Care Quality Commission

Abbey Healthcare (Cromwell) Limited

Cromwell House Care Home

Inspection report

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Huntingdon
Cambridgeshire
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Tel: 01480 411411

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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?	**Good**

Overall summary

Cromwell House Care Home is a three storey building located in the town of Huntingdon. The home provides accommodation for up to 66 people who require nursing and personal care. At the time of our inspection there were 52 people living at the home. Accommodation is provided over three floors and all bedrooms are single rooms with en suite facilities.

This unannounced inspection took place on 19 May 2015.

At our previous inspection on 02 June 2014 the provider was meeting all of the regulations that we assessed.

The home had a registered manager in post. They had been registered since February 2015 but had been managing the home since October 2014. 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.

Staff were trained in medicines administration. However, medicines were not always recorded or administered in a

Summary of findings

safe way. There were not always enough staff to meet the needs of people who used the service to ensure they received care and support when they needed it. The provider had a robust recruitment process in place. This ensured that only the right staff were recruited and offered employment.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find. We found that the registered manager was knowledgeable about when a request for a DoLS would be required. We found no one living at the home was being deprived of their liberty. Staff had limited knowledge and understanding of the MCA and DoLS. People's ability to make decisions based on their best interests were supported by records to demonstrate where this had been assessed as being lawful.

Staff consistently respected people's dignity and provided care in a compassionate way. People's requests for assistance were responded to but this was not always in a timely way.

Reviews of people's care records were completed regularly and more urgently when required. This was to help ensure that the information about people's care needs to inform and guide staff was relevant and up-to-date. People were supported to undertake their hobbies and interests.

People were supported to access a range of health care professionals. This included GP and community nursing services. Risks to people's health were assessed but were not always acted upon.

People were provided with a choice of home-made meals and supplements when required. People's independence with their eating and drinking was respected. There were sufficient quantities of food and drinks available and people were supported to access these.

People and their relatives were provided with information on how to make a complaint or compliment. Staff knew how to respond to any reported concerns or suggestions. Action was taken in response to compliments or concerns to drive improvement in the home. Access to advocacy services were offered in the home and people or their relatives were able to use these if required.

The provider had checks and audits in place to support their quality assurance of the care provided to people. This was to improve, if needed, the quality and safety of people's support and care. Plans were in place to implement changes as a result of identified concerns.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were not always supported by a sufficient number of suitably qualified and competent staff. Medicines were not always administered in a safe way.

Staff were only offered employment after their suitability to work at the home had been satisfactorily established.

Risk assessments were in place for the management of risks to people's safety.

Is the service effective?

Requires Improvement

The service was not always effective.

People's health needs were assessed. However, some people at an increased risk did not have their health needs safely met.

People were supported with their decision making and were supported with care that was in their best interests. Not all staff had an embedded understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards DoLS.

Sufficient quantities and choices of food and drink were available to people, including those people who required a soft food diet.

Is the service caring?

Good

The service was caring.

People were provided with care and support by staff who possessed a good knowledge of providing people with individualised care in a compassionate way.

Staff knew what was important to the people they supported. People could be visited at any time without restriction.

People were given every opportunity to maintain and improve their independence.

Is the service responsive?

Good

The service was responsive.

People's hobbies, interests and preferred social activities were supported by staff who knew people well.

People and their relatives were involved as much as possible in their care assessments.

Reviews of people's care helped ensure that changes and improvements were made to their care and support where this was required.

Summary of findings

Is the service well-led?

Good

The service was well-led.

Audits and quality assurance procedures were used as a way to drive improvement in the home. The register persons had notified the Care Quality Commission of incidents that we are required to be informed about by law.

People, relatives and visitors had access to the registered manager and regional manager, when required.

Staff were supported effectively to ensure they delivered people's care which was based on the beliefs and values of the provider.

Cromwell House Care Home

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 19 May 2015 and was completed by two inspectors.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at information we held about the service including statutory notifications. A notification is information about important events which the provider is required to tell us about by law. We also spoke with service's commissioners that pay for people's care, the local safeguarding authority and received information from the community nurses.

During the inspection we spoke with nine people living at the home, six relatives, the registered manager, the provider's regional manager, two nursing staff, four care staff and domestic and catering staff. We also spoke with three visiting health care professionals. We observed people's care to assist us in understanding the quality of care people received.

We looked at six people's care records, meeting minutes for people who lived at the home, relatives and staff. We looked at medicine administration records. We looked at records in relation to the management of the service such as checks on the home's utility services. We also looked at staff recruitment, supervision and appraisal processes records, and training planning records, complaint and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

People told us that they were safe living at the home. One person said, "The reason I feel safe is if I fall I know staff will help me." People and their relatives said they would report any concerns about their safety, should these ever arise, to the registered manager, nurses or senior care staff. Another person said, "Of course I feel safe. The staff are so careful when they help me."

Staffing levels were determined using a dependency tool. During the day we saw that there were sufficient staff to meet people's care needs including responding to requests for assistance promptly. However, people, relatives and staff told us that there was not always sufficient staff on duty at night times. One person said, "If I need the toilet at night and can't wait for staff I have to do it in my pad." Staff said, "At night there is a floating member of care staff for the first and second floors but invariably when you need help they are busy helping someone else. They added, "In the mornings people do have to wait and this means that their toileting needs are not always met in time." One person said, "Staff respond quickly when I use my call bell although it takes longer at night time. A relative said, "If I don't take [family member] out then they never do go outside." Another relative said, "My family member needs moving every four hours but it has been up to six hours. One person told us they had called at 5am that morning for a cup of tea but they didn't get one until breakfast at 8am. This showed us that people's care and support needs, especially during the early hours, were not always met in a timely manner.

This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they were able to cover short notice absences with working overtime or extra shifts. The registered manager told us that agency staff have been requested and that these were normally the same staff. A staff member said, "There are times when it gets very busy, especially if staff ring in sick but we help each other out." The registered manager told us that five more care staff were to be employed to reduce the need for agency staff.

We found that medicines administration records (MAR) included details of the level of support each person required. Medicines were stored correctly, accurately accounted for, and administered in a timely way. Staff's competency to administer people's medicines was regularly assessed after they had been trained. This was to ensure they maintained a good understanding of safe medicines administration. However, when we observed staff we saw that they failed to adhere to safe medicines handling practice. Nursing staff failed to sanitise their hands after administering people's medicines. In addition, nursing staff, accompanied by a care worker, checked one particular medicine before it was given to a person in their room. These staff did not complete identity checks or follow all of the safe checking procedures in line with the medicines administration policy. This put people at risk of receiving medicine that they had not been prescribed. Instructions on people's MAR stated that the amount of medicine could be varied at each dose. However, the actual amount given was not always recorded. This meant that there was a risk of people taking too little or too much medicine in a 24 hour period.

This was a breach of regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they were able to take risks including freely accessing all areas of the home using a passenger lift and accessible garden areas. Care staff told us and we saw that some people were supported with two staff. This was for those people whose assessed needs required this support for their safe moving and handling.

We found that risk assessments had been completed and reviewed by staff. This was to ensure that any risks to people were reduced or eliminated. One person said, "I do get around with my walking frame. The staff make sure I have it. Another person said, "I need a call bell near me and the staff move it whenever I move." We saw that this was the case. In addition, an emergency call system was in place for communal areas so that staff could request urgent assistance in an emergency. A relative said, "My [family member] used to live on their own and now I am confident that if there were any incidents such as a fall, staff would be there for them."

Staff had received training on how to protect people from harm and who concerns could be reported to. They were knowledgeable about the signs of harm and the correct reporting procedures if they ever suspected, or were aware, of this. Staff were also aware of the whistle-blowing policy and said that they had no reservations in reporting any

Requires Improvement

Is the service safe?

incidents of poor care practice, if needed. Information was displayed in the home about protecting people from harm and a service user guide supported people to access contact details for safeguarding organisations if required. One person told us, "I have no worries at all as the staff are just so nice to me." People were assured that the provider had measures in place to help ensure people were kept as safe as possible.

We found the registered persons had notified the CQC of all incidents involving people's safety and had taken effective steps. Examples of this included the review of risk assessments, agreed introduction of falls prevention measures and referrals to the falls team.

Records of staff's recruitment and staff we spoke with confirmed that there was a robust recruitment process in place. Checks included seeking appropriate written references, previous experience and photographic identification. These also included professional registration with the Nursing and Midwifery Council (NMC) for registered nurses and a record of the interview.

Staff told us about their induction and that this ensured they had a good knowledge of people, their needs and the skills required to meet these. However, agency staff's induction was limited to one hour and relied on staff passing on people's care needs whilst shadowing the permanent member of staff. This increased the risk of people's continuity of care being affected.

The registered manager told us, and records viewed showed, that a comprehensive assessment of people's needs was completed before people moved into the home. This assessment was then used as the foundation upon which each person's care was provided. This also helped determine people's level of independence and staffing levels for each person.

Risks to people's health had been identified including those at an increased risk. This was to help ensure that appropriate steps were taken to prevent or reduce any risk of harm. These included regular turns to help prevent and heal pressure areas. We found that these had not been acquired whilst people lived in the home. Other examples included intervention charts to ensure people had drunk a safe amount of fluid.

Requires Improvement

Is the service effective?

Our findings

People spoke confidently about staff's level of competence in meeting their needs. One person said, "I have only been here a short while and the staff are getting to know me and my preferences quickly." Another person said, "Since I came to live here I have got much better and I am now able to go to the dining room with some help."

People told us, and we saw, that access to a range of health care professionals including chiropodists, speech and language therapists, opticians and GP services were available and provided when requested. One person said, "I am always kept informed about GP visits which are weekly. If there are any changes such as to my medicines they let me know why." A relative said, "I chose this home for [family member] as, when I rang, the nurse really knew what she was talking about regarding [family member's] health conditions and how these could be supported safely."

However, we found that one person who was at an increased risk had, according to the records, experienced a significant change in their health. There was no clear evidence from the records we reviewed, and later confirmed by the provider, to show that action had been taken to address this. There was no evidence to demonstrate the assessed risks to this person had been managed during the eleven days prior to our inspection. On the day of our inspection the person had experienced further changes in their health. The day after our inspection, the registered manager told us that the person had required an increase in the previously prescribed dosage of their medicines. The delay put the person at risk of receiving unsafe care and did not safely ensure that the risks to this person's health were managed effectively.

This was a breach of Regulation 12 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received training on the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). However, staff had limited and in some cases no knowledge about this. The registered manager was aware that the on-line training for some of the more complex subjects was not ideal. Classroom based face to face training had been arranged for the MCA and DoLS. Staff were however, able to explain how they knew what decisions a person could make and when they could do this. They also knew the action to take if they suspected, or became aware, that a person's capacity to make certain decisions had changed. For example, informing the registered manager.

At the time of our inspection, no applications were required to lawfully deprive people of their liberty. We found that people were able to access all areas of the home including going outside. One person said, "I do like to go out into the gardens when its warm enough and I enjoy the trips out." The registered manager explained how people were supported in the least restrictive way possible and all possible options were considered. This meant that people were supported in a way which did not unnecessarily restrict their liberty.

People were supported to take risks such as being independently mobile. We found that where people required care that was in their best interests but they did not have full capacity to agree, the necessary steps had been taken to ensure that this was done in a lawful way. For example, information from relatives who had lasting power of attorney for health.

We saw that staff had a good understanding of the people they cared for. This was by ensuring they always received an appropriate consent from each person before providing any care or support. People's capacity to agree to their care had been determined. A recording tool was used to help staff determine if a person's capacity had changed. One member of care staff said, "One person tells us 'yes' or 'no' by their body language and this works really well." Another person was supported with a [brand name] device to help them communicate their wishes.

Staff told us about their training which was planned and delivered to ensure that they had the skills and sufficient knowledge to meet people's needs. This included subjects such as caring for people living with dementia, moving and handling, challenging behaviours and safeguarding people from harm. Other specialist training had been completed on subjects such as that for people who required support to eat in a safe way. For example, we observed a registered nurse meeting the nutritional needs of person with a percutaneous endoscopic gastrostomy This is a tube passed into the stomach through a medical procedure to provide a means of feeding when a person is unable to swallow foods safely.

Requires Improvement

Is the service effective?

The registered manager told us and showed us that plans were in place to ensure all staff received regular supervision and support. This included keeping themselves aware of staff's training and competencies. This was to ensure that staff were kept up-to-date with current care practices. One staff member said, "I have had a supervision and this was useful as it gave me the opportunity to check my training needs. Another member of staff said, "We do a lot of training on line but there is on-site training for moving and handling. The training planning records we looked at and staff we spoke with, confirmed that staff had regular and refresher training.

We saw that during the lunch time people were safely and effectively supported to eat in the place of their choice. We saw that food was served promptly and staff kept people informed of what they had chosen and of the other options available. One person said, "There is always two choices and sometimes three. If I change my mind it is never an issue." Another person said, "When I moved in the chef came to visit me and checked on my food preferences including my allergy." People told us, and we saw, that they had fresh fruit and other snacks and drinks during the day. Staff ensured that there was always plenty of food and drinks available. One person commented at the end of the meal, "That was lovely."

People at an increased risk of malnutrition were supported with diets appropriate to their needs. This included soft or pureed food options. In addition, regular weight monitoring had been completed to ensure people at risk were being effectively supported. This was until they had achieved a stable weight. We were told by staff and saw in records that people were referred to speech and language therapists promptly if any further weight loss was identified. This was to help ensure that people were supported to safely eat and drink sufficient quantities. This showed us that the provider took steps to ensure people ate and drank in a way which met their needs.

One person told us, "I love the food. There is always plenty of it and I can eat as much or as little as I want." A relative said, "When [family member] first started [to live] here they told staff what they liked and this is what they get. There is always something else to eat if [family member] is having an off day." This meant that people and their relatives could be assured that the provider had steps in place to ensure decisions about what people preferred and were offered to eat involved the person as much as possible.

Good

Is the service caring?

Our findings

People and their relatives told us, and we saw, that the staff offered and provided care that was sensitive to people's needs. One person said, "They [staff] are always polite, speak nicely and are compassionate." Another person said, "If I am having a bad day the staff pop in to talk with me and soon cheer me up." A relative told us, "It wasn't an easy decision where to settle [family member] but we chose this home as the staff are very caring. I soon found it easy to leave [family member] in their hands." A staff member said, "I like to put a smile on people's faces and that means a lot to me."

People had the option to have their door locked or left open if they preferred. People told us that they could choose the place they ate and the people they liked to socialise with during the day such as at meal times.

One person said, "I like my door open so that I can see what's going on but staff check with me to make sure it is okay for them to enter." We saw that people's privacy and dignity was respected by staff ensuring that people's doors were closed to maintain their privacy. One member of care staff said, "We always use towels as much as possible to protect people's dignity." However, one person told us they had been made to feel vulnerable. "When I had my wash this morning they undressed me and didn't cover me up. I was uncovered for several minutes."

People were supported at meal times, with their personal care and with things that were important to them. This was aided by information in people's care plans and staff's knowledge of people's life histories. People, their relatives or friends were involved in the reviews of the care provided. This was generally through conversation and also more formal reviews of care plans. One relative said, "My [family member's] relative did all the work with the [registered] manager so that everything was put in place to support them." The registered manager told us, "During reviews and talking people often tell you about their lives and often mention things that are useful to provide more individualised care to the person."

People's rooms were personalised and included decorations, furnishing and information which people found helpful. Throughout the day we saw that people's needs were attended to in a way which respected people's dignity. Staff told us that by talking and having a laugh with people it made the provision of personal care as dignified as possible.

People's care plans had been completed and updated to reflect the person's individual needs. We saw that the records contained guidance and sufficient detail so that staff, especially agency or those newly employed, had the information they needed to provide people's care in an individualised way. This included their personal life history and preferences such as when they liked to get up, what newspaper they liked and if they preferred a male or female care worker.

People were supported to access the equipment they needed to support their independence and mobility in and around the home. This included wheelchairs and walking frames. Staff supported people in a sensitive way including giving people time to complete their chosen activities. We saw that throughout the day staff offered people encouragement to help maintain and improve their independence. A relative told us, "The staff are attentive and conscientious."

Information regarding advocacy services through Age Concern was available in the home should the need arise. The registered manager told us that people or their relatives could access this whenever they felt a need.

Good

Is the service responsive?

Our findings

A detailed assessment of people's needs was undertaken prior to them living at the home. This was planned to help that the staff and registered manager were able to provide the nursing and personal care that people needed. One person told us, "I am a fussy eater. The home had a 'resident of the day' for each floor each month and this opportunity is used to check everything I need is in place including my food preferences. A relative told us, "[Family member] forgets things so I helped in providing details of the things that really matter them." We saw that tables and chairs which had been adapted to each person's needs were in place to support their independence as much as possible.

Hobbies and interests appropriate to each person were provided. An activities person provided planned activities such as sing-alongs, gentle seated exercises, dominoes and other hobbies which people liked to do. We saw that people were supported by staff who were enthusiastic in meeting people's assessed needs including their hobbies and interests. Two apprentices were engaged with people in a game of dominoes which they enjoyed along with general discussions about the game. One person said, "Generally, staff talk with me when they have time as I can't get about. I like listening to the radio and reading books and magazines." Staff and relatives told us that at weekends there were no planned activities other than for special occasions such as celebrations for VE day or the Queen's birthday. One member of care staff said, "It is getting more difficult to spend time on an individual basis with people as more people are now cared for in bed." They added that although they didn't have much spare time sometimes sitting with for a few minutes for a chat made a difference to people-.

People were supported to take part in things that were important to them. For example, quizzes, card games, target games and crafts. Other planned activities included a virtual cruise. This was where pictures and information was displayed about the countries visited. Staff then provided meals that were traditional in that country. One person said, "It reminded me when I was younger and where I had been. It was lovely." People were supported to maintain their independence and lifestyle including things that were important to them.

Information was provided to people and their relatives on how to raise suggestions, complaints and compliments. The provider analysed information from complaints for potential trends. This information was then fed back to the registered manager to put plans and actions in place to prevent future recurrences. This helped provide proactive responses before any concerns became a complaint. We saw that the registered manager had dates when each action had been, or was planned to be, completed. The record of complaints demonstrated that people's concerns and complaints were investigated and responded to the satisfaction of the complainant. These records were also used as an opportunity to put steps and measures in place to prevent the potential for further or similar complaints.

People and relatives told us that staff regularly asked if there was anything about the care provided that could be improved or changed. One person said, "All the girls are lovely. They are kind and considerate and I have never had to moan about anything." A relative said, "[Family member] has recently had to move in and so far it has been all they wanted. No concerns." One person said, "I know [name of registered manager] and I would just speak to them if there was anything to complain about, which there isn't." Staff told us, and we saw in staff and management meeting minutes we looked at, that they were able to voice their opinions about any concerns they had and that these were acted upon.

Good

Is the service well-led?

Our findings

The home had a registered manager in post. They had been registered since February 2015 but had been a manager at the home since October 2014. From records viewed we found they had notified the Care Quality Commission (CQC) of incidents and events they are required to tell us about. A notification is information about important events the provider must tell us about, by law.

Quality assurance checks completed by the provider and registered manager had identified deficiencies in the standard of care provided. This included the identification of recording errors in people's prescribed medicines, people's call bells not always being within reach and people's daily notes being too brief. We saw that the registered manager had a rolling action plan for these issues which had been prioritised according to the risk each issue presented. We also saw where additional checks had been implemented so that staff had to sign that a person's call bell was within their reach.

People and relatives knew who the registered manager was. One person said, "I would just speak with a nurse if I wanted to speak with the (registered) manager." People and all staff were complimentary about the fact that the registered manager was a very approachable person. We saw that the registered manager and all staff worked as a team. One person said, "I know them and they know me. It's like being at home." A relative told us that they found the staff were very supportive. They said, "The care home is their home (people who live there) and that is the ethic. It works well for us."

The registered manager and staff all told us that they would have no hesitation, if ever they identified or suspected poor care standards. This was by whistle blowing (whistle-blowing occurs when an employee raises a concern about a dangerous, illegal or improper activity that they become aware of through work) to the provider's management and the appropriate authorities including the CQC. Staff also told us that they would be supported in raising concerns.

People and staff told us that the registered manager was very much a 'hands on' manager who was frequently to be found talking with people and mentoring staff around the home. Staff told us that the registered manager and regional manager also called in unannounced to check on people including over weekends and at night time. This was to support staff but also ensure that the correct standard of care was being adhered to. This also enabled management to have an up-to-date view on the culture within the home and staff morale. One person said, "I see [name of registered manager] often and we get to chat sometimes. If I was worried about anything, which I am not, I would tell them." All staff confirmed that they could contact the registered manager about anything, anytime, day or night.

The registered manager attended the provider managers' forum where each homes good practice and knowledge was shared amongst the managers. This also helped them keep up-to-date with any changes in the CQC, such as how we inspect and also key developments in social care through organisations such as the Social Care Institute for Excellence (SCIE). This was for subjects including the Care Act 2014 and the Care Certificate. The provider told us and we found that there were staff champions in place for subjects including dementia care, dignity and nutrition. This was to develop staff skills throughout the home and had led to the introduction of nutrition cards for staff to know how each person liked their food. The registered manager told us and we saw that links had been made with the local community including visiting religious organisations and representatives of the Alzheimer's Society.

We found that information relating to people's care and those for staff's personal information was held securely. This also protected people's confidentiality. Only those staff and management with authority could access this information when authorised to do so.

A visiting hairdresser told us, "All the staff seem to get on well no matter which floor they work on." We saw that staff supported each other and that their morale was good. One staff member said, "The thing I like working here most for is the team spirit. We work well together."

The provider's incident and accident recording system was used to determine the number and pattern of incidents. This information was then used to develop and put action plans in place to prevent or reduce the potential for recurrence. For example, we saw that the provider had recently started auditing against the same standards used by the CQC to help determine how safe, effective, caring, responsive and well-led it was. Trends for accidents and

Good

Is the service well-led?

incidents were monitored for time, location, staff or other influences. This information was then used to help implement actions and measures to limit the likelihood for any recurrence.

Meeting minutes we looked at showed us that people, their relatives and staff had the opportunity to raise any suggestions to improve the service. Examples we saw acted upon was a request for new crockery.

Staff were regularly made aware of their roles and responsibilities and how to escalate any issues to the registered manager or provider if required. The registered manager also provided staff with guidance to develop key skills.

The registered manager monitored all staff training achievements and was aware that staff's knowledge about the MCA and DoLS were limited and they had plans in place to remedy this. In addition, they had decided that based upon the current e-learning that a classroom approach would benefit most staff.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: People were at risk of being administered the incorrect dosage of medicines. Recording of people's medicines was not accurate. Regulation 12 (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Risks to people were not always managed in a safe way. Regulation 12 (2) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: A sufficient number of staff were not available to meet people's needs in a timely way. Regulation 18 (1)