HC-One Limited

Blenheim Court

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

Blenheim Court Nursing Home is a converted house with a purpose built extension. The home is registered to provide accommodation for up to 44 people over two floors; however some of the bedrooms were large enough to accommodate two people. These rooms are now all single occupancy rooms and this means Blenheim Court now provide accommodation for up to 35 people. There were 34 people living at Blenheim Court on the day of our inspection. The home is a short distance from the local amenities such as shops, pubs, churches and has easy access to the city centre by public transport.

There was a manager at the service who was registered with CQC. It is a condition of registration with the Care Quality Commission that the home has a registered manager in place. There was a registered manager in place who was present on the day of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Summary of findings

Our last inspection of Blenheim Court was on the 5th July 2013 and the service was found to be meeting the requirements of the regulations we inspected at that time.

This inspection took place on 14th July 2015 and was unannounced. This means the people who lived at Blenheim Court and the staff who worked there did not know we were coming.

People told us they liked living at Blenheim Court. We were told "I love it here" by one person and another person told us "I think the staff here are very kind with me."

Most people, relatives and staff we spoke with told us there weren't enough staff available to care for people adequately. We were given examples of people having to wait for assistance to go to the toilet and waiting when two carers were needed to support a person to move safely.

We observed staff treating people with respect and upholding their dignity. They were kind and courteous to people. One person told us, "They (the carers) do a good job, considering they're so busy all the time." One relative said, "I don't doubt they're well trained, but it doesn't help if there aren't enough of them."

Staff recruitment procedures were in place and thorough which meant that people were cared for by suitably qualified staff who had been assessed as safe to work with people. Staff demonstrated an understanding of their responsibilities to protect people from harm.

Staff told us they felt supported by management. We saw evidence they had appropriate training and regular supervisions to enable them to undertake their jobs properly.

People and relatives told us that the registered manager was approachable and had mostly resolved any concerns they had raised.

There were activities available during the day for people to take part in, however these were limited and usually held in the main lounge. This meant they did not always meet the needs of every person living at Blenheim Court.

We saw care plans that reflected individual needs and preferences. However, there was no evidence that of mental capacity assessments had been completed. This means some people didn't consent to treatment and people who knew them well may not have been consulted on how to best care for the person.

We found the home was clean; however the people in the seven rooms upstairs in the original part of the house did not have access to a bath or shower on their floor. This meant the person had to be supported to access the lift whenever they wanted a bath or shower.

We found systems were in place to make sure people received their medicines safely.

There were systems in place to monitor and improve the quality of the service provided. Regular checks and audits were undertaken to make sure the policy and procedures in place were properly followed.

During our inspection we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014. You can see what action we told the provider to take at the end of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

There were not enough staff to meet everyone's needs in a timely manner.

Medication was managed safely.

Staff told us they had safeguarding training and understood what they needed to do to if they suspected a person may have been abused.

Is the service effective?

Requires improvement

The service was not always effective.

Care plans did not fully reflect whether a person had capacity to make decisions about their care.

There were keypad locks on the external and some internals doors which meant people may not have been able to move around their home freely.

People told us the food was good and they had choices of what to eat and where they could eat their meals.

Staff received appropriate training and had regular supervision to support them to undertake their jobs.

Is the service caring?

Requires improvement

The service was not always caring.

We saw that not all people were always treated with dignity and respect.

People told us staff were mainly caring.

Is the service responsive?

Requires improvement

The service was not always responsive.

There were activities available, but these were not accessible by all people. The activities didn't appear to meet the needs of people who lacked capacity to fully engage in the activities on offer or to those people who were unable to access the main lounge.

There was a clear complaints policy that was readily available. Most people told us that any issues they raised were resolved by the registered manager.

Is the service well-led?

Requires improvement

The service was well-led.

People told us the registered manager was approachable and responsive to any concerns they may have.

Summary of findings

People, relatives and staff were consulted about what happened at Blenheim Court and action was taken where appropriate.

There were systems in place to check that policies and procedures were adhered to.

Blenheim Court

Detailed findings

Background to this inspection

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

We carried out the inspection on 14 July 2015 and it was unannounced. The inspection team was made up of two Adult Social Care Inspectors, an Expert by Experience and a Specialist Advisor. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. This person had experience of caring for older people and dementia care. The Specialist Advisor is a professional with experience of working with someone who uses this type of care service. The Specialist Advisor was a registered nurse currently working in an acute setting with previous experience of working with older people.

Prior to the inspection we reviewed the information we held about the service and the registered provider. This included notification of any incidents which may impact on service delivery and any injuries or alleged abuse sustained by people living at Blenheim Court. We also spoke with a Sheffield Local Authority Contracts Officer prior to our inspection and they had no concerns to report.

We spent time observing the daily life in the service including the care and support being delivered by all staff. During the inspection we spoke with nine people living at Blenheim Court, four relatives, and nine members of staff, including the registered manager, administrator, and nurse.

We reviewed a wide range of records, including three people's care plans and another two people's admission files which included financial records. We looked at four staff files and the centrally held file for recent supervisions of all staff. We checked the medication administration record charts for people receiving medicines at lunch time. We also reviewed the policies, procedures and audits relating to the management and quality assurance of the service provided at Blenheim Court.

Requires improvement

Is the service safe?

Our findings

We spoke with the registered manager about staffing levels. In addition to the registered manager and administrator we were told there were two nurses on shift each day, one would work from 8am to 8pm and the other from 8am to 2pm. There were six care staff working in the morning and five in the afternoon. In addition there were two cleaners working every weekday, one until 2pm and the other until 4pm. There was one cleaner working at the weekends. There was a laundry assistant employed every day and a handyperson for maintenance issues was being recruited. We were told the kitchen was staffed everyday form 7am to 6.30pm and this was covered by one chef and two kitchen assistants. There was also an activities coordinator.

The registered manager told us that there were enough staff to meet people's needs but there were not enough toilets. She told us that a staffing dependency tool is used by the provider, HC-One Ltd and that nothing would be done to provide additional toilet facilities. A staffing dependency tool is used to work out how many staff are needed depending on the amount of people being cared for and their individual levels of need.

All six of the people we spoke to in depth and all four relatives we spoke with told us they did not think there were enough staff to meet their or their family member's needs in a timely way. Several people told us that nights and weekends were particularly short staffed. One person and their relative told us that recently they had pressed the call buzzer in the bedroom to ask for help to get to the commode. They waited for 20 minutes before a care worker attended and explained she could not help until another care worker was available. Then they waited another 20 minutes for the two care workers to come to help. The relative said "The care workers were apologetic, but X (person) was very uncomfortable and upset by then."

A person told us "They do their best, but there's no way the carers can get round everyone who needs help, especially after meals. You have to wait your turn, but it's difficult to hang on sometimes."

Another person said "The carers are always rushing around, they don't have time to stop and chat, they're always in such a rush."

We were told by a person, "You know the carers will get round to you eventually and there's a lot of people who need help more than me. But if we had more toilets and more carers the problem would be solved."

A relative said "The weekends are worst. Sometimes you're waiting for ages outside to get in the front door because the carers are all busy. Then when you finally get in, the carers are rushed off their feet with people all wanting the toilet. There just aren't enough staff to do it and it doesn't make for a pleasant time for anyone."

We interviewed four members of staff; they all told us they felt there weren't enough staff. One member of staff told us "we need more staff. We struggle with toileting because there aren't enough carers. People have to wait sometimes."

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

All of the people we spoke with told us they felt safe living at the home and all the relatives we spoke with thought their family members were safe. We saw that people were relaxed in the company of staff and that interactions were friendly. One person told us "The girls are lovely. They look after me well."

People and relatives we spoke with could all name people they would talk to if they had a concern and felt they would help them sort any problems. Some people told us they would talk to a care worker and other people told us they would speak to the manager. One person said "I'd go straight to the manager if there was any problem."

Most people told us they thought that their own, or their family member's medication was administered on time and correctly. However, one person told us that recently an agency nurse had wrongly stated that their medication did not need to be dissolved in water. When the person insisted it did, the nurse dissolved the tablet in lemonade instead of water. This person reported the incident to the deputy manager, who spoke to the nurse concerned. The nurse had administered the medication correctly the next time they were on duty and the deputy manager was assured that this matter had been resolved.

We observed medicine administration during our inspection. We observed the nurse in charge check the medicine packet, check the number of tablets left and

documented this along with her signature. Medicines were put into medicine pots and people were given a drink to take the tablets with. During the medicine administration process the nurse was interrupted by the delivery of an inhaler and had to leave the medicines trolley to find a prescription. She put all tablets back in the trolley and locked it before she went. This is correct practice and means medicines are kept safe at all times.

The nurse was knowledgeable about peoples' health needs. For example, she didn't give a laxative treatment to another person as she was aware the person had loose stools and would not require it that day. She wrote on the back of the MAR (medication administration record) chart to state why she had not given it and communicated this information in a book in the nurse's office for the GP the following day.

The MAR charts we saw had no gaps recording signatures to confirm medication had been given. Staff should also record the number of tablets left, however on some days we found staff had not recorded this. We talked to the nurse on duty and the registered manger about this and they explained that gaps were when agency staff were employed to cover staff shortages. They were of the opinion this was acceptable as it happened only occasionally and was not essential information.

Some prescribed medicines are controlled under the Misuse of Drugs legislation and these are often referred to as controlled drugs. We saw the controlled drugs (CD) cabinet was locked. The CD book was completed correctly to show to whom and when medications were given. This meant that these medicines were stored securely and only accessible to those that needed them.

The medicines fridge was new and installed on 7th July 2015. On the front of the fridge was a 'medicines daily temperature check form' which was fully completed and temperatures recorded were within the acceptable range. The clinical room temperature also needs to be recorded daily to ensure all medicines are stored safely. On four occasions between July 7th and July 13th the room temperature was recorded as above the acceptable maximum temperature of 25 degrees Celsius. We discussed this with the registered manager who told us it had been a particularly warm spell and fans had been switched on to effectively reduce the temperature in the clinical room.

Staff we spoke with confirmed they had been provided with safeguarding training so they had an understanding of their responsibilities to protect people from harm. Staff were also clear of the actions they should take if they suspected abuse had taken place so that correct procedures were followed to uphold people's safety. Staff knew about whistleblowing procedures. Whistleblowing is one way in which a worker can report concerns, by telling their manager or someone they trust. This meant staff were aware of how to report any unsafe practice, bullying or harassment. Staff, people and relatives said that they would always report any concerns to the manager and they felt confident that the registered manager would listen to them, take them seriously, and take appropriate action to help keep people safe.

We were aware of one safeguarding investigation in the previous twelve months that was made as a result of a whistle-blower from outside of the organisation regarding medication administration. The outcome of the safeguarding investigation by Sheffield Council was inconclusive. However an action plan was now in place to improve practice and we saw evidence this was being followed appropriately.

We looked at four staff files. Each contained two references, proof of identity and a Disclosure and Barring Service (DBS) check. A DBS check provides information about any criminal convictions a person may have. This helped to ensure people employed were of good character and had been assessed as suitable to work at the home. This showed that recruitment procedures in the home helped to keep people safe.

We looked at three people's care plans and saw that each plan contained risk assessments that identified the risk and the actions required of staff to minimise these risks. These had been recently reviewed by staff.

The service looked after some people's finances. We spoke with the administrator with responsibility in this area and looked at two people's admission files. We saw they had a financial contract with the service with information on what the person was willing to pay for. Financial transactions were recorded and receipts were held on the person's file. This reduces the risk of any financial abuse going undetected.

Requires improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interest. CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which apply to care homes. DoLS are part of this legislation and ensures that where a person without capacity may be deprived of their liberty that the least restrictive option to keep them as safe as possible is taken.

We looked at three people's care plans which all stated that the person did not have capacity. Although this was not specific about the decision the person was unable to make, and there was no mental capacity assessment within the persons care file. In addition, two of the care plans indicated that the person had bed rails in place. Bed rails can be used appropriately to keep people at risk of falling out of bed safe, however they can also be used as a type of restraint to prevent people getting out of bed. There was no evidence of a capacity assessment or best interest assessment being undertaken to ensure the rails were needed or in place in the person's best interest (if they lacked the mental capacity to make this decision). This meant the MCA and Code of Practice had not been followed when assessing a person's ability to make a decision.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014, Need for consent.

The registered manager told us that no person had a DoLS authorisation in place. Key codes were required to get in and out of the building and on some internal doors. In addition there was a stair-gate at the top of one flight of stairs. This meant that people could not leave the building or move freely around their home without asking for the codes, this could potentially mean that some people were being deprived of their liberty. We spoke to the registered manager about this and she agreed to review everyone living at Blenheim Court to confirm whether a referral for a DoLS authorisation was required.

People we spoke with told us they thought staff were well trained to do their job and were competent. One person said "They do a good job, considering they're so busy all the time." One relative said "I don't doubt they're well trained, but it doesn't help if there aren't enough of them"

We looked at staff training records. These showed that staff had received an induction and on-going training relevant to their job roles and responsibilities. The staff we spoke to had all received training on mental capacity and demonstrated an understanding of the legislation and what it meant in practice. A nurse told us that no person was currently administered medication covertly (without their knowledge). The nurse had a good, clear understanding of what covert medication means and what she would need to do if she felt a person required this. She gave us an example of one person who, although they took their medication, was likely to need covert medication in place in the future. She clearly explained to us a capacity assessment and best interest assessment would need to take place and this would include talking to their family, social worker, and relevant health professionals.

Staff told us they had regular supervision approximately every three months and yearly appraisals. We saw historical evidence of this on individual staff files and there was also a central file with all supervisions undertaken in the last 12 months. Supervision is an accountable, two-way process, which supports, motivates and enables the development of good practice for individual staff members. There was evidence of supervision taking place in the last two months on the six staff files we saw. Five of the six showed regular supervision had taken place prior to this. This meant the staff were adequately supported to carry out their roles and responsibilities.

Every person and every relative we spoke with told us the food was very good. One person told us

"It's the best food I've ever had." Another person told us "The cook here must be fantastic. I've never had a bad meal."

We observed people having lunch. The food on the day of our inspection looked appetising and was well presented, including the pureed meals. Two choices of hot meals were available. We tried samples of both meals and they both tasted good. It was evident they were freshly cooked. One relative we spoke with told us they were unhappy because their family member (who had suffered a stroke) was on a

Requires improvement

Is the service effective?

pureed diet, but they had found today they had been served a potato with skin, which they were unable to eat. This meant there was a risk to the person choking due to their reduced ability to safely swallow as a result of having a stroke. When the relative questioned the care worker, the care worker thought that the potato with skin was acceptable. The relative was going to discuss this incident with the registered manager.

People enjoyed their meals and were able to eat at their own pace. People could eat their meals where they wished, so people ate in the two dining rooms, in the lounges or in their bedrooms. One dining area was large and spacious. The other dining room was small, but quieter, for people who preferred a quiet environment.

Care workers and kitchen staff worked efficiently together to ensure people received warm meals, wherever they ate their meal. Several people needed full support with their meals and the care workers provided support in a sensitive manner, speaking appropriately to people and ensuring their dignity was maintained. However, one care worker in the small dining area stood up to fully support a person with part of their meal, which was not a sensitive way to assist. It is good practice to sit next to a person at a similar height to support a person with eating or drinking. This person's face was also inches away from the food waste tubs on the top of a trolley where care workers were scraping food into the tubs.

We saw that warm and cold drinks were served regularly during the day in the lounges and in bedrooms. People we spoke with told us there was always plenty to drink. Staff serving the refreshments seemed to know people's preferences for drinks and those who needed support with their drinks were assisted by staff.

Some people we spoke with could recall having support from other professionals. One person said "I had to have the doctor the other day because I wasn't so good, but I'm alright now." Another person said "People from the hospital come out to look at my legs. They're all bandaged up, but they're getting better now." However, one relative told us they were disappointed in staff's reaction to their concerns at times and felt staff did not take always their concerns seriously. The care plans we looked at contained information and contact details of other professionals involved in the person's care.

Requires improvement

Is the service caring?

Our findings

People and relatives we spoke with told us that the care workers were kind, compassionate and patient. One person told us "They're lovely girls and boys. I do think they work very hard and it's not an easy job." Another person told us "You get one or two grumpy ones, but who wouldn't be grumpy working such long shifts. But most of them are very nice people." A relative told us that "staff go above and beyond, feels like family."

One person who needed two care staff to assist them, told us that most care staff were good, "but a few are a bit rough on how they move me and they can hurt me." This person said they had told their relative and their relative had spoken to the registered manager about this.

We observed care interactions that were friendly and efficient, including transferring people from wheelchairs to arm chairs. We saw care workers speak with people respectfully before starting any care intervention to explain what they were doing. We also saw one care worker complaining about the long hours they had worked that week. They did not interact with people as positively as the other care staff.

Most people we spoke with told us that they were treated with respect and their dignity was upheld. We saw that people were well dressed and well presented. We heard care workers speaking courteously and respectfully to people. However, one person told us they had asked for a commode in their bedroom because they thought it was an undignified process to taken to a toilet just outside the communal lounge area where everyone could see them.

We witnessed a person in the large lounge asking loudly for help to get to the toilet for approximately 20 minutes after lunch and they were becoming increasingly distressed. Several staff spoke to the person explaining they needed two care workers to assist them so when two care workers were available they would help. We observed after 15 minutes that there were at least two care workers in the lounge, but they prioritised transferring people from the dining area into the lounge area and hoisting them into arm chairs. After 20 minutes two care workers assisted this person into a hoist to take them to the toilet by this time the person had been incontinent and was visibly upset.

A relative who visited regularly told us that she had occasionally seen this happen before.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Dignity and respect.

People told us their privacy was respected and we saw care workers knocking on doors before entering bedrooms. We spoke to one person who had specifically asked to receive all of their care in their bedroom and this request had been respected.

People we spoke with did not know about their care plans, but did not want to know anything more about them. One person said "I leave all that to my son." Relatives we spoke with told us they had been involved in care planning and were happy with their level of involvement. The care plans we saw reflected this.

Requires improvement

Is the service responsive?

Our findings

The registered provider's complaints procedure was displayed in the reception area. One person we spoke with had made a complaint. This person had spoken to the registered manager and felt their complaint had been listened to and resolved.

People we spoke with could all name staff members they would speak to if they had a concern. This staff member was not always their key worker. People seemed confident that the named staff member would listen to them, take them seriously and help to deal with their concerns.

People we spoke with told us they had choice about what to do, where to spend the day, when to go to bed, when to get up and what to eat. One person said, "Me and my friend don't like sitting in the big lounge – it's too noisy – so we can sit in the small lounge and it's only the two of us. I like it that way." Another person said, "I don't like all the activities, but I like the entertainers and the exercises, so I just go to those." Another person said, "I like to go outside when the weather's right and I can do that by myself. It's a nice garden to sit in." The same person said, "We go to the local club every so often. It's nice to get out."

On the day of our inspection there was an externally employed exercise therapist present, this was in addition to the activity coordinator. The session was well attended and we could hear laughter and happy conversations throughout the session. The exercise therapist came to Blenheim Court for a one hour session every three months.

We saw that there was an activities list for people Monday to Friday and the activities were often in the large lounge.

We also observed the activity in the afternoon of our visit in the large lounge, which was a discussion led by the activities co-ordinator, using a newsletter as a prompt. There were approximately ten people in the lounge and they were seated around the edge of the large room. People with hearing difficulties would not be able to hear. Some people appeared not to have the mental capacity to contribute to the discussion and some were asleep. This meant the activity may not have met the needs of everyone in the room.

There was no evidence that activities were person centred to meet individual needs. It was not clear from the weekly activities list what activities or stimulation was provided for people receiving care in their bedrooms. People we spoke with who received care in their bedrooms could not recall any activities they took part in. One person who received care in their bedroom said, "It does get boring at times."

The environment was clean and mainly well decorated, but not particularly stimulating. There were no design adaptations or enhancements visible to us for people with sensory disabilities or limited mental capacity. There was no evidence of reminiscence areas, sensory displays or resources that could be used by care workers to interact with people with specific needs. Interactions with care workers in the communal areas on the day of our visit were limited to brief, passing conversations, due to the pressure of care tasks.

Some bedrooms were spacious, as they were originally double rooms. Some bedrooms were personalised with people's possessions.

Requires improvement

Is the service well-led?

Our findings

During our inspection we saw the registered manager interact positively with staff, people and visitors. She was visible and approachable. All staff we spoke to told us that they felt supported by management.

Three people we spoke with knew who the registered manager was and told us she was approachable. One person told us that the management of the home had changed for the better recently and they were pleased to see the improvements made. This person said, "I've got more freedom now there's a new management system. It's a totally different ball game now. I hope the next manager keeps it up." This person had raised concerns about their care with the registered manager and felt they were resolved.

Two of the relatives we spoke with knew who the registered manager was. The other relative said, "I've no idea who the manager is because they keep changing so often." We talked to the registered manager about this and she agreed that there had been management changes.

The registered manager told us she had started to implement positive changes, such as reviewing all care plans and had increased the numbers of kitchen staff. She was also in the process of recruiting a deputy manager.

'Residents meetings' (coffee mornings) were advertised on posters. Only one person we spoke with could recall attending a 'residents' meeting'. This person said "I took the opportunity to say what I thought and they did take notice."

We saw evidence of notice of regular 'relatives' meetings' held alternatively between afternoons and evenings to try and accommodate attendance by as many relatives as possible. The registered manager told us that the last meetings had been cancelled as a result of non-attendance. The registered manager explained that people and relatives spoke to her directly if they had any concerns.

Staff told they felt consulted and we saw evidence of regular staff meetings taking place.

The home had policies and procedures in place which covered all aspects of the service. The policies and procedures were up to date. The service also undertook regular audits, this is where regular checks are made to ensure good practice is maintained and action is taken if standards are slipping. The registered manager was in the process of implementing an electronic medication ordering system to reduce the risk of errors. Medication audits were undertaken monthly and as a result action had been taken to increase medication training for senior carers.

Our inspection identified that the registered manager has made changes to improve the service. However, as we have identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, further improvements and evidence of sustained change is required before this question can be rated as "Good".

The registered manager was aware of her obligations for submitting notifications in line with the Health and Social Care Act 2008. The registered manager confirmed that any notifications required to be forwarded to CQC had been submitted and evidence gathered prior to the inspection confirmed that a number of notifications had been received.

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 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **There were not enough staff employed to meet people's needs in a timely manner.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Care plans did not contain mental capacity assessments where it was stated the person did not have capacity.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Not all people were treated with dignity and respect at all times.**