Care Quality Commission

Leyton Healthcare (No. 12) Limited

Delves Court Care 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

Overall summary

At our previous inspection on 17 June 2014 the provider was not meeting the law in relation to staffing, respecting and involving people and assessing and monitoring the quality of service provision. Following this inspection the provider sent us an action plan to tell us the improvements they were going to make by 31 August 2014. We carried out an unannounced inspection on 20 and 21 January 2015. During this inspection we found no improvements had been made since our last inspection.

Delves Court Care Home is a nursing home providing accommodation, nursing and personal care for up to 64 older people who may have dementia. The home is spread over three floors with the first and second floors providing nursing care. The home does not currently have a registered manager. The registered manager left in December 2014. A new manager was appointed in January 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

People's needs were not being fully met on the nursing floors of the home because there were not sufficient staff available at all times. We found staffing levels impacted

Summary of findings

on the quality of care people received and the length of time people were kept waiting to receive their care. You can see what action we told the provider to take at the back of the full version of the report.

We found people's medicines were not always administered safely. We found information available to staff to administer 'as required' medicines was not robust enough to ensure they were administered in a consistent way. We found medicines were not stored appropriately for them to remain effective. You can see what action we told the provider to take at the back of the full version of the report.

People and their relatives told us they felt safe at the home. Staff had knowledge of safeguarding procedures and how to report concerns they may have.

Staff's understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) needs to be improved. There was a risk that people's rights would not be appropriately supported.

People's nutritional needs had been assessed and plans were in place to identify people's individual requirements. People and their relatives told us food sometimes lacked variety.

People who lived at the home had access to other health care professionals as and when they required it.

People who lived at the home and their relatives thought that staff were caring. However, we found that people's dignity was not respected at all times. You can see what action we told the provider to take at the back of the full version of the report.

People who lived at the home and their relatives felt staff understood their care needs. People and their relatives told us that they had been involved in the development of their care plan. However, people's preferences and choices were not always respected.

Some people were supported with a range of hobbies and interests, which were suited to their needs. Other people received little stimulation throughout the day.

The provider had not managed complaints well. Some complaints had not been responded to and other complaints had not been recorded. People who lived at the home and relative's had a copy of the complaint's policy and felt confident to speak with the manager.

We found quality assurance systems were not effective in identifying issues or trends which would improve the quality of the home. People and their relatives were encouraged to share their opinions about the quality of the service. You can see what action we told the provider to take at the back of the full version of the report.

We have spoken with the provider following our inspection to discuss areas of concerns and to gain assurances that improvements will be made to the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

There were not sufficient staff to fully meet the needs of the people living at the home.

Some people's medical conditions were not being treated appropriately by the use of their medicines. Medicines were not safely managed and monitored so that people received their medication in a safe way which supported their health.

Staff understood how to keep people safe and protect them from harm and abuse.

Is the service effective?

Requires Improvement

This service was not effective.

There were gaps in some staff's training.

Staff understood people's nutritional needs. Food choice lacked variety.

Some staff did not fully understand the requirements of Deprivation of Liberty Safeguards (DoLS).

People's healthcare needs were met with the support of other health professionals.

Is the service caring?

Requires Improvement

The service was not caring.

Staff did not always demonstrate respect for people's dignity.

People felt their privacy was respected.

People and their families were involved in making decisions about their care.

Is the service responsive?

Requires Improvement

The service was not responsive.

People's needs were assessed. However people felt that their care was not always delivered when and how they wanted it.

People felt their preferences and choices were not always taken into account or respected.

Some people participated in a range of activities, but others received little stimulation throughout the day.

People and their relatives did not feel their concerns were always addressed.

Summary of findings

Is the service well-led?

The service was not well-led.

The provider carried out quality assurance audits in order to identify shortfalls. However, these audits were not effective in identifying issues or trends.

The provider did not carry out a robust analysis of accidents and incidents to identify trends.

People, relatives and staff were complimentary of the new manager and felt concerns would be listened to and issues addressed.

The provider had not taken action to improve on shortfalls we found at our previous inspection.

Requires Improvement

Delves Court 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 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 home, and to provide a rating for the home under the Care Act 2014.

This inspection took place on 20 and 21 January 2015 and was unannounced.

The inspection team consisted of three inspectors, a pharmacy inspector and an expert by experience. An expert by experience has personal experience of using or caring for someone who uses this type of care service. The expert by experience who accompanied us had experience of supporting family members who used residential care services.

Before our inspection we reviewed information we held about the home including information of concern and complaints. We looked at statutory notifications we had been sent by the provider. A statutory notification is information about important events which the provider is required to send us by law. We spoke with other agencies to gain their views about the quality of the service provided. This included the local authority and clinical commissioning group. We used this information to help us plan our inspection of the home.

During the inspection we spoke with eight people who lived at the home and eight relatives. We spoke with eight staff which included care staff and nurses. We spoke with the new manager and the regional manager. We looked at nine records relating to people's care. We also looked at 14 medicine records, two recruitment files and records relating to the management of the home.

During our inspection we used the Short Observational Framework for Inspection (SOFI) observation. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also used it to record and analyse how people spent their time and how effective staff interactions were with people.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 17 June 2014 we found that the provider was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because there were not sufficient numbers of suitably qualified, skilled and experienced persons employed at all times to meet people's needs. The provider sent us an action plan outlining how they would make improvements. When we inspected the home in January 2015 we again found concerns.

One person told us, "When I press the buzzer it takes a long time up to two hours for staff to come." Another person told us, "Staff do not always come I have to wait, I keep buzzing and staff say I have to be patient and wait as they are busy. Sometimes [it can take] an hour [before someone comes]." One relative told us, "I think they could do with more staff at the main times, if you are bringing someone back at the weekend that's difficult as often there is no one available to open the door."

We observed on the residential floor staff responded quickly to people's care needs. We saw that there were appropriate numbers of staff to meet people's needs. One relative told us, "On this floor (residential) they seem alright an extra pair of hands is always helpful."

The experience of people on the nursing care floors of the home was very different in respect of staff being available to provide support. We saw staff were rushed and did not have time to engage with people. One staff member told us, "It's a struggle to ensure people's care needs are met when short staffed." Another staff member told us, "There is not always enough staff, when people shout they have to wait, we will let them know we will get to them as soon as possible." We saw staff were polite but did not have time for conversations with the people they cared for. People we spoke with told us staffing levels affected the speed of staff's response when they needed help and sometimes care being given was rushed. Some people told us their preferences were not respected as there was not enough staff. We heard call bells ringing and saw that some people were kept waiting for up to ten minutes before these were answered by staff. We observed during meal times there was not enough staff to ensure people received their meals in a timely manner. We saw people were left waiting at the dining table between 25 minutes and one hour before being served their meal. We observed on the middle floor no staff were visible for one hour after meals were served. We saw people were left with untouched meals and saw no staff were available to offer them support. We noted one person was left in their wheelchair at the dining table for a period of two hours and 55 minutes before we saw a member of staff check on them. We observed one person becoming upset on several occasions and saw another person give reassurance because there were no staff available to offer support.

We saw that the provider used a dependency tool to calculate the number of care hours required to support people who live at the home. However information used to determine staffing levels had not been updated since August 2014, and had taken no account of the changed needs of people who used the service. The provider's regional manager told us that staffing levels exceeded the number of care hours that they had determined were required to meet the needs of the people who live at the home. However, we saw that there were insufficient staffing numbers of staff available to meet the care needs of the people who lived on the nursing floors, particularly at peak times of the day when people required more support to meet their healthcare needs. This was evident at mealtimes and when medication was being administered. Support with personal care needs of people were often not met in line with their needs and wishes. For example bathing and showering was not completed as frequently as people would like. Staff were seen to be very focussed on tasks and had little or no time to engage with people and meet their individual needs in a timely manner.

This was a continued breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Three people told us they received their medicines on time. One person told us, "Most of the time." Relatives we spoke with had no concerns about how medicines were managed. One relative told us, "As far as I know, everything's okay."

We looked in detail at 14 medicine administration records and found that people's medical conditions were not always being treated appropriately by the use of their medicines. For example people who required medicines to be administered at specific times were not receiving those medicines at the times specified. We looked at records and found that they were not able to evidence that people

Requires Improvement

Is the service safe?

received inhaled medicines as prescribed or that medicinal skin patches were being applied safely. We found that where people needed medicines administered directly into their stomach through a tube staff had not ensured that the necessary safeguards were in place to ensure these medicines were administered safely. Some people took their medicines 'as needed' such as paracetamol. One person told us, "It can take up to two hours for someone to come with my pain relief." We saw that information was not robust enough to ensure that medicines were given to people when they needed them.

We observed some poor administration practices taking place during the morning medicines administration round. We saw that administration records were being signed before the medicines had been given. We found that medicines were not being stored securely or correctly so they would remain effective. The fridge temperature records showed that on the middle floor the fridge temperature had dropped below the minimum temperature and no action had been taken to ensure the safety of the insulin being stored in there.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

One person told us, "Staff treat me well, I am happy, I feel safe." Five people told us they felt safe living at the home. One relative told us, "[Person's name] safe because they got someone with [person's name] 24/7." Other relative's told us they felt their relatives were kept safe at the home.

Staff we spoke with understood the concept of keeping people safe and protecting people from harm. One staff member told us, "If anything goes wrong I wouldn't hesitate to report it." Staff told us they were aware of how to 'whistle blow' on poor practice if required and felt confident to do so. Whistleblowing is the term used when someone who works for an employer raises a concern which harms, or creates a risk of harm, to people who use the home. However, we were aware that in some instances senior members of staff had failed to report matters which required referral to the local safeguarding authority. The manager said this issue would be addressed through additional guidance to staff regarding the reporting of safeguarding matters.

One relative told us, "I am fully involved in [person's name] care plan and risk assessment." Staff demonstrated an awareness of people's risks and care needs, such as with their moving and handling. We saw personalised risk assessments had been completed and reviewed to reflect people's changing need. Staff knew to report any concerns about changes in people's needs to the nurse in charge or to the manager. We looked at people's records and saw that risks to people had been assessed and plans put in place for staff to follow. For example for those people who required their skin to be monitored, information was clearly documented and skin care guidance was being followed. We saw that specialist equipment was provided and being used where this had been identified as a requirement for someone.

People we spoke with told us the home was clean and tidy. One person told us, "Oh yes, you can't say nothing about this place because it's always done." A relative told us, "Yes, it's always spotlessly clean." We saw cleaning schedules and audits had been developed and were being used by staff. We observed that staff maintained the home to a good standard of cleanliness. Systems were in place to minimise the spread of infection within the home. Staff we spoke with knew the procedure to control an outbreak of infection and understood the necessity for high standards of hygiene and infection control.

Requires Improvement

Is the service effective?

Our findings

One person told us, "I think it's very good really. They can't do everything but they look after us really very well." Another person told us, "Yes, they do look after you. Sometimes they might be busy, I think it's alright." One relative told us, "They always seem to know how [person's name] feeling, so I think they talk to him." All the people we spoke with told us that staff had knowledge about people's needs.

Staff we spoke with told us they had access to training and were appropriately trained to meet the needs of the people who lived at the home. We looked at records which showed that not all staff had received training in the areas considered as necessary for them to carry out their roles safely, such as safeguarding and moving and handling. We saw gaps in staff training were being addressed and outstanding training had been arranged. The manager informed us that infection control training had been arranged for staff in February 2015. One member of staff told us they had completed an induction and 'shadowed' experienced members of staff before starting their role. An induction is a process of introducing someone to a new job. Staff we spoke with told us they received one to one meetings with the manager. We looked at records which showed that one to one meetings had not been conducted regularly with staff. We saw that since our last inspection, three nurses had received a one to one meeting. Therefore there was a risk that issues of staff performance or training would not be addressed. The manager told us they were reviewing how one to one meetings were managed to ensure staff received the appropriate level of support to do their job.

We looked at how the home was meeting the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguard (DoLS). The MCA ensures that the human rights of people who may lack mental capacity to take particular decisions are protected. DoLS are safeguards used to protect people where their liberty to undertake specific activities is restricted. We spoke with staff about their understanding of MCA and DoLS. Some staff demonstrated a good understanding, others were unsure what of what it meant and the impact it would have on people's liberties and freedoms. We saw the manager had arranged staff training in this topic. People we spoke with told us staff asked for consent before providing care.

One person told us, "Staff always gain consent to do my personal care." We looked at records and saw mental capacity assessments had been completed for people. We saw that people were free to move around the home and we did not see any restricted practices which might contradict someone's rights. The manager told us there was no one living at the home who was currently subject to a Deprivation of Liberties Safeguard (DoLS).

One person told us, "You get a good choice of food in here." Another person told us, "Some of the meals leave a bit to be desired, they need more variety, be more appetising." One relative told us, "They look alright. They've just changed the menu." We saw meal times were not a positive experience for some people because support to eat meals was not provided and meals were left to go cold. One person showed us a menu with photographs which helped people choose meals each day. We asked people what happened if they did not want anything from the menu. People we spoke with told us staff would offer an alternative choice. We observed one person who did not want any of the main meals offered being given cake as an alternative. We saw another person being offered the same meal choices for both breakfast and lunch. This did not demonstrate that people received a balanced diet. We looked at records to determine whether people were receiving enough to drink to keep them properly hydrated and promote their health. We saw records contained guidance for staff about how people should be encouraged to drink enough liquids. We observed people were kept waiting at meal times for drinks. We saw one person repeatedly request a drink from staff for one hour before being provided with a drink. We found in one record a person had lost weight. Staff were instructed to monitor the person's food intake. We observed during mealtime staff encouraging the person to eat.

We noted that there was a very short period of time between each mealtime. We saw breakfast was still being eaten by people at 10.20am. Lunch was served at 12.35pm with some people still waiting to be served at 13.30pm. We saw people being called through to the dining areas at 16.05pm for their main meal. This meant that people may not have an appetite for the main meal of the day.

One person told us, "I've had the doctor this week. He sent me some tablets down and I think it's done the trick. The district nurse comes every day." One relative told us that their relative had missed two hospital appointments

Requires Improvement

Is the service effective?

because appointment letters had been "Stuck in the office." We looked at people's records and saw that the home worked with other healthcare professionals to make sure people's health needs were met such as speech and language teams (SALT) and dieticians. We saw one person's weight was being monitored and the home had sought involvement from a healthcare professional. We saw that referrals to other healthcare professionals had been made promptly by staff when concerns were identified.

Requires Improvement

Is the service caring?

Our findings

At our last inspection on 17 June 2014 we found that the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because people's dignity, privacy and independence were not always respected. The provider sent us an action plan outlining how they would make improvements. When we inspected the home in January 2015 we again found concerns.

A relative told us, "They close the curtains and door when personal care is given." One person told us, "They knock the door. They're polite like that." We observed staff knocked on people's bedroom doors and closed doors when providing personal care to ensure people's privacy was maintained. We saw that people's dignity was not always respected. One relative told us, "[Person's name] was annoyed because they were late taking [person's name] to the toilet." One person told us they were left all night in soiled bedding. We heard one person ask a member of staff for help. The staff member told the person "Wait a bit, I will go and look for staff." We saw the member of staff did not look for other staff to support the person but continue with updating records. We observed no staff member attended to the person's needs for 20 minutes. We heard another person request a staff member to take them to the toilet. The staff member replied "You will have to wait until after I done the toast." We did not observe any member of staff take the person to the toilet.

We observed people were not given a choice where they wanted to receive their blood sugar tests and medicines which were being administered directly into the stomach. We saw both of these medical procedures completed in front of other people. We observed two staff member's supporting someone to transfer with the use of a hoist on the nursing floor. We saw neither staff member talk to the person to explain what they were doing but continue with their conversation. We observed another person being given drinks in a child's feeder cup. This showed that staff did not recognise or promote people's dignity when responding to or delivering people's care.

This demonstrated a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

One person told us, "I couldn't ask for anything more, the carers are very attentive." Another person told us, "Staff don't always care you have to wait." One relative told us, "I find them really friendly, very approachable." We observed on the residential floor positive interactions between staff and people who lived at the home. We saw one staff member sitting with a person engaging in conversation while completing paperwork. We saw staff responded to people's care needs quickly and speak with people in a kind way.

One person told us, "Staff always involve me in my care needs." Another person told us, "I'm not involved in any decisions for anything. They don't ask me what I want." One relative told us, "I am fully involved in my relative's care plan and risk assessment." People we spoke with told us they did not always receive their care and support when they wanted or needed it because staff were busy. One person told us, "They phoned the doctor. I was surprised when he came in because I didn't know they'd sent for him." This showed that people were not always consulted about their care needs. People told us that they did not feel listened to or consulted with because staff were often busy and did not have time to engage in conversation.

Requires Improvement

Is the service responsive?

Our findings

One person told us, "I only have a shower every couple of weeks. I would like it more often but the carer's have been stretched." A relative told us, "[Person's name] was always used to baths or showers two or three times a week. [Person's name] has to have one when they can get round to it." Staff told us sometimes they were not able to respond to people's requests because they were short staffed. People told us the staff were not always responsive to their individual needs. People told us they had to wait for help with their care needs. We observed this during our inspection when we saw delays in responding to people's personal care needs.

We saw that people's needs had been assessed and were reviewed regularly. We saw that people's representatives had signed care plans to acknowledge agreement with them. We looked at nine people's care plans and saw that these gave detailed information about peoples social and health needs. We saw care plans were specific to people's needs. We observed staff meeting people's needs in line with their care plan. For example we saw in one record a person required turning regularly to maintain their skin integrity. This was confirmed by the person and their relative.

We observed some people taking part in activities during the day. One person told us, "I went to Asda last week and met loads of people I wouldn't have met otherwise." Another person told us, "I really enjoyed the pantomime and choir at Christmas." The home employs two activities co-ordinators. We saw that when the activities co-ordinator arranged group activities people were keen to take part. People and relatives told us they enjoyed the activities they took part in. However, when the activities co-ordinators were not available on the nursing floors staff did not have time to support people in this way. One person told us, "I am in my room I do not do any activities occasionally staff will come and talk." Another person told us, "There are no activities offered in my room." We saw some people were left sitting for long periods of time without having the opportunity to take part in activities which stimulated them nor did they have any interaction from staff.

People and relatives we spoke with told us they were supported to maintain relationships. Relatives told us that they were welcomed at the home and could visit throughout the day.

Complaints had not been responded to in a timely way. We spent time talking with people and their relatives about how the manager responded to their concerns or complaints. People and relatives we spoke with told us they would be happy to approach the manager if they had any complaints. One person told us they had complained to staff that they were "left all night in wet sheets." Staff told the person they were "Too busy looking after sick people to respond." Another person told us they had raised a concern about a member of staff's attitude but had not received a response. We looked at the complaint records and saw that there were no outstanding complaints. We spoke to the manager about the concerns raised and they told us they would investigate. We looked at the notes of a recent meeting held with people who lived at the home. We saw that one person had raised a concern about the length of time staff took to respond to their call bell. We spoke with the person and they told us they "Felt anxious when no one comes." The person told us they often had to wait for staff to respond and this was the reason they raised it at the meeting. This person requested that staff acknowledge the call bell even if they couldn't respond to the request immediately. They told us they had not received a response to their concern. We spoke with the manager about this and they told us they had not been made aware of the issue. The manager told us they would address the matter. We saw that the home had recirculated the complaints policy following feedback in August 2014. Relatives we spoke with confirmed this.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection on 17 June 2014 we found that the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because the provider did not have an effective system in place to manage risks and assure the health, welfare and safety of people who receive care. The provider sent us an action plan outlining how they would make improvements. When we inspected the home in January 2015 we again found concerns with the auditing and quality assurance systems. We looked at a number of records to assess whether the provider had addressed our previous concerns. We looked at how the provider ensured the quality of service the home provided.

We found that there were systems in place to collect information but that there were no processes in place to assess and monitor the quality of the home. We found little evidence of how information collected was used to identify concerns and issues that would improve the quality of care people received. We saw incident and accidents were recorded appropriately. However, we saw no evidence that the information was not used to identify risk or trends to people living at the home. We saw safeguarding concerns were reported but there was no system in place to log the number of safeguarding allegations received nor the type of abuse reported to enable identification or trends or patterns to reduce risks to people who lived at the home.

We were made aware by the local authority that following visits made to the home a number of concerns had been identified such as infection control. Action plans were issued and progress was being monitored. We found that recommendations made by other agencies had not been addressed by the provider in a timely manner. For example medicine management issues identified by the clinical commissioning group (CCG) in September 2014 were still outstanding at our visit. We found the provider's quality assurance systems had offered little evidence of improvement since our last inspection. We saw that issues identified during our inspection such as medication and staffing had not been identified by the homes audit systems.

We saw a survey had been carried out in July 2014 with people and their relatives. Information was analysed and as a result the complaints policy was recirculated and menu's reviewed. People and relatives we spoke with confirmed this.

We found that the provider had not fully implemented the action plan, sent to us following our inspection in June 2014, to meet shortfalls in the requirements of Regulations 10.

This demonstrated a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People and relatives we spoke with said that there was a new manager at the home they told us that they were friendly and approachable. One relative told us, "Staff morale was low, it feels better now." Another relative told us, "The manager is visible I've seen them on the floors observing." One staff member we spoke with told us the manager has "Injected a new atmosphere, they have lots of new ideas, morale is lifting." We saw that the manager was welcoming and was developing good relationship with people and their relatives. We saw that the home had a clear management structure in place and the manager had an 'open door' management style. We saw that staff and relatives felt at ease to approach and ask for advice and support as required. This indicated that the new manager was promoting an open culture in the home.

The home does not have a registered manager in post. However, a new manager has recently been appointed in January 2015 and has been in post for one week. The manager was aware of our requirement to apply for CQC registration. They informed us they would commence the process once they had completed their probation period. One relative told us, "The new manager is very good and has responded quickly to questions and concerns." Staff we spoke with were complimentary about the new manager. The manager was aware that the home has a number of issues which needed to be addressed quickly. The manager and regional manager were both relatively new to the organisation and were unable to answer questions regarding processes and systems previously used within the home. They informed us that they were now reviewing

Requires Improvement

Is the service well-led?

shortfalls identified by the local authority and CCG and introducing systems and processes to identify and manage risks to people's health and well- being who lived at the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not assess and monitor the quality of services provided.**

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider had not taken appropriate steps against the risks associated with the unsafe use and management of medicines, by means of making appropriate arrangements for recording, handling, using, safe keeping, dispensing and safe administration of medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The provider had not ensured peoples dignity was respected at all times.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered person must take appropriate steps to ensure that at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed at the location to safeguard the health, safety and welfare of service users.**

This section is primarily information for the provider

Enforcement actions

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