Sandylane Limited

Regent Hotel

Inspection report

11 North Marine Drive
Bridlington
Humberside
YO15 2LT

Tel: 01262673338

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Regent Hotel is a care home that accommodates up to 29 older people, some of whom may be living with dementia. The home is situated on the sea front in Bridlington, a seaside town in the East Riding of Yorkshire. Bedrooms are located on the ground, first and second floors and there is a passenger lift to reach the first and second floors. On the day of the inspection there were 25 people living at the home, including five people who were having respite care.

At the last inspection in March 2015 we were concerned that people's nutritional and hydration needs were not being met, that staff training was out of date, that the premises were poorly maintained and that recording was inconsistent. We issued requirements in respect of Regulation 14, Regulation 15, Regulation 17 and Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we saw that staff had completed training on health and safety, fire safety, safeguarding adults from abuse, and infection control during the previous 12 months. New staff were undertaking induction training and shadowing experienced staff before they worked unsupervised. The provider was no longer in breach of this regulation.

Repairs had been carried out to the premises as part of the refurbishment programme and maintenance of the fabric of the home had improved. The provider was no longer in breach of this regulation.

People told us they were happy with the choice of meals provided at the home. People's nutritional needs were recorded and their food and fluid intake was being monitored when this was an identified area of concern. Although we saw that people were receiving sufficient to eat and drink, the recording on monitoring forms remained inconsistent.

The manager carried out audits to ensure people were receiving the care and support that they required, and to monitor that staff were following the policies, procedures and systems in place. These audits required more detail about the action taken to address any identified shortfalls.

Care planning described the person and the level of support they required. However, there were some anomalies in recording, although none of these had affected the care the person had received.

We have made a recommendation in the report about the need for recording to become more consistent.

We identified concerns about the prevention and control of infection. The systems currently in place did not fully protect people from the risk of infection.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

You can see what action we asked the provider to take at the end of the full report.

Sufficient numbers of staff were employed to make sure people received the support they needed, and those staff had been safely recruited. People told us they felt safe living at the home.

People were supported to have maximum choice and control over their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Risks to people were assessed and reduced where possible. Staff received training on safeguarding adults from abuse. They were confident when describing different types of abuse they may become aware of and the action they would take to protect people from harm.

Staff were kind, caring and patient. They encouraged people to be as independent as possible and respected their privacy and dignity. However, we were concerned that two toilets downstairs did not have locks and this compromised people's privacy and dignity. This will be addressed outside of the inspection process.

Staff told us they were well supported through supervision and staff meetings.

Although we did not see any activities taking place on the day of the inspection, we were told that the activities coordinator worked on three days a week, and we saw a programme of activities for those days.

People understood how to express any concerns or complaints and were given the opportunity to feedback their views of the service provided.

There was a registered manager in post. They were also managing another service operated by the same provider. A new manager had been appointed and a gradual handover was taking place. The new manager told us they would be applying for registration with the Care Quality Commission (CQC) when they were fully confident in the manager role. People who lived at the home and staff reported that the service was well managed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The arrangements in place for the prevention and control of infection were not robust.

There were sufficient numbers of staff employed and they had been employed following safe recruitment practices.

Medicines were well managed to ensure people received the right medicines at the right time.

Is the service effective?

Good

The service was effective.

Staff were aware of their responsibilities under the Mental Capacity Act 2005.

People were happy with the meals provided and had their nutritional needs met.

Staff received the training they needed to enable them to carry out their roles effectively.

Is the service caring?

Good

The service was caring.

We saw positive interactions between people who lived at the home and staff.

People told us that staff were kind and considerate, and respected their privacy and dignity.

Staff promoted people's independence.

Is the service responsive?

Good

The service was responsive to people's needs.

People had their care needs assessed and care plans were

developed to guide staff on how to best support the person.

People were aware of how to make a complaint should they have concerns.

People had the opportunity to express their views about the service provided at the home.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Some recording needed to improve so there was an accurate account of people's needs in care plans and in monitoring records.

There were quality monitoring systems in place but these needed to be more robust so there was a record of action taken to address any identified shortfalls.

There was a registered manager in post and staff reported they were well supported.

Regent Hotel

Detailed findings

Background to this inspection

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

This was a comprehensive inspection that took place on 6 July 2017 and was unannounced. The inspection was carried out by two adult social care inspectors.

Before this inspection we reviewed the information we held about the home, such as information we had received from the local authority and notifications we had received from the registered provider. Notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. The registered provider was asked to submit a provider information return (PIR) before this inspection. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was submitted within the required timescale.

On the day of the inspection we also spoke with six people who lived at the home, one relative, four members of staff, a visiting health care professional, the day-to-day manager and the registered manager. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked around communal areas of the home and some bedrooms, with people's permission. We also spent time looking at records, which included the care records for three people who lived at the home, the recruitment and training records for three members of staff and other records relating to the management of the home, such as quality assurance, staff training, health and safety and medication.

Requires Improvement

Is the service safe?

Our findings

Staff described to us how they promoted good hygiene practices by using personal protective equipment such as gloves and aprons, and washing their hands before and after assisting people with personal care. In addition to this, people who lived at the home told us the environment was maintained in a clean and hygienic condition. However, we observed that, although there was evidence of regular cleaning, some areas of improvement were required to ensure staff were consistently following best practice in relation to the prevention and control of infection. For example, the shower room did not contain any hand wash or paper towels. The shower curtain was dirty and there was a wheel in the shower tray. We informed the manager about this and they were not able to explain where the wheel came from, although they felt it could have been from an unused wheelchair. The bathroom contained inappropriate items, such as a metal frame and continence aids stored on the floor. It appeared to us to be 'out of use' but staff assured us it was used by people who lived at the home. One of the ground floor toilets included a clinical waste bin with a foot pedal so staff did not need to touch the bin with their hands. The foot pedal could not be used as the bin was stored on top of a set of drawers. The drawers contained items that belonged to individuals who lived at the home, such as a hair brush. Spare toilet rolls were not stored in a container, as recommended and one toilet seat and a stand aid had not been thoroughly cleaned.

Although there was no record of when mattresses were checked for cleanliness, we found most mattresses were clean. Similarly, most pressure care cushions were clean although we saw one pressure care cushion had a tear in it, meaning it would not be possible to keep it clean. Most settees and chairs were comfortable but not made of wipeable material; this made them difficult to keep clean. We saw that the laundry facilities at the home were satisfactory.

We were shown the infection control audit, and we discussed with the manager that this was more like a cleaning audit than an infection control audit, and they acknowledged this. The list recorded tasks that required completion, but not the frequency, and there sometimes no record of when these tasks had been completed.

Prior to the inspection we had been informed that the home had a problem with excessive flies. This was confirmed by a person who lived at the home. They told us, "Oh yes, it's horrid. This is the worst corner [pointing to the bay window]. They don't come in my bedroom though." Staff also confirmed to us that this was a concern. There was an insect repellent in the lounge but this had not been effective in alleviating the problem.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

The home had previously received a food hygiene score of three, and in April 2017 this had increased to four. The inspection checked hygiene standards and food safety in the home's kitchen.

People told us they felt safe living at the home. One person said, "Yes, it's lovely living here." Staff described

to us how they kept people safe. Comments included, "We support people to go upstairs in the lift; no-one uses the stairs" and "Staff go on training such as medicines and moving and handling. They have to do this before they can support people."

Care needs assessments had been carried out, and when risks had been identified, action was taken to minimise potential risks without undue restrictions being placed on people. We saw risk assessments in respect of use of the emergency call system, nutrition, use of the lift, pressure area care and mobility / falls. The risk assessments were reviewed monthly so they remained up to date and relevant to the person concerned. None of the people who currently lived at the home required positional changes to be carried out by staff. However, we saw staff assisting people to mobilise and noted this was carried out safely.

Staff received training on safeguarding adults from abuse. They were confident when describing different types of abuse they may become aware of and the action they would take to protect people from harm. Staff told us they would pass on any concerns to the manager and were confident their concerns would be dealt with immediately. We were aware of one incident that had occurred when no alert was submitted to the safeguarding adult's team. We discussed this with the manager and concluded this was an isolated incident; the manager was not aware an incident of this nature required an alert to be submitted to the safeguarding adult's team or a notification to CQC.

On the day of the inspection we saw there were enough staff on duty. One person told us, "There are staff about and they are not in too much of a rush" and another said, "They always help you if you need it." However, one person said they felt they could do with more staff, especially for supporting people to use the toilet. Staff told us they were happy with staffing levels and that managers always tried to cover short notice staff absences by staff working additional hours or by using 'bank' staff. One member of staff said they felt there were sufficient numbers of staff to ensure people received the assistance with personal care they required, but not enough to enable them to spend time with people. We observed on the day of the inspection that only one member of staff spent some quality time talking with people.

Ancillary staff were employed in addition to care staff. This included cooks, kitchen assistants, laundry assistants and domestic assistants. This enabled care staff to concentrate on supporting people who lived at the home.

We checked the recruitment records for two members of staff. These records evidenced that references and a Disclosure and Barring Service (DBS) check had been obtained. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults to help employers make safer recruitment decisions. However, there were occasions when this information had not been received prior to the person's start date. The manager told us that people were only allowed to carry out training or shadowing until all safety checks were in place, and we advised that this should be recorded in the person's records so there was evidence that only people considered safe to work with people who may be vulnerable had been employed. There was no photographic evidence for one new employee and the manager assured us this would be obtained.

There were thorough policies and procedures in place on the management of medicines, and staff were careful to adhere to administration practices. We saw that medicines were stored safely, obtained in a timely way so that the person did not run out of them, administered on time, recorded correctly and disposed of appropriately; this included the management of controlled drugs (CDs). CDs are medicines that require specific storage and recording arrangements. We saw that staff were very patient with people when encouraging them to take their medicines, and did not sign the medicines records until they had seen the person swallow their medicines. People confirmed they received the right medicines at the right time.

Accidents and incidents were recorded, and each month a summary was prepared of the total number of accidents, the number of times an ambulance was called, the number of people taken to hospital and the number of CQC notifications submitted in respect of these accidents. Body maps were used to record where on the body the injury occurred, and to assist staff to monitor the person's recovery.

There was a contingency plan that provided advice for staff on how to deal with a fire and a passenger lift breakdown. This would benefit from the inclusion of information in respect of emergencies such as bad weather conditions, utility failure and IT failure. People had a personal emergency evacuation plan (PEEP) in place that recorded the assistance they would need to leave the premises in an emergency.

We reviewed service certificates and these evidenced that equipment and systems had been appropriately maintained. This included the fire alarm system, fire safety equipment, mobility and bath hoists, the electrical installation, portable electrical appliances, the emergency call system and gas appliances / systems. In-house maintenance was carried out; this included two-weekly fire alarm tests, checks on emergency lighting and checks on window opening restrictors.

Good

Is the service effective?

Our findings

At the last inspection of the home we identified concerns about people's nutritional intake and associated record keeping. At this inspection we observed that people's special dietary requirements and their likes and dislikes were recorded in their care plan and we saw people had appropriate nutritional assessments and risk assessments in place. Care plans recorded referrals to speech and language therapy or dietetic services when risks of choking or malnutrition had been identified.

People told us they liked the meals at the home. One person said, "The food is very good. We get a choice. They come round after breakfast and ask you what you want for lunch and tea." We saw a list of alternatives to the main menu on display on one of the notice boards, and noted that people received different meals.

We observed the serving of the three course lunch; the meal looked appetising and we saw that people were offered a choice of meals and hot or cold drinks. Tables were set with cloths, place mats, condiments and glasses. People received appropriate assistance to eat their meals. There was no menu on display and we discussed with the manager how this would serve as a reminder to people during the day about the meals that were on offer.

Record keeping in respect of food and fluid intake remained inconsistent and this has been recorded under the Well-led section of this report.

At the last inspection of the home we had identified concerns about staff training. It was acknowledged that staff had not completed all of the training considered to be essential by the home, and had not kept up to date with refresher training. At this inspection we saw that this had been addressed.

Staff received induction training when they were new in post, and also shadowed experienced staff as part of their induction training; this was confirmed by staff who we spoke with. Training records showed staff had completed training on the topics considered essential by the home, including safeguarding adults from abuse, health and safety, fire safety and infection control. Some staff had completed additional training such as dementia, first aid, food hygiene, medicines, equality and diversity, challenging behaviour, end of life care, dental health and mental health awareness. We discussed with the manager that, ideally, all staff should complete training on dementia care as the home provided a service for people who were living with dementia. Records showed that nine of the 18 care staff had completed a National Vocational Qualification (NVQ) at either level 2 or 3. We acknowledged that the topic of dementia may have been included in this training, but discussed with the manager that this needed to be evidenced in training records.

The manager told us that most new staff had chosen to enrol on NVQ Level 2 rather than the Care Certificate, although two people had chosen to complete the Care Certificate. The Care Certificate is a set of standards that social care and health workers observe. It is the minimum standard that should be covered as part of induction training of new care workers.

Staff told us they felt well supported, in both staff meetings and regular supervision meetings. Supervision

meetings give staff the opportunity to meet with a manager to discuss people's care needs, identify any training or development opportunities and address any concerns or issues regarding practice. A new supervision system had just been introduced which meant senior staff would be supervising care staff. Senior staff told us they were confident they would receive support from the manager whilst they were new to this role.

At the last inspection of the home we had concerns about the maintenance of the premises and equipment. At this inspection we saw that these issues had been addressed.

We observed that people who could mobilise independently walked around the home without restriction and had no problem with finding their way around. There were photographs and names on some people's bedroom doors to assist them to locate their room, but not on others. There was a bathroom on the top floor and a shower room on the first floor so people could choose which one they preferred, although staff told us most people chose the shower.

Some paintwork was in need of redecoration. However, there was a monthly maintenance plan that recorded the redecoration that would be taking place, new flooring that would be fitted and any equipment that needed to be replaced. A new carpet was being fitted in a bedroom on the day of our inspection.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw the record of DoLS applications that had been submitted to the local authority for authorisation. However, on one occasion this had not been recorded in the relevant part of the person's care plan.

We found that staff had an understanding of the MCA, DoLS and the importance of obtaining people's consent to their care. When people had capacity to do so, they had signed consent forms for such areas as photographs being taken and staff assisting with the administration of medicines. We noted that one relative had signed to agree to their family member's service user plan. We advised the manager that consent forms could only be signed by a relative when they had a legal right to make decisions on the person's behalf. If this was not the case, it would be preferable to leave the form unsigned and record that the person did not have capacity to give consent.

Staff told us that they always asked people what they would like to do and offered them choices, and that people were able to make day to day decision for themselves. One member of staff said, "One lady wants to get up at 7.00 am and others don't get up until 10.00 am. Some have breakfast in bed." We saw evidence of best interest meetings that had been held to help people who lacked capacity to make important decisions about their life.

People were supported by GPs, community nurses and other health care professionals. One person told us, "The district nurses come twice a week to dress my legs – they are very good." The contact with health care professionals was recorded and any advice given by health care professionals had been incorporated into care plans. We asked a health care professional if staff followed their advice and they told us, "Yes, they are fine with that."

People had patient passports in place, although some contained only minimal information. The manager assured us that additional information would be added. These are documents that people can take with them to hospital admissions when they are not able to communicate information about their care and

support needs to hospital staff. They provide hospital staff with information about the person to enable them to meet their needs.

Good

Is the service caring?

Our findings

We observed that staff were kind, caring and patient and we saw positive interactions between people who lived at the home and staff. People told us that staff genuinely cared about them. Comments included, "Staff are kind and caring" and "The carers are very kind. They'll help you if they possibly can. They try to do their best."

We saw people who lived at the home looked well cared for, were clean shaven (when this was their choice) and wore clothing that was in keeping with their own preferences. People's bedrooms were personalised to make them feel 'at home'.

People told us that staff respected their privacy and dignity. One person told us, "Oh, yes they do – no problems. They keep you covered on the way to the bathroom." Staff were able to describe how they promoted people's privacy and dignity, such as closing doors and curtains, and always knocking on doors before entering. One member of staff said, "That's a big thing of mine. I'd always challenge someone if I saw them going into a room without knocking." A health care professional told us that staff assisted people to their bedrooms for treatment to protect their privacy. However, we were concerned that two toilets downstairs did not have locks and this compromised people's privacy and dignity. This will be addressed outside of the inspection process.

People were supported to be as independent as possible. At lunchtime we saw that one person had special cutlery and another had a plate guard so they were able to eat their meal independently.

There was information available in the home about advocacy services. This included information about an Independent Mental Capacity Advocate (IMCA). IMCAs provide support for people who lack the capacity to make their own decisions and have no-one else to represent them.

Staff told us they had training on equality and diversity, although they did not currently support anyone with specific religious or cultural needs. There was a notice on display advising people that they could arrange visits from their local place of worship and a private room would be provided for them to use.

We saw that written and electronic information about people who lived at the home and staff was stored securely. This protected people's confidentiality.

Good

Is the service responsive?

Our findings

At the last inspection of the home we were concerned that care plans contained contradictory information, and did not always contain information to guide staff on how to effectively meet people's needs. We did not see any evidence of this during this inspection.

Managers completed an initial assessment of people's needs before they moved into the home; this included the use of recognised assessment tools for tissue viability and nutrition. A care plan was developed from these assessments. Care plans contained information for staff about how to meet people's needs in a variety of areas, including nutrition, mobility, medicines, personal care and pressure area care. We saw that care plans contained sufficient information to ensure staff were aware of people's specific care and support needs and to enable staff to provide care that was centred on the individual. This included their hobbies and interests, their likes and dislikes and family relationships. When risks had been identified as part of the assessment process, there were risk assessments in place.

Care plans were reviewed regularly, including a four-weekly evaluation completed by key workers, to ensure that information was reflective of people's current needs.
There were a small number of examples of when care plans had not been updated. For example, one person's care plan did not record that one of their medicines had recently been changed to liquid form instead of a tablet, and another person's care plan did not record that a DoLS application had been submitted. We have addressed this in the Well-led section of the report.

Daily handover meetings provided staff with up to date information. Records showed staff discussed any concerns about people who lived at the home, as well as a record of the staff on each shift.

People were supported to keep in touch with family and friends and visitors were made welcome at the home; we observed this on the day of the inspection.

There was an activities coordinator who shared their time between Regent Hotel and the provider's other service nearby. They spent 16 hours a week at Regent Hotel. We saw a short survey had been carried out in January 2017 to ask people which activities they would like to be provided, and at what time of the day. Most people said they preferred activities to be provided in the afternoons, and it was agreed that outings and one to one time would be included.

The activities plan on display in the home recorded that people were offered bingo, dominoes, nail care, art, outings and bowling. However, the only activity that was mentioned to us was bingo. Some people told us they enjoyed this activity, but others did not. One person told us, "There are library books knocking about and a lady comes in twice a week to do bingo." Each person had a sheet that recorded the activities they had taken part in. Most of these were bingo, nail care and sing-alongs, although one person had been helping staff to paint some benches in the garden. Only one person had been for a walk along the promenade. Care staff also carried out activities as part of their day to day duties when the activities coordinator was not at the home, but the feedback we received indicated that these were minimal.

Information about making a complaint was on display in the home. People told us they would speak to a member of staff if they had any concerns, but they had not needed to. One person said, "I would speak to staff, or my daughter would, if I had any concerns." They said they felt staff would help them to alleviate any concerns if they could. A health care professional told us, "If I had any concerns I'd just raise them." We spoke with a relative who told us the staff were fine and they had no particular concerns.

People who we spoke with were not aware of any meetings for people who lived at the home. However, we saw the minutes of a 'residents' meeting that had taken place in May 2017. These evidenced that a suggestion box, activities, garden space, live entertainment and respect for each other had been discussed. This showed that people were able to give feedback on the quality of the service they received.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection of the service we identified concerns about record keeping and quality monitoring. Medicines records, care plans and monitoring charts were not always accurate or up to date, and quality monitoring systems had failed to identify some of the concerns we found.

At this inspection we saw that medicines records were accurate, but there were still some inaccuracies in care plans and monitoring charts. The registered manager carried out quality audits to monitor that systems at the home were working effectively and that people received appropriate care. These included audits on accidents / incidents, medicines and infection control. However, we noted that some of these were checklists rather than audits that recorded any areas that required improvement and when these improvements had been actioned. We discussed this with the manager at the end of the inspection and they told us how they would improve these audits to include the suggestions we had made.

There were a small number of examples of when care plans had not been updated, and some charts used to monitor people's food and fluid intake had not been completed at every mealtime. Although there was no evidence that people were not receiving sufficient amounts of food and drink, inconsistent recording meant the details of food and fluid intake were inaccurate.

We recommend that the provider ensures recording at the home is consistent and that staff understand the implications of poor recording.

We found the registered manager had informed CQC of most significant events in a timely way by submitting the required 'notifications'. The submission of notifications allows us to check that the correct action has been taken by the registered persons following accidents or incidents. However, we were aware of one incident when a statutory notification had not been submitted. We concluded that this was an isolated incident associated with a safeguarding event; the manager had not realised that incidents of this nature required an alert to be submitted to the safeguarding adult's team, and consequently had not submitted a notification to CQC.

The provider is required to display their inspection rating following a CQC inspection. The rating for the inspection conducted in May 2016 was not clearly displayed within the service. The failure to display the rating was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This will be addressed outside of the inspection process.

There was a manager in post who was registered with the Care Quality Commission as required by a condition of the provider's registration. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like 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. A new manager had been appointed and they told us they would apply for registration when they were confident they could manage the home unsupervised. At the time of the inspection they were being supported by the current registered manager.

We asked for a variety of records and documents during our inspection, including people's care plans and other documents relating to people's care and support. We found that these were well kept, easily accessible and stored securely.

Two people who we spoke with told us they did not know who the manager was. However, another person was very clear about who the manager was and told us they would speak to them if they needed to see a GP and commented, "I've never had any problems with them." They also said that the manager would help staff when they were 'short staffed'.

Staff spoke positively about the new manager. Comments from staff included, "They're getting to the crux of what we need. We feel we can trust them and they take our suggestions on board" and "Staff morale has gone up 100% - we are now a team."

Staff meetings were held on a regular basis and staff told us they could raise concerns or make suggestions at these meetings.

Staff described the culture of the service as "Open and friendly", "Families are welcomed" and "Very person centred." The manager told us that they treated people how they would treat members of their own family. They said, "It's their home and we want to provide the best care possible."

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 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment was not provided in a safe way for people who used the service by assessing, preventing, detecting and controlling the spread of infections. Regulation 12 (1)(2)(h)