. Staff told us the electronic care system enabled them to identify if people were at risk of choking. Care plans viewed supported this.

People had access to health and social care professionals. Records confirmed people had access to a GP, dentist and an optician and could attend appointments when required. We saw medicine reviews were on-going by with the GP. A visiting healthcare professional told us service contacted the community nursing services appropriately and they had no concerns.

Good

Is the service caring?

Our findings

Relatives felt staff were caring. A relative commented, "I have never once felt any negative attitudes from staff. Staff interacts with her (family member) in an endearing way and they are very respectful." We saw a written compliment from another relative which stated, "Thank you for the fantastic care, kindness and patience."

People were relaxed and smiling and interacted with staff through their body language, posture, smiling and use of short sentences. Staff were attentive and responded to them with respect and due diligence. When people were not able to communicate their needs verbally, for example when expressing discomfort, staff knew them well enough to be able to interpret what they were trying to communicate.

Staff demonstrated a good knowledge of people's needs and gave examples of how they supported people with their care. For instance a staff member commented, "[Name of person] is not mobile. We use a hoist to move them and place them in their wheelchair." Care records supported this and showed how staff should support people in various aspect of care such as, mobility, eating and drinking hygiene and communication styles.

People's preferences and personal histories were known to staff. When continuing to talk about the person they supported the staff member commented, "[Name of person] loves music and likes listening to the radio. They have a nephew and friends who regularly come to see them." During our visit people received visits from family and friends. We saw there were no restrictions placed on the times visitors could attend.

People's confidential personal information was securely protected and other confidential management information was placed in lockable cupboards or protected on computers only accessible by passwords. A staff member commented, "I always discuss personal information in the office."

Staff told us how they involved people in their care. For example another staff member commented, "I would ask [name of person] what time they would like to get up in the morning and how they would like to be helped." A relative told us they felt involved in decisions concerning their family and commented, "They (staff) will call me if they have any concerns."

People's privacy and dignity was respected and staff promoted their independence. For example, staff told us they made sure doors were closed and curtains were drawn when they carried out personal or intimate care. A staff member gave an example of how they encouraged a person to be independent. They commented, "There was a day when a person said they couldn't brush their teeth. I encouraged them to try and reassured them that I was here if they needed help." This was supported by care records which detailed what people could or could not do and how staff should assist them.

The deputy manager had completed the Skills for End of Life Care course in order to make sure people at the end stages of their lives were treated with dignity, respect and compassion. They had already acknowledged relevant training was required for more staff and was in the process of arranging this.

Do not attempt to resuscitate (DNARs) were in people's care records where applicable. These forms were completed by a medical professional when they believed cardiopulmonary resuscitation (CPR) would unlikely be successful.

Requires Improvement

Is the service responsive?

Our findings

The provider had installed a new electronic person centred care system that was installed on 5 July 2017. The person centred care system did not have the facility to allow staff to document reviews of care held with people, their family members and health professionals. We asked management to provide us with written records of care reviews that had taken place. The provider was not able to provide us with this information during or after our visit. This meant people or those represented them were not involved in decisions relating to their care. We recommend the service seeks nationally evidence-based guidance for how to carry out reviews of care.

Initial assessments were carried out and included people's immediate and longer term needs. For instance, these covered cognition; communication; behaviour; physical needs; nutritional needs; social needs and medical histories. We noted initial assessments were not always included on the person centre care system. The deputy manager explained that they were still in paper format and had been archived. We recommend the service seek current guidance on how to make sure initial assessments are easily accessible and available in people's care records.

We looked at whether the service ensured people had access to information they needed in a way they could understand it and were compliant with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Information displayed in the home was not always in a format people could understand. For example, the service's complaints procedure was displayed in the communal area and in people's rooms. The information displayed was in small print and appeared to be written for people's relatives rather for people who used the service. We recommend the service seek current practice and best practice on how to display information for people with a disability or sensory loss.

Care plans were personalised and contained information about people's likes, dislikes and the people who were important to them.

People had a keyworker. A key worker is a named member of staff that was responsible for ensuring their care needs were met. This meant people received care and support from staff who had a good understanding of their needs and their families and friends had a named staff member to discuss any concerns with.

Care records were often task focused however: during our visit we observed staff's interaction with people was person centred. For instance, we observed one person whilst sitting in their wheelchair undid their lap belt. However, as staff was monitoring the person, their risk of falling had been minimised. In another example, we observed one person who was restless and whose behaviour affected those in their immediate surroundings, responded well to staff supporting them to walk in the garden. We saw other people who had become anxious in the person's presence, became more relaxed.

People were supported to take part in social activities of their choice. A wide variety of activities were on offer and was visibly displayed in the main lounge. People were able to exercise their choice, as some chose to remain in the main lounge whilst others chose to participate in the morning activity. The activities co-ordinator told us they maintained a record of people's participation in activities which included, short interactions. Staff were encouraged to interact meaningfully with people and recorded these interactions. Our observation of the activity sessions and a view of care records confirmed what the activity co-ordinator had told us.

The service had a cat and we observed several people interacting with it throughout our visit. Staff told us one person had taken it upon themselves to ensure the cat was fed and this had given them a sense of purpose. The provider had been recognised by The Cinnamon Trust, a national charity supporting the elderly and their companion pets, as a pet friendly home. We saw a document from The Cinnamon trust giving the home the highest rating.

Detailed hospital 'passport' information sheets contained people's photograph; personal details such as date of birth, contact details for significant others, GP, medical diagnosis, a summary of their personal needs and records of daily notes leading up to their admission. This made sure people received consistent, co-ordinated and person-centred care when they had to move in between services.

There was a system in place to make sure people could make a complaint about their care and treatment. A complaints policy and procedure was in place and staff told us what action they had taken when they had received complaints. What they told us was in line with the complaints policy.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection on the 6 and 8 July 2015 we found there was no effective management in place and no effective system to enable the service to analyse any trends and the care plan audits was ineffective in practice.

Although the service had a registered manager, they had taken a leave of absence for approximately a year. A statutory notification was sent to the Care Quality Commission (CQC) by the registered manager notifying us they would be absent from the service from 15 August 2016. In their absence the deputy manager had taken responsibility for running the service. The proprietor informed us the registered manager had recently decided not to return back to work and was currently working out their notice. A new home manager had recently been recruited and was present during our visit.

We spoke to the deputy about the support they had received during this period. The deputy manager showed us a training schedule covering May 2016 to July 2016 given to them when they secured the post as a trainee assistant manager. This detailed the subject areas they had to be knowledgeable in; what actions they had to take to make sure the service was compliant and completion dates. The deputy manager told us during this period they had to shadow the registered manager and received additional support from the human resources (HR) and compliance manager.

Although the deputy manager had received guidance and feedback from the HR and compliance manager, they were unable to provide us with records to show the on-going support and supervision received during the year they had been running the service. We noted there was no assessment of how effective their understanding of regulatory compliance was and any training received at managerial level. For instance, we noted the deputy manager had completed the same level training for MCA as care staff and therefore, their knowledge of specific actions that was required when a person's freedom was being legally restricted was minimal. Therefore, mental capacity assessments and best interest meeting were not consistently undertaken when people were unable to make specific decision. This meant the provider did not make sure managerial staff was appropriately supported and obtained further qualifications that would enable them to perform their job role.

This is a breach of Regulation 18 of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014.

Quality assurance systems in place were not effective in monitoring the quality of service being delivered and the running of the home. We found an area of concern related to records.

DoLS applications shown to us had post-it notes regarding progress of applications. For example, when health professionals had visited. This meant there was a margin for confusion about the provider's knowledge of any progress of applications, as the post-it notes could be easily dislodged.

End of life wishes and preferences were not always recorded. We found no records of discussions held with

people or their relatives in relation to their wishes and preferences in regards to end of life care. Staff told us they had previously discussed people's end of life wishes with the person or their significant other but this had not been integrated into new electronic care plan system. The provider told us they were already aware of this issue and they were looking into ways to record a person's communication about their wishes.

A person was identified as not being able to use the call bell system to request assistance and had behaviour that challenged which may present when personal care assistance was required. Care records did not record if the person was checked at specified times and how staff should approach the person if they were agitated. The note on their record simply stated 'use distraction.' We observed staff knew the person well and approaches made to the person were effective in meeting the person's needs.

In regards to medicine managements, records showed us staff had checked the office room temperature and fridge temperature but staff did not record actual fridge temperatures. This was because the provider paperwork had not directed staff to record actual fridge temperatures. One staff member was unable to show us how they recorded the temperature. Records showed the current temperatures were within safe guidance for medicine management.

This showed the service did not maintain accurate, complete and up to date records in respect of people who used the service.

Quality assurance visits were regularly undertaken however progress against plans to improve the quality and safety of services did not happen as appropriate action was not taken without delay. A policy was in place for the administration of emollient creams where an individual was prescribed this. Staff administered the creams (often during a personal care intervention) and entered this into the electronic system when completed. However whilst the system showed staff administered a cream, it did not have the details which part of the body the cream had been administered. In another example, a person had a prescribed transdermal patch applied, staff did not record site of application. This meant the site of application of people's patches may not be applied in line with the manufacturer's guidance and may be ineffective. The provider had completed a list of people's medicines found in front people's MARs. We viewed people's MARs and found medicine changes had not been updated. On one MAR we found incorrect information about why a medicine was being administered. We viewed a medicines audit carried out by a pharmacist on 25 February 2017 which highlighted the concerns above but had not been addressed by the provider at the time of our visit. This meant the service's quality assurance system was ineffective in identifying when quality and safety was being compromised.

This is a breach of Regulation 17 of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014.

Actions in response to medicines audits were not always promptly addressed. We have made a recommendation for the service to seek current guidance on how to respond promptly to findings from medicines audit.

During our visit we found the provider was not registered with the Information Commissioner's Office (ICO). The Data Protection Act 1998 requires every organisation that processes personal information to register with the ICO unless they are exempt. We discussed this with the proprietor and the operations manager and was told this would be immediately addressed.

People and relatives felt the service was well managed. A person commented, "It's a very nice place here." When referring to the leadership of the service a relative commented, "I think they are all approachable. I

know everyone by name."

Staff described the culture of the service as "Friendly, we have lots of laughs, singing and can approach the manager any time." They told us they felt confident to raise concerns. Another staff member commented, "If I suspect wrong doing, I will speak out and tell the manager. If they don't do anything about it, I will go higher."

People and those important to them had opportunities to feedback their views about the home and quality of the service they received. Minutes of residents meeting recorded people being asked for feedback on areas such as, staff; cleanliness and food. People were positive in their feedback and where people provided suggestions, the deputy manager responded with what action would be taken. We saw the minutes of a 'family' meeting held on 25 August 2017 held with the proprietor, senior management and people's relatives. We noted relatives were given the opportunity to express their opinions and provide feedback on various aspects of the service.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. A view of the complaints register showed the provider logged complaints and their responses, times taken to respond and outcomes. The provider's response to complaints received, valued the comments raised by the complainants with a view to service improvement and to avoid repeat complaints.

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 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 There were no records of best interest meetings that involved the person, their relatives or other health professionals, to look at the least restrictive options.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service did not maintain accurate, complete and up to date records in respect of people who used the service. The service's quality assurance system was ineffective in identifying when quality and safety was being compromised.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not make sure managerial staff was appropriately supported and obtained further qualifications that would enable them to perform their job role.