Embrace (South West) Limited

The Laurels 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

We carried out this inspection on 22 March 2017. When the service was last inspected in January 2016 there were two breaches of the legal requirements in relation to 'person centred care' and 'need for consent'. Following the inspection in January 2016 the provider wrote to us to say what they would do to meet the legal requirements. At this inspection we checked that the provider had made sufficient improvements. Although they were meeting the legal requirements in relation to the regulations breached at the last inspection there had been a decline in the standard of service. We found breaches of other regulations at this inspection.

The service is a nursing home and is registered to provide care and support for up to 36 older people. On the day of our inspection there were 27 people living at the service.

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had quality monitoring systems in place which were used to bring about improvements to the service. These systems had been ineffective in ensuring that the service was meeting the regulatory standards.

Staffing was not organised in a way to meet people's individual needs. Whilst we observed staff working with people in a kind and compassionate way, people told us that this was not always reflective of care provided to them. People did not receive adequate person centred personal care.

The home was not suitably clean and maintained. Equipment was not stored safely. Fire risk was not effectively managed.

Records containing confidential information were stored inappropriately.

The staff had received training regarding how to keep people safe and they were aware of the service safeguarding and whistle-blowing policy and procedures.

People's needs were regularly assessed and care plans provided guidance to staff on how people were to be supported; however not all care plans contained sufficient information about people's needs. People's care, treatment and support was personalised to reflect people's preferences.

The staff had a clear knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). These safeguards aim to protect people living in care homes from being inappropriately deprived of their liberty. These safeguards can only be used when a person lacks the mental capacity to make certain

decisions and there is no other way of supporting the person safely. Meetings had been arranged in order to enable people's best interest to be assessed when it had been identified that they lacked the capacity to consent to their care and treatment.

There was a robust staff recruitment process in operation designed to employ staff that would have or be able to develop the skills to keep people safe and support people to meet their needs.

Staff demonstrated a detailed knowledge of people's needs and had received training to support people to be safe and respond to their support needs.

The service maintained daily records of how peoples support needs were met and this included information about medical appointments for example with GP's and dentists.

There was a complaints procedure for people, families and friends to use and compliments could also be recorded.

We saw that the service took time to work with and understand people's individual way of communicating in order that the service staff could respond appropriately to the person.

We found four breaches of regulations at this inspection and will be asking the provider to send us a report of the improvements they will make.

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 meet people's basic needs promptly.

The home environment was not suitably clean and maintained. Equipment was not stored safely and fire risk was not proactively addressed.

Staff knew how to recognise and report abuse and were aware of the service safeguarding and whistle-blowing policy.

Risk assessments reflected actions required to reduce risks to people.

The administration of people's medicines was in line with best practice.

Is the service effective?

Requires Improvement

The service was not effective

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Staff had received appropriate supervision and training but did not follow always follow their training.

The provider protected the rights of people living in the home in line with the Mental Capacity Act 2005. DoLS applications had been made for all people that required them.

Risks relating to people's nutritional needs were managed effectively.

Is the service caring?

Requires Improvement

The service was not always caring.

We received a variable response from people about staff and were told of occasions where peoples' care and dignity were compromised.

Is the service responsive?

Requires Improvement

The service was not responsive.

People were supported to use healthcare services, however recommended professional advice was not always followed.

Care plans were generally person centred however some of the plans did not provide enough detail to inform staff of the care people needed .

People received group activities. People nursed in bed did not receive person centred activities.

There were systems in place to respond to complaints.

Is the service well-led?

Requires Improvement

The service was not well led.

The systems in place for monitoring quality and safety were not effective in ensuring that the risks to people were identified and managed.

The provider failed to act and respond in a timely way to requests made by people and relatives in relation to improving the service.

Statutory notifications had been made to the Commission for notifiable incidents.

The Laurels 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 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.

The inspection took place on 22 March 2017. This was an unannounced inspection, and was carried out 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 care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form the provider completes to give some key information about the service, what the service does well and improvements they plan to make. The provider returned the PIR and we took this into account when we made the judgements in this report.

Prior to the inspection, we reviewed information we held about the service including statutory notifications. Statutory notifications are information about specific important events the service is legally required to send to us.

Some people at the home were not able to tell us about their experiences. We used a number of different methods such as undertaking observations to help us understand people's experiences of the home. As part of our observations we used the Short Observational Tool for Inspection (SOFI). SOFI is a way of observing care to help us understand the needs of people who could not talk with us.

As part of our inspection, we spoke to 13 people who used the service, the registered manager, two relatives, seven members of staff and a visiting professional.

We tracked the care and support provided to people and reviewed care plans relating to this. We also looked at records relating to the management of the home, such as the staffing rota, policies, recruitment and training records, meeting minutes and audit reports.

Requires Improvement

Is the service safe?

Our findings

There were not enough suitably skilled staff to meet people's needs.

People we spoke with said "Could do with more staff especially at night" and "If I ring my bell they pop in and say 'can you just give me 5 minutes', but another person might need them more before they get to me so it can take 20 minutes; once they are here I get their full support. Another person said "I do not always feel safe, as I have to wait for 10 minutes, or up to 30 minutes for my buzzer to be answered, on one occasion I sat on the toilet for an hour waiting for someone to come back to me, I was distressed and sore. There are definitely not enough staff here, especially at night, and there are a lot of agency staff". A further person said "They could do with more staff, I have to wait 15 minutes for my buzzer to be answered."

A visitor said "At weekends there are mainly agency staff and at handover times there is never anyone to respond to call bells. I think it would be better if there was just one more member of staff." Another visitor said "Staff do their best but do not have training and there are not enough of them."

The majority of staff we spoke with said there was enough staff on duty to meet people's needs. Comments included "We're usually fully staffed", "We always have enough staff" and "We usually have enough staff but not necessarily every day; weekends are worse". However, the layout of the building meant that at times it was difficult to locate a member of staff. For example, we heard one person calling "help me" several times. We went to check the person was ok and they showed us they had spilt a cup of tea which had gone onto their bedding. We had to walk along the corridors in order to find a member of staff, which took approximately ten minutes. Although the spilt tea was cold, the person had to wait for their bedding to be changed. On another occasion, we observed one person had been incontinent and was sitting in the lounge in visibly wet clothes. We informed the staff member in the lounge but they were providing 1:1 support to another person and was therefore unable to assist and so they rang the buzzer for another member of staff to come and help the person. They rang the buzzer and a staff member arrived 13 minutes later which meant the person was sat in wet clothes in the lounge with other people for that time which was undignified as well as being uncomfortable. We also observed that at 12.10, staff were serving morning coffee and biscuits to people later than usual as they had previously been too busy; lunch however was due to be served at 12.30.

We also found whilst looking at complaints there was a theme of people's needs not being met due to a lack of staffing. One person complained their personal care was not attended to because of staff being busy during lunchtime. Another complaint was around lack of personal care.

These failings amounted to a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed equipment such as hoists, wheelchairs and an open trolley containing clean laundry being stored in bathrooms which were in use during the inspection; we brought this to the attention of the registered manager who explained that a lack of storage had led to bathrooms being used as temporary

storage. These incidences increased the risk of cross contamination and the spread of infections and did not contribute to ensuring a safe environment.

We observed equipment being stored in corridors directly under signs which stated that equipment should not be stored in the corridor. The storage of equipment in this manner increased the risk in event of an emergency evacuation and had been highlighted as part of the service's fire risk assessment.

Within communal areas of the home skirting boards were dusty and walls were flaking paint and marked. We noted that carpets were also stained. One area of the building in particular was malodourous we told the registered manager about this. One resident had a supply of air fresheners in their room because of this. Throughout the day we checked toilets, these were not always clean. Some of these issues had been noted during a provider quality assurance tool audit in January 2017; there was no action plan to address these issues. Despite the audit there were no signs of improvement on the day of the inspection.

We also looked at the fire risk assessment for the home and found some high priority concerns which had been detailed in an accompanying action plan and had not been addressed since 26 January 2015. The provider had failed to ensure they were managing risk and a safe environment for people.

These failings amounted to a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had risk assessments within their care plans for areas such as moving and handling, falls and mobility. When people needed assistance to change position, the risk assessments contained details on how staff should support people to do this safely. For example the assessments contained hoist and sling details. In one person's care plan it had been documented that a referral had recently been made to the re-enablement team which demonstrated that the team were aiming to promote the person's independence as much as possible.

Some people had bed rails in situ to prevent people falling out of bed. The care plans for these people had bed rails risk assessments in place to ensure they were still being used safely.

However, one person was receiving continuous oxygen therapy. There are considerable risks associated with this, including the risk of fire and the risk of trips due to the oxygen tubing. There was no care plan in place in relation to the use of the oxygen. We discussed this with the deputy manager during the inspection and a plan was written and put in place before we left.

Medicines were managed safely. Medicine administration records (MAR) contained photographs of people and there was a clear system in place to highlight people's allergies. There were PRN (as required) protocols in place and when PRN medicines were administered, the reasons had been documented. Stock balances of medicines were maintained and there were no gaps in the administration records which indicated that people received their medicines as prescribed. Medicines that required refrigeration were stored in a locked medicines fridge. The temperature of this was monitored daily and records showed this had taken place, with no gaps noted.

Controlled medicines were stored safely and again, stock balances were maintained and checked regularly. When medicines were no longer needed, the disposal process was safe. Monthly internal medication audits had been undertaken, and the most recent ones that we looked at showed a compliance rate of 100%. The deputy manager and the nurse on duty showed us the processes they had in place in order to ensure safe medicines management.

People were protected from the risks of avoidable harm and abuse. Staff said they had received training in how to safeguard people and all demonstrated that they knew what abuse was and knew how to report it. Staff were also familiar with the term whistleblowing and all said they knew how to report any concerns, either internally or to the commission. One said "There are posters up telling you what to do if you have any concerns."

Accidents and incidents were recorded, they were analysed by the registered manager or senior staff. The analysis was discussed with staff and subsequent action plans were put in place to reduce the likelihood of reoccurrence and to keep people safe. The records we viewed showed a system which recorded timescales for response to concerns, outcomes and actions taken.

There was a robust selection procedure in place. An enhanced Disclosure and Barring Service (DBS) check had been completed. The DBS check ensured that people barred from working with certain groups such as vulnerable adults would be identified. We saw that the recruitment process also included completion of an application form, an interview and previous employer references to assess the candidate's suitability for the role.

The service had emergency procedures in place which included the actions to be taken in the case of fire. People also had personal evacuation plans which clearly identified their needs if evacuation was required.

Requires Improvement

Is the service effective?

Our findings

People had access to ongoing health care services. Care plans showed when people had been reviewed by the GP, the Mental Health team and the speech and language therapy team (SALT). We spoke with a visiting professional; they told us that staff did not always encourage and motivate people to follow professional advice around their treatment.

Staff said they had undertaken training and understood how the training applied to their roles. We found that training for staff was up to date. Despite this we found that people felt staff were not adequately trained. For example one person said "Staff are not careful and not trained, I slipped when an agency carer who was helping me did not know how to use the hoist." Another person said "Because the sort of new people coming in puts pressure on staff, they are not trained for it," Nurses also had access to ongoing professional development such as PEG training (percutaneous endoscopic gastrostomy), urinary tract infections and training on the Mental Capacity Act. They said some training was provided from external organisations; for example the local Mental Health team.

Staff said they had regular supervision sessions. Comments included "I have supervision every couple of months" and "I had one not long ago, last month I think". All staff said they felt well supported. Comments included "I feel very well supported, I have no worries about asking anyone about anything", "If I have any problems, I speak to the manager, she's very understanding" and "The manager is definitely supportive. She's friendly and very open with the staff. We can contact her any time and know she will support us."

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.

Consent to care was sought in line with legislation and guidance. Where able to, people had signed a form to indicate they consented to their care and support plans. Alongside this, we observed staff asking people for consent throughout the inspection. For example, we saw staff asking people where they would like to sit and being asked what they would like to order for lunch and supper. Staff demonstrated a good knowledge of the Mental Capacity act and understood the importance of offering people choice.

The provider had met their responsibilities with regard to the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm. Appropriate DoLS applications had been made specifically around people's constant supervision by the service. We spoke with staff and found that they were knowledgeable about DoLS.

People were supported to have enough to eat and drink. Nutritional and choking assessments were in place and people's weights were regularly monitored. When necessary, advice was sought from SALT and this was

documented within people's care plans. We saw that one person was overweight and the care plan detailed low calorie meal suggestions that staff should offer. Nobody was having their food intake monitored at the time of the inspection. One person was having their fluid intake restricted due to their medical condition and staff we spoke with were familiar with this.

People were offered a choice of options for lunch and for supper. When people did not want what was on offer, they were able to choose an alternative. There were drinks available for people and we observed people being offered drinks throughout the day.

People said "They monitor what I drink, I try to drink as much as I can but they nag me to drink more", "Food is nice, I can have more if I want it", "Food is usually first class, occasionally I am offered something I do not like" and "Food is reasonably good, we get quite a variety." A relative said "My [relative] moans about the food, and timings, as they have a cooked breakfast, followed by tea and biscuits mid-morning then has lunch at 12."

Requires Improvement

Is the service caring?

Our findings

Staff knew how to respect people's dignity and privacy; this was not however fully reflected in people's experience of care at the service. Staff discussed providing personal care behind closed doors and ensuring curtains were closed. However, as mentioned under the safe domain of this report, people's dignity was not always maintained because we observed one person sitting in wet clothing in the lounge while they waited for a staff member to come and assist them. People made mixed comments about staff; "[Staff name] and [staff name] are excellent, others not so good" and "Carers are mixed, some very good others are not" and "Carers are absolutely wonderful, experience comes with age, the older ones are best, they are so kind and will do anything for me." Another person told us they had been 'moaned at' for calling staff.

We were told of occasions when people felt that staff had been less than respectful towards them. One person we spoke with told us they had been told by staff to 'Go in their pad' rather than be assisted onto the toilet. Another person said "They told me I have to wee in my pad and use it even if I have diarrhoea I have done this reluctantly and had to sit in it, I was disgusted." People told us they were not asked about their preferred gender of carer. We were told of an occasion when there were no female staff available to assist female residents. These incidences failed to maintain people's dignity and respect

People were at risk of neglect of their personal care. We observed that some people had dirty teeth. A visiting professional also commented on the dirty state of people's teeth and that people's skin was very dry. They thought that personal care provided to people was not thorough.

We observed a person in their room at 4.50 pm with food debris around their mouth and on their chest from lunch. Staff had been in their room three times since the person had finished their lunch but had not ensured that the person was clean. People told us they did not receive baths or showers as often as they would like them or personal care in a timely way. One person said "I do not have a shower or bath, often no more than a lick and a promise; I thought I would receive treatment as it was a nursing home, but I just get basic care." A visitor said "My [relative] says they enjoy the food, but they do not drink enough because they would need to go to the toilet, and cannot get there on their own, and they do not like to soil their pad, this has resulted in several UTIs."

We asked for records of personal care; we found it was not clear when baths and showers had been offered to or received by people; there was a lack of assurance that people received the appropriate assistance with their personal care.

These failings amounted to a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we observed positive interactions between staff and people using the service. The atmosphere was calm and friendly. There was plenty of laughter and we saw examples of good relationships between staff and people, such as one member of staff laughing and joking with one person and a relative sharing a joke with another member of staff. During lunch we observed a staff member assisting a person

with their lunch. They were talking with the person throughout which made the meal a more sociable occasion.

Staff spoke positively about the care that was provided. Comments included "Everyone knows everyone here, it has a family feel about it", "People are smiling and happy here, that's how I know I've done a good job" and "I know and trust the staff here. I know we all work really well". However, one visitor to the service did say "I don't think all of the staff are caring."

Staff knew the people they were caring for and understood their needs. When we asked staff about the care they provided, they spoke knowledgably about people and demonstrated that they knew them well. Comments included "I know what people want from reading the care plans, talking to them and their relatives" and "I know about people from asking them what they want. The nurses tell us about any changes in handover." We found however the observed level of service provided to people was contrary to the staff knowledge of their required needs as mentioned earlier in this section of the report in relation to personal care.

People's wishes in relation to end of life care had generally been documented. It was clear from care plans that staff had initiated discussions with people and where they had expressed their wishes these had been documented. For example, in one plan it had been documented "Refused to discuss, but does want to be resuscitated."

Requires Improvement

Is the service responsive?

Our findings

Care plans did not consistently reflect people's individualised needs. The quality and content of care plans were variable. There was detail documented about people's preferences and choices in relation to their care. For example, in one person's plan it was documented that they had a history of self-neglect and the plan detailed how staff should encourage and support the person to ensure their hygiene needs were met. In other plans we saw that people's preferences in relation to their preferred time of getting up and going to bed, how they liked to dress had also been documented. For example, in another plan it was documented that the person liked to wear matching jewellery and nail varnish.

One person had visual difficulties and the plan detailed how staff should keep the person's glasses clean, close to hand and ensure they had their call bell close by. However, some of the plans did not provide enough detail to inform staff of the care they needed. For example we looked at two care plans for people with diabetes. One plan was detailed and described what diabetes was and the signs and symptoms of hypo and hyperglycaemia. The other person's plan made reference to them having diabetes but there was no diabetes specific plan in place. The same person had a urinary catheter in situ but there was no catheter care plan in place. The same person was also receiving oxygen therapy, and yet there was no plan in place for how staff should provide this. The registered manager agreed to rectify these care plans immediately.

Some people were at risk of skin breakdown (pressure sores). In these instances, care plans detailed how this should be prevented. Some people had air mattresses in place to relieve the pressure on their pressure points. The mattresses we looked at all needed to be set according to the person's weight. All but one of the mattresses we looked at were set correctly and the one that was incorrect was immediately rectified when we pointed it out to the nurse on duty.

The home had a complaints procedure available for people and their relatives. The service had a complaints log and a policy and procedure for people to use. The complaint records demonstrated that people were supported to make complaints when they needed to and that the registered manager responded quickly and appropriately to any concerns identified to resolve the complaint. People and visitors said they knew how to complain. One said "I have not had to complain, I can call the manager if I want to talk." Another person told us they had made a complaint and told us complaint had been resolved by the registered manager. This person said; "I have had clothing go missing, the manager has paid to have some items replaced."

Whilst formal complaints were dealt with as per the provider's policy we found that less formal complaints about improvements required by people were not dealt with to people's satisfaction. This is further detailed in the well led section of this report.

Where able to, people had signed their care plans to indicate they agreed to them. However, although the plans had all been reviewed monthly, there was nothing documented to indicate that people or their relatives had ever been involved in a review.

People had access to activities. People spoke highly of the Activities Co-ordinator who was on leave on the day of our visit. There is a full programme of events which take place daily Monday to Friday. These include skittles, bingo, dominoes, snakes and ladders, arts and crafts and there are occasional outside entertainers. We found however there was no evidence to suggest residents who remained in their rooms received any one to one activity time. On the day of our visit three members of the housekeeping team did a short impromptu exercise session to music in the lounge during the morning, several residents joined in and appeared to enjoy it. During the afternoon there was a bingo session, run by a member of staff who was also caring for a resident on a one to one basis.

Requires Improvement

Is the service well-led?

Our findings

The provider's quality assurance systems and processes did not ensure that they were able to assess, monitor quality provision and mitigate the risks and relating to the health, safety and welfare of people and others who may be at risk in the service.

The quality assurance systems used by the provider and the service were ineffective in assessing where the service required improvement and implementing and sustaining improvement effectively within a reasonable timescale. For example infection control audits had not picked up on issues in relation to the storage of equipment and laundry is bathrooms and the compromise in infection control and prevention. Since our last comprehensive inspection there had been deterioration in the level of service provided.

There had been a resident/relative meeting held several days before our visit this was organised by the activities coordinator. Issues had been raised by people around the lack of regular baths and showers; we were told by the registered manager they had not been aware of peoples' views around this issue until very recently. We found however that staff meeting minutes from November 2016 clearly highlighted the need for staff to ensure that people received baths and showers at least once a week and stated 'No set rules on when or how many residents are up and washed in the mornings or at night and that it is the residents' choice.

People and relatives told us about issues they had raised repeatedly that had not been addressed. One person told us they have repeatedly asked to have separate male and female toilets but that no one listened to them. A relative told us they had been assured that their loved one's room was going to be upgraded when they moved in more than a year ago, but despite many meetings and promises this has not happened. Another relative said "The heating does not work properly… the window frames are rotten, there are draughts and the glass in the windows is obliterated, so my [relative] cannot see out. At the last resident and relatives meeting a few days previously people had been given an assurance that the windows in the home were going to be replaced and a new central heating system installed. These issues had been ongoing with no confirmation of plans to start the works. The registered manager was unable to tell us if these works were approved or when they were due to take place despite people having been given assurances the works would take place.

Records were not stored securely. We found boxes of archived files and material stored in an area which was accessible to anyone within the home. These documents contained confidential information.

These failings amounted to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff said they attended regular team meetings; they said these were planned for the year ahead and there was a staff meeting on the day of our inspection. All staff said they felt well informed in relation to how the service was running. For example, one member of staff said "The manager keeps us informed and involved with everything" and another said "If the manager left, I'd leave."

Several staff spoke about the importance of teamwork. They said "We are a team here, which is why it works so well", "The nurses, the carers, the kitchen staff and the cleaners, we all help each other" and "We have a family feel here and the smallness (of the home) makes us a good team. We all pull together."

Despite raising concerns and issues about the provision of the service people and relatives told us the registered manager was approachable and easy to talk to. Relatives told us they are made to feel welcome when they visited.

All services registered with the Commission must notify the Commission about certain changes, events and incidents affecting their service or the people who use it. Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled. We found that the registered manager had made appropriate notifications.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity and respect. There was a lack of assurance that people received the appropriate assistance with their personal care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to ensure they were managing risk relating to the premises and a clean and safe environment for people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's quality assurance systems and processes did not ensure that they were able to assess, monitor quality provision and mitigate the risks and relating to the health, safety and welfare of people and others who may be at risk in the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough suitably skilled staff to meet people's needs.