Southern C C Limited

The Meadows Nursing Home

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 was an unannounced comprehensive inspection which took place on 3, 4 and 13 October 2017. This inspection was in to response to information of concerns received, and raised by relatives of people living at the home.

The provider of The Meadows is registered to provide accommodation with personal and nursing care for up to 36 people. Care and support is provided to people with dementia, personal and nursing care needs. Bedrooms, bathrooms and toilets are situated over two floors with stairs and passenger lift access to each of them. People have use of communal areas including lounges and dining rooms. At the time of this inspection 35 people lived at the home. The home is split into different areas The Pines and Willows provide nursing care for people and on the first floor The Beeches specialises in dementia care.

There was a manager who had just started their employment but was not yet registered with the Care Quality Commission. They were present at the three days 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 of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People did not always feel safe because there were insufficient staff to care for them. Many were agency staff who people felt did not always understand or know their needs. People's daily records were not completed promptly. People were not always given a choice of food. The monitoring of people's fluid and food intake was not always completed in a timely manner.

Staff did not always receive supervisions, so were not given opportunity to reflect on their practice and identify their training needs. Not all staff had the skills or training to support people living with dementia. People were not supported to maintain their hobbies and interests. There was a lack of specialist activities available for people living with dementia.

People's consent was sought by staff and where necessary people and their families had been consulted on their care.

People told us they didn't always enjoy the food on offer. A care staff member was standing in for the cook, as there was a staff vacancy. The food offered was sometimes difficult for people living with dementia to eat. The monitoring of people's fluid and food intake was not always completed in a timely manner.

People liked the staff that cared for them; however people felt the inconsistency of staff made it difficult for staff to understand their care needs. People's privacy and dignity was not respected.

People and their relatives knew how to make a complaint.

Staff reported accidents and incidents to the office however; the management team did not review them to ensure appropriate action had been taken and to reduce the risk of incidents happening again.

Frequent changes in the management of the home left staff feeling unsupported. Staff changes meant that regular checks of the home did not happen. Systems in place to assess and monitor the quality of the service provided were not effective. The provider failed to identify risks and keep people safe.

During this inspection we found significant shortfalls in the quality of the care being provided. We found the registered provider to be in breach of five regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

People' s access to staff was limited because there were not enough staff to respond to people's needs. People's health and risks to their health were not fully understood by staff and there was a reliance on agency staff.

Staff failed to recognise environmental hazards that could put people at risk from harm.

Is the service effective?

Requires Improvement

This service was not always effective.

People were cared for by staff that were not supported and supervised regularly.
People were not supported by staff that had not been training in dementia care.
People had access to health professionals when they required in order to maintain their health and wellbeing.

Is the service caring?

Requires Improvement

This service was not always caring.

People were not always treated with dignity and respect. People told us they liked the staff that cared for them, but were unable to establish relationships with care staff because of the high use of agency staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not receive support to participate in activities or to pursue their interests.
Care plans were not sufficiently detailed and did not give the staff the information they needed to care for people in the way they liked.

Is the service well-led?

Requires Improvement

The service was not always well led.

People's care and the quality of care had not been reviewed and updated regularly. People's choices were not adequately sought. The registered provider did not have adequate systems to ensure people's care was consistently monitored. □

The Meadows Nursing 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. At the last inspection in July 2016 the service was rated as good.

This was an unannounced comprehensive inspection which took place on 3, 4 and 13 October 2017 and was completed by two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using, or caring for someone who uses, this type of service and has knowledge about people living with dementia.

We brought this inspection forward due to the information and concerns received about the care provided. As part of the inspection we considered the concerns we had received and other information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us by law.

We requested information about the home from the local authority, clinical commissioning group and Healthwatch. The local authority and clinical commissioning group has responsibility for funding people who lived at the home and monitoring the quality of care people received. Healthwatch is an independent consumer champion, which promotes the views and experiences of people who use health and social care.

During our inspection we spent time with people in the different communal areas of the home. We spoke with 13 people who lived at the home, two relatives, six staff members, the maintenance person, two registered nurses, the manager and the quality assurance officer.

Many of the people who lived at the home were not able to tell us in detail, about how they were cared for

and supported because of their complex needs. However, we used the short observational framework tool (SOFI) to help us assess whether people's needs were appropriately met and to identify if people experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We spoke with two relatives of people who lived at the home by speaking with them when they visited their family member. We did this to gain people's views about the care and to check standards of care were being met.

We looked at a range of documents and written records including four people's care records, staff training records and minutes of meetings with staff. We saw the checks made by senior staff on the administration of people's medicines. In addition, we looked how complaints processes were promoted and managed.

We also looked at information about how the provider and manager monitored the quality of the service provided and the actions they took to develop the service people received further.

Requires Improvement

Is the service safe?

Our findings

At this inspection we found people who lived at the home could be at risk of harm. This was because risks to people's safety had not been identified with appropriate actions put in place to reduce people experiencing avoidable harm.

People told us there was not enough staff to care for them. One person told us, "At night I've had to wait for over an hour when I press my call bell." Another person said, "They [staff] are very overstretched sometimes especially between one and two [in the afternoon] you can't get a carer [staff] then, for love nor money." A relative told us, "[Family member's name] is left in bed at the weekend – due to staff shortages." Another relative told us, "They could always do with more staff." Staff on The Beeches unit told us, they had recently had an increase from three to four staff members since the new manager had started in post. A staff member told us, "We used to just have three care staff I told [Nominated Individual's name] he said just deal with it. This new manager has upped it to four [staff] so it's better, but not really enough we just about manage. Some people need one to one care and hoisting. They are at risk of falls so it's difficult." Following our inspection feedback the manager told us they would increase the staffing levels to help ensure safety risks to people's care were reduced.

On the first day of our inspection we had concerns about the staffing arrangements to support people living with dementia on The Beeches unit. We saw people were at risk because of the assessed staffing arrangements did not include staff with the knowledge and skills to support people with their particular needs. For example, there were insufficient staff to monitor and support people safely. There were examples of staff not being able to effectively and safely respond individual needs, which on one occasion meant people were at risk from falling. On another occasion people were at risk from themselves and other people due to their behavioural needs. We saw one person physically threaten other people. Staff did not show through their practices they had the knowledge and abilities to manage these situations. For example, a person's anxieties' were not consistently reduced by staff practices knowing how to support the person with their feelings and behaviour.

We found the needs of some people were quite complex and the availability of staff together with the deployment of staff did not always provide people with the support they required. For example, staff were not consistently available to respond to the particular needs of people who were able to and enjoyed independently walking around their home.

One staff member explained how people did enter other people's rooms and it was not always possible to see and be there to supervise people. Some people living at The Beeches unit had physical difficulties and were unable to prevent other people living at the home from entering their room and potentially interfering with their medical equipment.

Following the safety concerns we identified, the manager increased staffing numbers were increased from four to five on the second day of this inspection. We saw this made an improvement as support for people was managed in a less chaotic way to assist in supporting people's anxieties.

Where risks to people had been identified records did not always include the actions staff had taken to mitigate these risks and keep people safe. For example, some people's records had highlighted a risk of their skin becoming sore and so required regular turning to relieve pressure. However we found charts recording when the person was last turned and into what position had not always been recorded.

The provider did not have arrangements in place to assure themselves staff's practices were always keeping people safe from risks relating to the environment. Doors to some rooms including those containing potentially hazardous material or equipment were left unlocked on The Beeches Unit. For example, sluice rooms, and fire doors were left open. On The Beech unit we found a toaster plugged in and stored on a small trolley in the lounge area which people could readily access and cause harm to themselves should touch it. In addition there was uncovered food left out which was attracting flies, which any of the people living there could access and people relied on staff to keep them safe from potential hazards. We found bare wires exposed on the fire door stop with no action plan in place to ensure this potential hazard was remedied. In the bathroom and some bedrooms we found some people's prescribed creams and gloves were left on radiators in the corridor areas. There were no risk assessments as to the potential dangers of these items to people who enjoyed exploring their home but who also relied on staff to support them from harm.

People at risk of falling did not consistently have their risks assessed and mitigated. For example we saw people were not always encouraged to walk with their aids. We saw one person mobilising without their walking frame, which put them at further risk of falling.

We looked at how people were supported with their medicines. We found some discrepancies with the Medication Administration Records (MAR) and other recordings to accurately show people had consistently received their medicines. For example on one person MAR sheet a nurse had signed to say they had given a person their medicine for diabetes, but on the additional recording sheet the entry had been missed. We saw one person had been given their injection into the same arm on two consecutive days rather than using an alternative arm to avoid the person experiencing potential soreness. We found several missed signatures on the MAR sheets and in some cases a dot had been placed instead of a signature, which indicated staff were not following best practice of signing immediately after administering the person's medicines to reflect the person had taken their medicines. We saw the medicine fridge temperatures and medicine cabinet temperatures were not always recorded to show medicines were stored within a safe range so they continued to be effective. Where people were prescribed 'as required' (PRN) medicines there were not sufficiently detailed protocols in place to guide staff as to when the medicine may be required.

The provider had not consistently ensured risks to people had been identified with guidance in place and staff followed the guidance which included medicine administration and storage. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. Safe care and treatment.

We saw risks to people's safety had been considered and managed on The Pines and The Willows for example people were assisted to use their mobility aids.

We spoke with staff about how they made sure the people they provided support for were safe. They were able to tell us how they would respond to and report allegations or incidents of abuse. Staff could describe the different types of abuse people were at risk of and were able to explain the different agencies that they could report concerns to. One staff member told us, "If I am concerned about anyone I'd report it to the manager."

We saw there were plans in place for responding to emergencies. The registered provider had an emergency fire evacuation plan in place. We saw each person had a personal emergency evacuation plan (PEEP). The

plans outlined the support people required should there be a need for them to be evacuated from the premises in an emergency.

Staff we spoke with told us the appropriate pre-employment checks had been completed. These checks helped the provider make sure that suitable staff were employed and people who lived at the home were not placed at risk through their recruitment processes. The provider had a system in place for ensuring all Disclosure and Barring Service (DBS) checks were made. The new manager was in the process of recruiting a number of new staff.

Requires Improvement

Is the service effective?

Our findings

Staff told us they did not receive regular training. We saw from the provider's training records many staff had not received training in dementia, diabetes, epilepsy and behaviour that may challenge. We saw how this impacted on people's wellbeing, when staff on The Beeches unit did not reflect in practice effective communication skills when supporting people living with dementia. During our inspection we saw examples where staff's practices did not consistently support people so their levels of anxieties' were reduced. For example instead of reassuring a person when they were asked if they wanted to use the bathroom when the person's response was "No", a staff member said, "Come on you need to use the toilet." This impacted on the person's emotional wellbeing and we saw through their facial expressions and body language their anxieties raised even further. A staff member told us, "I have no training in dementia". During the inspection the inspectors had to intervene on three separate occasions to reassure a person who was becoming distressed and assist the person with their emotional feelings.

We were not provided with clear plans on how the provider had planned to make sure all staff had the training they required to effectively meet the needs of people they cared for. However, on the third day of our inspection we were told by the manager they had arranged for staff to attend a variety of training courses. These included dementia and training to provide activities to support people who lived with dementia.

We spoke with new staff about the training they had received from the provider. Although new staff completed an induction period it was not linked to the Care Certificate. The Care Certificate is a set of standards that should be covered as part of induction training of new care workers. The manager told us, there were plans in place to introduce this in the near future for all new employees.

Staff told us they did not receive regular support and supervision. One staff member told us, "I've never had supervision since working here." [The staff member had worked at the home for several months]. We found the provider had not assured through their quality checking procedures staff had the knowledge, skills and one to one support required to effectively meet all the individual needs of people who lived at the home. When we asked staff about the staff meetings they had attended, one staff member told us. "Our last staff meeting was to meet the new manager. Previously it was the nominated individual visiting last week, but we've not really had a conversation with them."

The provider did not ensure sufficient numbers of suitably qualified, competent, skilled staff were deployed. This was a breach of Regulation 18(1) HSCA 2008 (Regulated Activities) Regulations 2014

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).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We reviewed how the provider had ensured people's freedom was not restricted. We found applications had been made to the local authority.

We also reviewed how the provider had made a decision about a person's capacity to make decisions. We saw in people's care records some decisions had been made in a person's best interests, people, their relatives and healthcare professionals had been involved in the decision making process where appropriate. For example this process had been completed when a person required their medicines to be administered covertly. People had their medicines disguised in their food.

When we asked people about the quality of food they were served, we received mixed responses. One person told us, "My meal is often stone cold." A relative commented, "Over the last twelve months the quality of the food has gone downhill." When we provided feedback about people's comments about the food offered to the manager they told us they were in the process of recruiting a new cook and presently a care staff member was covering the role. Although the care staff member had completed food hygiene training they were not a qualified cook who was familiar in catering for a large number of people who lived in a nursing home, all with individual nutritional needs. On the first day of our inspection spaghetti bolognaise was one of the choices on offer, but people living with dementia found this hard to eat.

On The Beeches Unit we found people had been given drinks, but we found they were not always in reach of each person. One person we spoke with told us they were "thirsty." We noted there was a cup of squash available but it was placed on a table behind them so they were unable to reach this. One person told us, "I have a catheter and not enough attention is paid to that and not enough water to drink." Whilst walking down the corridor we heard a person calling for assistance they told us, "Please can I have a cup of tea, I've not had a drink since before lunchtime." We made staff aware so the person could obtain a drink. We checked people's fluid intake charts and found them to be filled in retrospectively and in some instances entries missing. Although we saw people being asked and served food and drinks throughout our inspection. We saw there were inconsistencies in the recording of people's eating and drinking to support effective monitoring so people remained healthy.

People told us they had access to health professionals as required in order to stay healthy. The GP visited the home on a weekly basis. We saw from people's records each person had a "Hospital passport" a document stating people's individual health histories and requirements, should they need to be admitted to hospital.

Requires Improvement

Is the service caring?

Our findings

People were not always treated with kindness and thoughtfulness in order to show people respect and support their dignity. We saw people had not always been supported to maintain their appearance. We saw examples whereby people who relied on staff to support them with their personal care looked unkempt. For example, some gentleman had not been assisted to shave, none of the people had socks or tights on and some people walked around with bare feet. We saw when a staff member had taken a person outside when they brought the person back in they struggled to assist them out of the wheelchair by themselves and didn't ask for help. When they helped the person back into the chair the person's slipper fell off, the staff member didn't put it back on. We saw a person with their incontinence pad showing across their lower back, because their trousers were too big and kept falling down, compromising their dignity.

This was a Breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014. Dignity and Respect.

People's right to confidentiality was not always protected. We saw in the dining room on The Willows/The Pines Unit there was a whiteboard with people's names and how they required their food to be served, anyone visiting the home would have access to this information.

We saw staff were extremely busy and did not have the opportunity to stop and chat to people. As staff walked past people they just said comments, such as "You alright darling/ sweetheart?" A person told us, "Most of them [staff] look after you some of them just speak and then go away. Usually they are okay, some are learning and they have someone with them." Another person said, "Nothing wrong with the staff here I get on with them all." A staff member said, "We just do the routine we have no time for anything else. We can't spend time with the residents [people who lived at the home]."

Staff members described how they had acted with kindness to improve the quality of life for people. A relative told us, "The staff here are golden, they are brilliant people. " We heard another example of staff caring as a staff member gave a person something they liked from their own personal use, because a person living at the home could not afford to buy their own.

On The Willows/The Pines Unit people told us they were involved with the way the care was delivered. One person told us, "I go to bed when I want. I choose when I want to stay in bed. The last few days - because I felt poorly."

There were a number of rooms, in addition to people's personal rooms, where people could meet with friends and relatives in private if they wished. People told us they could have relatives and or friends visit whenever they liked. We saw how one relative was invited to join their family member to have lunch in the dining room. They told us they always felt welcomed and offered drinks when they visited.

Requires Improvement

Is the service responsive?

Our findings

During our inspection we saw little planned activities for people living on The Beeches unit. We saw people who gained enjoyment from exploring their surroundings were brought back into the lounge area by staff. We saw people become frustrated and demonstrated physical aggression towards others. Staff intervened but did not show the skills necessary to diffuse the situation and reassure people. For example when we spent time in the lounge area we saw one person who required one to one care as the person was at risk of falls. The person kept getting up and was very unsteady on their feet. There was no attempt to engage the person with any activity, staff just tried to keep them away from other people and from exploring their own surroundings on their own A staff member told us, "For activities we take some of them [people who lived at the home] downstairs for bingo and exercises I think. I don't really know what the activities coordinator does with them."

We looked at the minutes of the last relatives meeting in September 2017. We saw relatives commented that the provider needed to recruit more staff, encourage more activities as "There is not enough stimulation for people." Throughout our inspection we saw examples whereby staffing arrangements and consistently creating moments of fun and interest to respond to people's individual needs was not reflected in practice.

We found people did not consistently receive care and support which was responsive to their particular needs. For example one person was becoming very distressed repeatedly saying they had pain in their knee for at least an hour. Although staff had reported this to the nurse on duty saying the person's knee was painful and swollen, it took over an hour before the nurse came to apply the pain relief. The unresponsive of staff to meet this person's needs had an impact on the emotional wellbeing.

We saw information about people's care requirements recorded in care files was not always current. For example one person's care plan indicated they could use a cup, however when we spoke with the person we saw they required a specialist beaker to maintain their independence.

When we spoke to some staff, they could not tell us about people because they were agency staff and unfamiliar with people's needs. For example, we saw staff being unsure of people's names, what sort of meal they required and how people liked to be cared for.

This was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014 Person centred care.

People who lived at the home and their relatives told us they had been consulted about the way they wanted to be supported and cared for. One relative told us, "I was involved in the care planning. Care is quite reasonable here, but I would like to try a purpose built home."

On the Pines and Willows units we saw recreational activities did take place. The activities co-ordinator had arranged a baking session for some people, and other people music of their choice had been made available for them to listen to. We saw people were given copies of the "Daily Sparkle" (newsletter

highlighting past significant events), but noted these were not current, and were a month out of date.

On the Pines and Willows unit staff appeared more relaxed and we saw more positive interactions with people. People smiled and chatted with staff. For example when a staff member noticed one person was without their glasses they said, "Oh [persons' name] are your glasses in your room? I will go and get them".

People and relatives told us they would feel confident to complain, if they needed to. We looked at the provider's records and found one complaint had been received over the last twelve months. The managers told us how they had dealt and met with the relatives, to discuss the necessary actions that needed to be taken to resolve their concerns promptly.

Requires Improvement

Is the service well-led?

Our findings

Since our last inspection in July 2016 there had been several changes in registered manager. We noted the provider did not have a registered manager between the end of July and August 2017 A new manager had been appointed in September 2017, but had not started the registration process of registering with the Care Quality Commission.

We found the provider's quality checking arrangements had not been effective in making sure the care offered was of a consistently good standard for people who lived in all parts of the home. We identified different aspects which if they had been identified and action taken would have assisted staff in their developing their knowledge and understanding about how to provide safe and effective care. For example, people who lived on The Beeches unit had varying levels of dementia and were supported by staff who had not all been provided with the relevant training opportunities. Throughout our inspection we saw how staff's caring practices although with all good intentions were ineffective in providing the level of care to always meet people's dementia care needs safely.

When we spoke with the manager she told us about the number concerns she had identified, since coming into post. They told us they were concerned over the staffing levels and the fact "Staff did not have a good level of knowledge of dementia." The manager told us thirteen people who lived at the home lived with dementia. Staff we spoke with had not completed dementia specific training to ensure they understood best practice ideas. The provider had not ensured staff received the right training, support and supervision to carry out their roles and understand their responsibilities.

Throughout our inspection we had serious concerns about the knowledge and skills of staff who supported people on The Beeches unit together with the staffing arrangements. Although the manager had increased staffing numbers since being in post we saw with the staff's lack of knowledge and skills it had impacted upon how people's individual safety and care needs were being effectively responded to. The manager was responsive to the concerns we raised and increased staffing numbers on The Beeches however we could not be assured this would be sustained.

There had been changes in managers at the home which had resulted in inconsistencies in identifying and driving through improvements which we found the provider's own quality monitoring arrangements had not been strong enough to do. For example, we saw bare wires on the fire door stop in the lounge (on the Beeches unit) which had not been identified by the provider's quality checks. In addition, during the period between managers, the provider had no consistent overview of accidents and incidents to ensure lessons were learnt and improvements to people's safety were made. We found there were no incident reports recorded since the end of July and August 2017. People were not protected from the risk of accidents and incidents because systems were not in place to ensure the provider monitored and implemented learning from them.

This was a breach in Regulation 17 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have effective arrangements in place to monitor and improve the

quality and safety and welfare of people who lived at the home.

The manager told us she wanted to make The Beeches unit more of a friendly, comfy, homely environment." She told us she had already started to make changes for example she had changed the sensory room into a dining room, so people could eat their meals in a quiet area.

People we spoke with were positive about the new manager. One person told us, "The new manager is nice." Staff we spoke with thought the new manager was good. One staff member described, "[Manager's name] works up here [The Beeches unit], they work weekends and is very good… I've learnt some things."

Staff showed a clear understanding of their roles and responsibilities within the team structure and also knew who to contact for advice outside the home. Staff knew about the company's whistle blowing procedure and said they would not hesitate to use it if they had concerns about the running of the home. Although some staff we spoke to were confused over who owned the home and the role of the nominated individual.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive care that met their individual care 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's dignity was not always promoted.

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 The provider had not consistently ensured risks to people had been assessed and the risks mitigated. People's medicines were not always stored and administered safely.

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 The provider did not always have effective arrangements in place to monitor and improve the quality and safety and welfare of people.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 18 HSCA RA Regulations 2014 Staffing

The management and the deployment of staff did not always ensure their were sufficient staff to safely meet the needs of the people at all times.