Caritate Limited

Caritate 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?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 13 and 14 February 2017 and was unannounced.

Caritate Nursing Home provides nursing care for up to 24 people with a range of health care needs and physical disabilities. At the time of the inspection, there were 19 people living at the service.

The service was managed by two registered managers. 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.

We carried out a focused inspection on 2 October and 17 November 2016. During that inspection, we found breaches in regulations. We found that there was not an established, effective accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons. In addition at the previous inspection, we found that the service was not meeting the requirements of the Mental Capacity Act (2005), including the Deprivation of Liberty Safeguards (DoLS).

At this inspection, we found improvements had been made in these areas. People's rights were protected as the principles of the Mental Capacity Act 2005 (MCA) were followed by staff. Applications had been made to the supervisory body when necessary to authorise people's care and treatment under the Deprivation of Liberty Safeguards (DoLS). However, we noted that people's consent was not always appropriately recorded. The registered manager took action to address this issue. We also observed occasions where staff did not seek consent before assisting people with aspects of their care or before accessing their bedroom.

We found some concerns relating to the coordination and documentation of people's health care needs. In particular in relation to one person who had a number of complex health concerns. We also found one person's nutritional needs were not being effectively monitored due to inconsistent completion of charts by some staff.

We found some issues relating to medicines management. There was no system to report or record errors or omissions and medicines audits were not being undertaken at the service. We observed an excess of some stock and some staff signing medicine as being administered before the person had taken it.

As part of the service's quality assurance procedures senior staff submitted monthly reports to the registered managers, for example, the lead nurse, maintenance person and the head chef. These reports were reviewed in order to identify concerns that might require action. However, this process had not identified the concerns with medicines management, consent and the recording and coordination of some health care needs.

Feedback on the service was sought through the distribution of quality assurance surveys and via a

comments book which was accessible to people and their relatives. However, there were no staff meetings or residents' meetings to provide people and staff the opportunity to raise concerns or share ideas collectively. Some staff felt they were not listened to or respected by senior and nursing staff.

Staff had received training in order to carry out their roles effectively, however a number of staff had lapsed in their mandatory training. We were told this was being actively addressed by the registered manager.

Feedback from staff, people and their relatives about the registered managers was generally positive. Relatives we spoke with felt involved in their family members care and this was reflected in people's care records. Complaints were investigated and responded to in a timely manner and learning was used to assist learning and drive improvements. One person told us they had not been supported to make a complaint and this was reported to the registered manager who said they would look into this allegation.

People and their relatives told us the staff were caring and we witnessed kind and compassionate interactions between people and staff. We saw suitable levels of care staff who were able to respond to people in an unhurried way.

People's care records were well organised and contained details about people's likes, dislikes background and history. There was suitable guidance for care staff around people's preferred routines and how they chose to spend their time. Care records were regularly reviewed and updated. People had access to activities in the home such as arts and crafts and there was a volunteer who attended the service to assist with this. There were visitors to the service such as entertainers and a petting animals service. There was a mini bus which was used to take people to appointments.

People were supported by staff who were safely recruited and who had undergone checks to ensure they were suitable to work with vulnerable people. People's safety was protected as staff understood their role in recognising and reporting signs of abuse or mistreatment.

The service was visibly clean and free from adverse odours throughout. There were suitable levels of PPE (personal protective equipment) and we observed staff following good hand washing procedures. There were checks of the building and equipment to ensure they were safe and fit for purpose.

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

Aspects of the service were not always safe.

People's medicines were not always safely managed and there was no system in place for recording mistakes.

People were protected by staff who understood their role in recognising and reporting potential signs of abuse or mistreatment.

People were protected by staff who were safely recruited.

People were protected from the risk of cross infection as infection control practices were robust.

Is the service effective?

Requires Improvement

Aspects of the service were not always effective

People's consent was not appropriately recorded.

People's health care needs were not always managed in a structured or consistent manner.

Staff had received training to carry out their roles, but many staff had not received refresher training to keep their training up to date.

People's dietary needs were met and they were given enough to eat and drink.

Is the service caring?

Good

The service was caring.

People were supported by caring and compassionate staff.

Staff knew the needs of the people they cared for.

People and their relatives were involved in their care planning.

People's confidential information was not always securely

stored.

Is the service responsive?

Good

The service was responsive.

There was a system in place for receiving and investigating complaints.

People's care records were detailed documents which provided guidance for staff on meeting their care needs.

People had access to activities within the service and were supported to participate in activities in the community.

People were supported to maintain relationships with people who mattered to them

Is the service well-led?

Requires Improvement

Aspects of the service were not always well led.

Quality auditing processes were not sufficient to ensure the on-going quality and safety of the service.

Recording of some people's health care needs was not effective and this had not been identified by auditing processes.

Staff felt the registered managers were supportive and approachable.

The registered manager gave out quality assurance surveys to invite feedback on the service, which was used to drive improvement.

Caritate Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 13 and 14 February 2017 and was unannounced. The inspection was undertaken by one adult social care inspector and a specialist advisor (SPA), who had a professional background in nursing. On the first day of the inspection, an expert by experience was also in attendance. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed information we held about the service. This included notifications we had received. A notification is information about important events, which the service is required to send us by law.

During the inspection, we looked around the premises and observed the lunchtime experience. We spoke with nine people who lived at the service, three relatives and one visiting professional and a volunteer. We also spoke with 12 members of staff, including nurses, care staff, administrative staff, kitchen staff and the maintenance person. We were supported on the inspection by one of the registered managers.

During the inspection, we looked at training records for all staff. We looked at five records relating to people's care, handover sheets and daily records. We also viewed policies and procedures, recruitment files for four staff members, documentation relating to the maintenance of the building, quality assurance surveys and information relating to complaints.

Requires Improvement

Is the service safe?

Our findings

We found some concerns relating to medicines management. Systems for recording medication incidents/errors did not show how they were investigated. We were told that tablets that were found in the blister packs having not been given were thrown away, and why they had not been given was not investigated. There were no audits of; medicine stock, MAR (Medicine Administration Record) charts, or of drugs requiring more strict controls. Medicines audits are important in ensuring people have their medicines as prescribed. We observed three occasions when staff signed that medication had been administered before the person had taken it, and did not stay with the person to ensure the medicine had been taken. We also noted that there was an excess stock of some medicines. These issues were highlighted to the nurse in charge and the registered manager.

This was a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 12 (1), 2 (g) - Safe care and treatment.

Medicines were stored appropriately and there was a system in place to ensure that keys were securely stored. MAR charts were completed for each person, however cream applications were not recorded on these charts. Oxygen was used in the home and was prescribed for individual people. Clear hazard warning signage was displayed. Medicines fridges were kept locked and daily temperatures were recorded. All temperature recordings were within the correct guidelines to ensure that the medicine was safe to use.

People told us they felt safe living at the service. Comments included; "They always come quickly when I use my call bell, that's what makes me feel like I am safe" and "I feel comfortable and not threatened at all living here". One relative told us; "I feel safe having my relative here as they really do look out for him".

People were protected by staff who knew how to recognise and report signs of potential abuse. Staff told us reported signs of abuse or poor practice would be taken seriously and investigated thoroughly. Staff knew who to contact externally should this be required. Comments from staff included; "I would report abuse to the nurse, the manager, safeguarding, CQC or even the police" and "There is a policy in place and I would not be afraid to use it".

The service was visibly clean and well maintained. We observed domestic staff cleaning bedrooms and shared areas throughout the inspection. There was a laundry room which was well organised and where colour coded bags were used to reduce the risk of cross infection. There were appropriate levels of PPE (personal protective equipment) throughout the service and staff were observed to carry out robust handwashing practices.

We observed suitable levels of staffing on the days we inspected the service. We saw that staff were able to respond to people's needs in an unhurried way and that they had time to stop and chat to people. One person told us; "I feel safe because the home is not too big so the staff always have enough time for you". One relative commented; "There is always enough staff on duty, that makes me feel settled."

People had risk assessments in place, detailing action to be taken by staff to minimise the risks identified. These were regularly reviewed and updated. Accidents and incidents were logged by staff and this information was reviewed by managers to look for themes which might reduce the likelihood of a reoccurrence.

People were supported by staff who had been safely recruited. Checks had been undertaken ahead of the staff member commencing their employment, to ensure they were suitable to work with vulnerable people. This included Disclosure and Barring Service (DBS) and reference checks.

People were kept safe within the environment at Caritate. There was a system of checks in place to ensure that the building was maintained and equipment, such as hoists was serviced. The maintenance person submitted a monthly maintenance report to the registered managers detailing work that had been undertaken and areas to be addressed. People had personal evacuation plans (PEEPS) in place, to ensure that their level of support in the event of an emergency evacuation was known.

During our observations, we noted that a storage room door was left open containing COSHH (care of substances hazardous to health) products such as floor polish, stain remover and disinfectant. This was reported to the registered manager, at the time of the inspection and they took immediate action to ensure this did not happen again.

Requires Improvement

Is the service effective?

Our findings

At the focused inspection on 2 October and 17 November 2016, we found that the service was not meeting the requirements of the Mental Capacity Act (2005), including Deprivation of Liberty Safeguards. At this inspection, we found that improvements had been made.

We checked whether the service was working within the principles of the Mental Capacity Act (MCA) and whether any conditions attached to or authorisations to deprive a person of their liberty were being met. The 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 as far as possible people make their own decisions and are helped to do so when needed. When a person lacks the mental capacity to make particular decisions, any made on their behalf must be in their best interests and the least restrictive.

Staff demonstrated an understanding of the Mental Capacity Act (MCA) and had undertaken training. People's support plans included information about people's capacity in relation to different areas of their care and lifestyle. Care plans highlighted when people were able to make decisions for themselves or when best interest processes would be needed to support them.

People can only be deprived of their liberty in order to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). DoLS authorisations had been applied for on behalf of people as required and this was carefully monitored by the registered managers. In addition, people's care records indicated that staff had communicated with the supervisory body around restrictions in people's care plans and sought advice as necessary.

We saw examples where consent had not been appropriately recorded. For example, some people's care records indicated that a relative had consented to elements of their care without the legal authority to do so. Nobody can consent to an adult's care without legal authority. This is called a lasting power of attorney (LPA) for welfare. In the absence of a LPA, a best interest decision is required. This was reported to the registered manager who took action to address this. We also noted that some people who had the capacity to consent to their care had signed to confirm this. We saw examples, where these documents were signed in 2014 with no evidence of a review.

We observed some staff sought consent from people before assisting them with care. For example, we heard a staff member ask; "Can I help you with your lunch? Would you like me to help you?" However we also saw some staff carrying out tasks without first seeking consent. For example, one staff member placed an apron over a person at lunchtime without explanation, or first seeking consent. In addition, we were talking with one person in their bedroom and on two occasions staff members knocked and entered without waiting to be invited to do so. One staff member said; "I don't think we always re-visit consent. We sometimes make assumptions. Like just because they like orange juice, they'll always want it". We reported these observations to the registered manager.

People's consent was not always gained before staff provided them with assistance. This was a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 11: Need for consent

Some people's health care needs were not always effectively documented, which meant we could not be sure their needs were being addressed. For example,one person's weight was being monitored using a weight chart. We noted a 10 kilogram increase in their weight between the commencement of the chart and the most current reading several years later. The file did not contain an explanation as to whether the weight gain was a desired change or what the person's weight should be.

There was an unstructured approach to the coordination and documentation of one persons care. This person had a number of complex health issues. It was unclear whether staff were following specialist guidance from external professionals which was found in their care plan. The care plan also contained a form to summarise the care being provided but this form had not been completed. Recording of tasks associated with the person's physical health care was inconsistent and found in different places in the care home. This created the potential for important information to be missed and made it difficult to gain an oversight of the care being provided. We were unable to find details in the person's care plan of what action staff should take in an emergency if there were problems with equipment required to manage one of their healthcare issues. We were told that the person had two infections affecting two separate parts of their body. They had just completed a course of antibiotics. Staff were unclear which of the two health concerns the antibiotics were treating, or if they provided treatment for both. We also found that advice from a health care professional for staff to contact them to arrange a review of one of these infections had not been followed up. We highlighted these concerns to nursing staff and the registered manager.

Another person had a catheter in-situ. Records were in place to monitor and record the person's food and fluid intake. A member of staff told us that this food and fluid chart was not completed consistently and some staff forgot to make the recordings. The inconsistent completion of the chart and lack of recording of their output meant that the chart did not reflect the person's food and fluid intake. The monitoring of their nutrition lacked a consistent and coordinated approach and It was not possible for us to see if this person's nutritional needs were being sufficiently met.

People were supported by staff who were skilled and had received training to carry out their jobs effectively. Feedback from one relative on the most recent quality assurance survey stated; "Carers are very good at their jobs. Some are like little mothers and treat them as people, not patients". Staff had received training in areas identified by the provider as mandatory, such as moving and handling, infection control and fire safety. We noted that a number of staff members had lapsed in their training due to staff changes, however this was being actively addressed by the registered managers who had purchased a new programme of e-learning for staff to complete. Aside from mandatory training, staff had also received training which was specific to the needs of the people they supported, such as percutaneous endoscopic gastrostomy (PEG) care.

People's bedrooms were bright and spacious and personalised with their own belonging such as photographs, furnishings and decorations. One person enjoyed painting and had canvases set up in their bedroom.

We observed the lunchtime experience. People were supported by suitable numbers of staff. Those who required support with eating and drinking were assisted promptly and not kept waiting. People, where necessary had specialist equipment such as large handled cutlery and plate guards. The atmosphere in the dining room was pleasant and calm. Tables were laid with clothes and condiments and there was a menu on display detailing the meal on offer. This was also presented in pictorial form for those who may have had

difficulty with reading. People were offered a choice of drinks with their meal. The food appeared appetising and plentiful. Comments from people included; "The food is excellent" and "The food is very good and always fresh vegetables".

People were offered a choice of what they ate and were able to contribute to the menu plans. People's dietary needs were known by the cook and recorded in the kitchen. Some people had their food pureed. We observed the pureed meals to be well presented and resembling the food in its original form. Any changes to people's dietary needs were communicated with the kitchen staff. One person was going out for the day and a packed lunch had been prepared for them. Another person was going swimming, so they had eaten their meal at an earlier time, so that it would be digested and not interfere with their scheduled activity.

There was a structured and consistent approach to the care of people with diabetes. Blood sugars were regularly checked and documented and people were provided with the appropriate diet to help ensure their condition was well managed.

People had access to a range of health care professionals. We saw a chiropodist and a physiotherapist attend the service during the inspection. The service arranged hospital, doctors and dental appointments for people and transport was provided through use of the service's minibus. One person's records evidenced that they had been coughing. Staff had suspected a chest infection and had contacted their GP who had prescribed antibiotics. Another person's feet had become swollen. Staff had contacted the GP who had visited and changed the dose of their medicine which had addressed the issue.

Good

Is the service caring?

Our findings

People and their relatives told us the service was caring. Comments from people included; "I get on really well with all the staff" and "The staff make this home, they create a nice friendly atmosphere". Comments from relatives included; "The care is very good, I get on well with the staff" and "I'm very happy about the care, each individual gets the care they need".

Staff we spoke with were compassionate and kind and committed to providing good quality care. Comments from staff included; "All staff work from the heart"; "It feels like home here"; "I treat these residents as I would want my family treated" and "They [people living at the service] are like our friends and family".

We observed positive and caring interactions between people and staff. Staff spoke about people with fondness and affection. Staff clearly knew the people they cared for well and shared appropriate humour with them. One staff member said; "We have a laugh and a joke with people within professional boundaries". We observed staff placing their arms around people's shoulders supportively or using appropriate touch when talking to people and carrying out care.

People were made to feel valued and important. One staff member told us; "We spoil people and give them cuddles. It takes a long time to build a rapport, but after a while you build trust". People's birthdays were celebrated with cakes and entertainment and families attended. One staff member told us; "I always like to come and spend Christmas Day with them". Staff knew the needs of the people they cared for well and were able to talk about them in detail and with enthusiasm. People's individual preferences were known by staff and we saw incidences, where they had gone out of their way to make them feel special. For example, one person told us; "They know I like birdwatching so they put two bird feeders outside my window. I can watch the birds and squirrels all day now";

People and their families were involved in their care planning, where possible and this was evidenced in their care records. One relative had commented in the most recent quality assurance survey; "Any decisions with [relative's name], always involve the family. We are treated with confidentiality, dignity and respect".

People's confidential information was not always securely stored at the service. We noted that the nurse's station was accessible to visitors and that detailed information about people and their care was not locked away. There were times when a member of staff was not at the station and therefore the information was left unattended. Some information was left on the top of the station and could have been accessed by people who did not need to see it. This was reported to the registered manager who said they would conduct a risk assessment around this.

Good

Is the service responsive?

Our findings

At the focused inspection on 2 October and 17 November 2016 we found that an effective accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons had not been established. At this inspection, we found that improvements had been made.

There was a system in place for receiving and investigating complaints. Where concerns had been raised, the registered manager responded quickly and apologised. Responses demonstrated that the service was committed to raising standards and improving. Where concerns had been raised, they were used constructively to assist learning and outcomes were shared with staff. During the inspection, one person told us that they had been discouraged from making a complaint by senior staff. A staff member we spoke with also referred to this incident. This was reported to the registered manager who said they would look into the alleged incident further.

There was a thorough pre-assessment process in place for people that were considering coming to live at the service. This included gathering information from the person and their family and professionals who worked with them in the community. Risk assessments were completed as well as a full medical history. This helped staff to understand how to support the person when they arrived at the service and to ensure it was the right place for them.

Care plans were informative and regularly reviewed and updated. They contained information about the persons care requirements and guidance for staff on how to meet their needs. People's allergies were documented in their records. One person was allergic to penicillin and this was highlighted at the front of their file. Detailed information such as the person's requirements at bed time and their ability to maintain their body temperature were recorded in their care plans. Care records were personalised and contained information about the person's life history. This included their pastimes, travel, hobbies and interests. There was also an easy read version of people's life history on people's records. These were appropriate and contained the information in a pictorial form.

People's care records also contained a quick reference guide to their care needs. This had been compiled for bank and agency staff, so that they could quickly get to know important, key facts about the person. This covered areas such as their reason for admission, their daily routine and any equipment they required.

There were handover meetings between shifts, so that staff could be updated with any changes that had occurred. Changes in people's needs were responded to in a timely manner at the service. One person told us; "The home arranged a Dentist to come and see me". Comments from relatives included; "They arranged for my dad to go for a scan to the hospital" and "My husband has his hair cut every two weeks and they arranged for his feet to be done every six weeks".

People had access to activities within the home. A volunteer attended the service to undertake arts and crafts and bingo with people. We observed six people joining in a game of bingo with the volunteer which they appeared to enjoy. Staff told us that other activities were arranged on an ad-hoc basis, such as pamper

sessions, watching DVD's, completing puzzles and painting people's fingernails. People also undertook activities away from the service, such as swimming and trampolining and one person attended a day centre. As we arrived at the inspection, staff were taking two people out for coffee. There were also visitors to the service, such as entertainers, a hairdresser who attended fortnightly and a beauty therapist who attended monthly to offer manicures and massages. During warmer weather, people accessed the large gardens and patio areas. There were barbeques and people enjoyed gardening.

People's independence was promoted at the service. One person enjoyed sewing and had recently taken up making clothes labels and undertaking small clothing repairs for the other people living at the service. The person told us this gave them a sense of achievement and that they had been encouraged and supported by staff.

People were encouraged to maintain relationships with people that mattered to them and there were no restrictions on visiting times. During the inspection, relatives were seen to visit their family member and to have a good rapport with staff.

Requires Improvement

Is the service well-led?

Our findings

There was a system in place for monitoring the quality of the service. Monthly reports were submitted to the registered managers by senior staff, including the lead nurse, the maintenance person and the head chef. These reports were reviewed by the registered managers to identify and address any concerns raised. This process was used to drive improvement within the service. However, these systems had not identified the concerns with the medicines management, for example, missed medicines. They had also had not identified the issues in the care records relating to consent and the recording of some people's specific healthcare needs. This meant they were not always effective.

Some of the records and recording procedures we looked at did not provide a sufficient account of people's care arrangements or demonstrate how people's needs were being met by the service. For example one person had a tracheostomy in place, but the sheet in their care record intended to document the tracheostomy care had not been completed. The absence of written documentation could mean the registered manager might not have an overview of how people's needs were being met by the service, or be able to demonstrate that needs were being met consistently and in a way people chose and preferred. There were also multiple files to record care details such as the handover sheet, gastrostomy book, turning charts and a blood sugar book. This number of seperate documents made a complex system from which it was more difficult to obtain an oversight of people's care.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Caritate nursing home was managed by two registered managers who were also the owners of the care home. They employed a deputy manager who was responsible for many aspects of the day to day running of the service. There was also a clinical nurse lead employed by the service.

Most people and their relatives told us the service was well led. Comments included; "The Manager is very good, I get on well with her"; "You can raise things with the staff and you know it'll get passed on". Comments from relatives included; "You just get a good feeling about this place" and "The manager has been very supportive to me, she is brilliant". However, one person told us; "I complain to the staff about things, but they never listen". Another person and a staff member had told us that a senior staff member had discouraged the person from making a complaint. This may not have been consistent with a culture of openness and transparency. We were also told that there were no staff meetings or residents/relatives meetings. This meant that such opportunities for collectively sharing ideas or concerns were missed.

Staff spoke positively of the registered managers. Comments included; "I have a good relationship with the owners and they are approachable"; "The managers are very friendly and approachable". Although comments from staff on the registered managers were positive, some staff raised concerns about senior and nursing staff. Some staff commented that they did not feel respected or listened to.Some staff also raised concerns about how the rota was managed and felt that it was disorganised at times, leading to periods where not enough staff, or too many staff were on duty. These comments from staff were passed to the

registered manager. Other staff members told us morale at the service was good. Comments included; "I love it"; "Morale is good"; "We all get on well" and "It's a laid back place and we all work in sync".

Feedback on the service was sought through a cycle of quality assurance surveys which were sent to people, relatives and staff. We reviewed the most recent feedback and saw that comments were positive. We also saw that concerns raised were addressed. For example, one relative had raised a concern about the stairs, which was addressed. There was also a comments book in the reception of the service which people and relatives were able to use to document compliments or concerns.

People benefited from being supported by staff who understood and were confident about using the whistleblowing procedure. The service had a whistle-blowers policy which supported staff to question practice. It clearly defined how staff that raised concerns would be protected. Staff confirmed they felt protected, would not hesitate to raise concerns to the registered manager, and were confident they would act on them appropriately.

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 11 HSCA RA Regulations 2014 Need for consent People's consent was not always sought before staff provided them with assistance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicine administration charts (MAR) were not always recorded accurately and there was no system in place for recording mistakes. There was an excess stock of some medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to monitor the quality of the service had not always identified areas which required improvement.