Whiston Hall Limited

Whiston Hall

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out this inspection on 21 November 2017. The inspection was unannounced, which meant the people living at Whiston Hall and the staff working there didn't know we were visiting. The service was previously inspected in January 2017 and was meeting all the fundamental standards. However, we had received concerns regarding this service so we bought this inspection forward.We identified the service had declined at this inspection. However, the manager had left and there had been a period without a manager, the provider had identified the concerns and was taking action to ensure improvements were made.

The service did not have a registered manager. However, the provider had appointed a new permanent manager who had been in post three weeks at the time of our inspection and they had commenced the process to register with CQC. 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.

Whiston Hall is a care home which providers accommodation for up to 48 people. The home is within easy reach of the local amenities such as the shops, village hall and public transport. There were 35 people using the service at the time of our inspection.

Staff we spoke with understood what it meant to safeguard vulnerable people from abuse, and they were confident management would take any concerns they had seriously and take appropriate action. However, issues we identified during the day did not support this and we submitted a safeguarding referral to the local authority.

We found there was a dependency tool to determine staffing levels. However this was not reviewed when there were changes and it was not clear from talking to staff and people who used the service if there were sufficient staff on duty to meet people's needs in a timely way.

Risks to people had not always been identified and if they were identified we found these were not always followed. Systems were in place for safe management of medicines. However, we identified some areas of documentation could be improved.

People were not always protected by the prevention and control of infection procedures. We found some areas of the service were not kept clean or hygienic to ensure people were protected from acquired infections.

We found procedures were followed for the recruitment of staff. Staff supervision took place although staff told us this was not effective. However, staff told us they felt supported by the new manager. Staff received training that ensured they had the competencies and skills to meet the needs of people who used the service.

We found the service did not always meet the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Most staff we spoke with did not have a satisfactory understanding and knowledge of this, and people who used the service had not been assessed to determine if a DoLS application was required. We also found people's best interest decisions were not always considered.

People were offered a well-balanced diet; however, we saw people were not always supported to maintain a balanced diet. People accessed health care services when required. Referrals were made quickly to health care professionals when people's needs changed.

People and their relatives we spoke with all said the staff were kind and caring. People also said staff respected them and maintained their dignity. However, staff did not always recognise when people required support as the call system could not be heard throughout the building.

Care plans identified people's needs and had good detail of how to manage people's needs. However, we identified that some documentation did not always reflect peoples current or changing needs.

People told us they were listened to by the new manager and were confident any concerns would be dealt with by them. Activities took place, however, more could be organised that met the needs of people living with dementia.

There were processes in place to monitor the quality and safety of the service. Some of the issues we had identified had been picked up and an action plan was being implemented by the new manager to resolve the issues.

During our inspection, we found four 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.

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.

Risks had been identified but were not always followed to ensure people were safe.

Systems were in place to manage medicines safely but documentation was not always properly recorded to evidence they were given as prescribed.

We found the service was not well maintained and was not kept clean.

Recruitment procedures were followed to ensure the right people were employed to work with vulnerable people.

Is the service effective?

Requires Improvement

The service was not always effective.

People's consent was not always sought in line with legislation and guidance.

We found people were offered a well-balanced diet however; support provided to ensure people received adequate nutrition to meet their needs could be improved.

Staff monitored people's healthcare needs and made referrals to healthcare professionals where appropriate.

Staff received training to fulfil their roles and responsibilities, were supervised and received an annual appraisal of their work.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us that the staff were kind, considerate and caring, although care could be rushed and task orientated.

We saw that staff respected people's privacy and dignity.

Staff did not always recognise and respond to people's needs in timely way.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The programme of activities did not meet the needs of everyone living at Whiston Hall.

Care records identified people's needs. However, they did not always reflect the person's current level of need.

There was a complaints system in place; complaints had been recorded and resolved and people told us they were listened to.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service was well led, but the changes in management had impacted on the quality monitoring. The new manager had improved the monitoring but it needed embedding into practice, to ensure it was effective.

There was not a registered manager, however, the new manager had applied to CQC to become the registered manager.

Staff told us the new manager had improved the service, it was much more inclusive and a positive culture.

Whiston Hall

Detailed findings

Background to this inspection

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

We carried out the inspection on 21 November 2017 and it was unannounced. The inspection team was made up of two Adult Social Care Inspectors and an expert by experience; this is a person who has personal experience of using or caring for someone who uses this type of care service. .

Prior to the inspection visit we gathered information from a number of sources. We looked at the last 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. However we did not request one for this inspection as it was bought forward due to concerns.

We looked at notifications sent to the Care Quality Commission by the registered provider. We also obtained the views of professionals who may have visited the home, such as service commissioners, healthcare professionals and the local authority safeguarding team.

We spoke with the regional support manager, the manager, two team leaders, three care staff, catering staff and a domestic. We also spoke with ten people who used the service, three relatives, and one health care professional. Observations helped us evaluate the quality of interactions that took place between people living in the home and the staff who supported them.

We reviewed a wide range of records, including people's care records and staff files. We checked the medication administration records. We observed people having breakfast, lunch, and evening meal, we observed an activity. We also reviewed the policies, procedures and audits relating to the management and quality assurance of the service provided at Whiston Hall.

Requires Improvement

Is the service safe?

Our findings

People we spoke with all told us that they felt they were safe at the home. Relatives we spoke with also told us people were safe. One relative said, "I think [My relative] is safe here I would know if anything was wrong." Another relative told us, "We visit every day and if we thought there was anything wrong [My relative] would tell us straight away."

Staff we spoke with were knowledgeable about safeguarding people from abuse. They told us how they would recognise abuse and that they would report any concerns to the acting manager. One care worker said, "I would report anything I felt concerned about." Another care worker said, "We have completed safeguarding training and we know what to look out for." However, we found staff did not always identify and meet people's needs and we referred a safeguarding concern to the local authority following our inspection.

Risks associated with people's care and support had been identified. However, some care records did not contain enough information to help minimise the risks from occurring. For example, one person had a risk assessment in place regarding mobility. This stated those two care workers were required to support the person in a hoist using a grey sling with yellow piping. There was no size or loop configuration available. We also identified that the nutritional risk assessments were not being scored correctly so the risk was assessed as low when it was not. Therefore people's weight loss was not being safely managed. For example, one person we looked at showed over two months they had lost 3.8kgs and the nutritional risk assessment had incorrectly scored them zero but they should have scored two. The score of two meant they should have been referred to a dietician and this had not been done.

We found medication procedures were in place to guide staff and ensure safe medication administration. We saw most of the procedures were followed by staff. However, we found people were prescribed medication to be taken as and when required known as PRN (as required) medicine. For example, medication prescribed for pain relief. Some protocols were not in place and others lacked detail. They did not explain when to give PRN medication or detail how people presented when they required the prescribed medication. Staff told us some people who lived at Whiston Hall were living with dementia so were not able to verbally tell staff when they required PRN medication. Therefore the protocols were required to guide staff to be able to determine if people required any PRN medication. Without this information people may be in pain or agitated and not received medication as required.

We found the systems in place for recording topical medication were not followed. For example, one person prescribed cream directed to apply three times a day, we found this had not been signed by staff as given. On some days it was only signed once and on others it had not been signed on any occasion. It was therefore not possible to determine if creams were being administered as prescribed.

We checked controlled drugs (CDs), these are drugs covered by the misuse of drugs regulations. We found these were correct.

The medication was administered by staff who had received training to administer medication. The manager told us all staff had received competency assessments, yet the staff had not identified that protocols were required and that the topical medication was not properly recorded. Therefore these were not effective.

We completed a tour of the building with the manager and found areas which required attention. Although we saw decoration was on-going at the time of our inspection there were many areas that were not well maintained and therefore could not be effectively cleaned. There were also areas in the home with a strong unpleasant odour.

We saw damaged wall plaster, areas that were damp with wallpaper peeling off, some carpets and floor coverings were dirty and not securely fixed and one carpet was threadbare. Store cupboards had items stored on the floor which made them difficult to clean. The store used to house activity equipment was very untidy and items were also stored on the floor and piled up on top of each other. The sluice area was not accessible as it had items stored in the room, making it difficult not only to access but to keep clean. The staircase leading to an outside door and a store area was extremely slippery and could be a risk to staff using this area. This store room was also cluttered and untidy. The registered provider had an environmental plan and the manager told us these areas would all be addressed.

The service had a call system where people who needed support could ring for assistance. The care system had two panels situated on the ground floor of the home. The call system could only be heard if you were in the vicinity. For example, if someone used the call system and staff were on the first floor, they could not hear the call. This meant there would be a delay in responding to someone, and this could be an emergency.

This is a breach of regulation 12 (10 (2) (a)(b)(g)(h) of The Health and Social Care Act 2008 (Regulated Activities) regulations 2014. Safe care and treatment.

The provider had a dependency tool in place to identify the number of staff required to support people safely. However, this was not always reviewed when there were changes. For example, when people's needs changed or new people were admitted. Therefore it was not evident that there were adequate staffing hours provided to meet people needs.

Staff told us they felt there were not always enough staff on duty to meet people's needs in a timely way. People we spoke with also told us there could be more staff. One person said, "I keep asking for things and staff don't respond, I asked four times for a blanket today and haven't got one. There are no staff about, if you want to go to the toilet you will wait ages, you may as well sit here and do it."

We observed staff were present during the day in communal areas. However one person said, "We are short on staff at the moment I think its holidays. But whatever time of year I can guarantee at 1pm they [the staff] all disappear and there's supposed to be someone here all the time." We observed that at 1pm there was only one member of staff present in only one of the lounges.

We observed staff interacting with people who used the service. Staff appeared to rush from one task to another. We spoke with staff to gain their view about the numbers of staff available. One care worker said, "Sometimes we have to rush, but it depends who is working with you. Some are quicker at doing things than others." Another care worker said, "There is not enough staff. We have to rush at everything." Another care worker said, "If we have five staff on in a morning it is fine. If we are down to four it's hectic."

When we heard call bells they were ringing for a long time unanswered and one person told us, "I have a call

bell in my room sometimes they don't answer it very quickly because they are busy."

This is a breach of regulation 18 (1) of The Health and Social Care Act 2008 (Regulated Activities) regulations 2014. Staffing.

We looked at three staff recruitment files and found the registered provider had a safe and effective system in place for employing new staff. Staff told us they had to complete an application, attend a face to face interview and provide suitable references before they were able to start work. Files we saw contained pre-employment checks which had been obtained prior to new staff commencing employment. These included a satisfactory Disclosure and Barring Service (DBS) check. The DBS checks help employers make safer recruitment decisions in preventing unsuitable people from working with vulnerable people. This helped to reduce the risk of the registered provider employing a person who may be a risk to vulnerable people. However, one file we looked at referred the registered provider to view the DBS check prior to them commencing employment. The manager could not evidence that this action had been taken.

Requires Improvement

Is the service effective?

Our findings

People told us the care staff were good and looked after them. People told us they were given choices and given time to make decisions.

People's needs were assessed and care plans were in place. However, these did not always reflect people's current needs and did not always follow best practice guidance and advice.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found the service was not always meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Most staff we spoke with did not have enough knowledge about this subject to ensure people received support in line with the MCA. We found people's best interests were not always documented, did not always involve all relevant people and the outcome was not documented. Decisions being made were sometimes very general and not specific. For example, one person used a specialist chair throughout the day, but there were no evidence to indicate that the person's best interests had been considered. This person's care plan indicated that they lacked capacity, however, a mental capacity assessment, specific to this interaction, had not been completed.

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

Staff told us they felt supported by the new manager and had received supervision. Supervision is an accountable, two-way process, which supports, motivates and enables the development of good practice for individual staff members. Staff also received an annual appraisal of their work. Appraisal is a process involving the review of a staff member's performance and improvement over a period of time. Staff also received training that enabled them to fulfil their roles and responsibilities. Staff told us the training was good.

We observed breakfast, lunch and the evening meal during our inspection. The dining room was bright, clean and nicely decorated, there were tablecloths, napkins and cruet sets on the tables. Protective aprons

were offered to people who required them people were given the choice of wearing one.

At breakfast we saw people were offered a choice of a cooked breakfast if they wanted. People appeared to enjoy their food. We saw people were offered regular drinks and snacks throughout the day. From records we saw it was not always evident that people received the diet which met their needs. For example, one person required a fortified diet due to recent weight loss. Food and fluid charts maintained did not always evidence that this had been provided. Another person had lost a considerable amount of weight over seven months. The senior care worker informed us that they were being weighed on a weekly basis and food and fluid charts were in place to record the person's dietary intake. However, these were not always fully completed or reviewed to ensure staff were monitoring the person effectively.

At lunch time there were 18 people seated in the dining room and they waited 25 minutes for the food to be served. As they had sat waiting for a long period one person left the dining room before food was served.

The food looked appetising and was hot. However, we observed that seven people left the lamb. We observed one person who was living with dementia persist and tried to eat it but clearly it was very gristly or tough. Because of this not all people ate well. People we spoke with all had complaints about the food. One person said, "Yesterday we had meat and potato pie, two pieces of broccoli and some mashed potatoes and we couldn't even cut the meat it wasn't edible, it was really bad, I had the potato broccoli and yoghurt." Another two people who sat at the same table both agreed with this. One said, "It was terrible."

During the meal everyone had assistance who required it. We saw that staff were very encouraging and comforting, there was very good interaction throughout. Six members of staff were available during lunch service.

We saw the evening meal and everyone was sat in the lounges no one was taken through to the dining room, staff told us it was people's choices but it was not evident if this was the case.

We discussed the meal with the manager who explained they had an agency chef on the day of our inspection because the permanent chef had left. They were recruiting and she agreed to look into and address the issues we identified.

People accessed health care services, we saw people had been referred to dieticians and speech and language therapists. However, we saw that where some people had deteriorated and required another referral, this had not always happened. Therefore people's needs were not always met. Although one person who we identified had deteriorated, when we discussed with staff they did follow this up during our inspection to ensure their needs were reviewed by a health care professional.

We found people's needs were not always met by the adaptation, design and decoration of the home. The registered provider had not considered the needs of people living with dementia. The corridors were bare; although some were being decorated they were being painted all in one colour. One person we spoke with asked, "What time is it? I can't see that clock it's too small." The clock had a pale face and tiny hands not easy for people to see.

Requires Improvement

Is the service caring?

Our findings

People told us the staff were kind and caring. They said they respected them and maintained their dignity. One person said, "They look after me very well, very well." Another person said, "The staff are very nice they try their best to help, you can't expect them to work any faster than they do."

Although observed interaction between people and the staff throughout the day were kind and respectful, the staff were very busy and there was little time for conversation. Care was mostly task orientated and not person centred. It was also not clear from care plans we looked at if people were involved in their care planning to ensure their choices, preferences, likes and dislikes were considered for their care and support.

We observed some very positive interactions between staff and people who used the service. For example, one care worker spoke kindly to people they explained patiently and waited for an answer. We also saw most people were well presented and clean. Although we did notice some people had dirty nails and one person was sat in the corridor and their trousers had a large dried stain, they said, "It was breakfast I spilled some food, they [the staff] were supposed to be going to change it." They still had the stained clothes on in the afternoon.

We also heard staff throughout the day discreetly ask people if they required the toilet or if they required any support. We heard staff mentioning discreetly to other staff, 'we need to take [the person] to the toilet.' Everyone we spoke with told us staff were polite and compassionate and had no complaints.

Relatives we spoke with told us the staff were caring. One relative said, "They are always loved and cared for the carers have a bit more time for them now, they seem more relaxed now but it's still not enough we hoped for a bit more personal attention."

Staff told us there was access to advocacy services if required. Independent advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them, defend and safeguard their rights and have their views and wishes genuinely considered when decisions are being made about their lives. We saw there were advocacy notices throughout the home.

Most people told us they were listened to and felt their preferences were respected. Although people told us staff did not always respond to their requests in a timely way. However, two people told us staff did not listen, one person said, "Staff don't really listen I asked for cheese flan and got lamb casserole for dinner." Another person said they had asked for a bath but didn't always get one. They said, "I like a bath not a shower and I like my hair washing at the same time. You ask for a bath and they say we are too busy or one of the taps isn't working, and before you know it another weeks gone."

Staff told us that church services were held occasionally to ensure people's religious needs were met. However, it was not clear how often these took place as people we spoke with could not remember the last service. One person said, "I can't remember being taken to a service." They also said they had didn't

remember any one coming into the home. Following our inspection the registered provider informed us the church service takes place every month.

Requires Improvement

Is the service responsive?

Our findings

We looked at care plans belonging to people who used the service and found they didn't always meet people's current needs. For example, one person had a risk assessment in place regarding the use of the hoist. However, their care plan regarding mobility stated that the person walked with a walking frame and staff were to encourage them to maintain their mobility. We asked staff about this and they told us that the person no longer walked and the hoist was used at all times. The care plan had been evaluated but stated that there was no change. This meant the care plan did not include any information regarding the use of the hoist, what size sling to use and what the loop configuration was to be used. This meant that staff had not recognised that the care plan required updating to meet the people's needs.

We looked at another person's care plan and found they required support with their dietary intake as they were prone to losing weight. The person had a Malnutrition Universal Screening Tool (MUST) in place which was incorrectly completed. The person had lost weigh over eight months, but the MUST had no overall score for the risk of malnutrition. The person's GP and dietician had advised they should have a fortified diet. However, the food and fluid charts in place did not evidence that this was being provided.

There was a dedicated activity co-ordinator. We observed the activity coordinator had meaningful conversations and positive interactions with people throughout the day. People told us they really enjoyed the activities and liked the coordinator. One person said, "[The activity coordinator] is marvellous, she does a lot for us."

The activities board showed five in house activities since September 2017, on the day of our inspection the activity coordinator held a quiz game in the morning and bingo in the afternoon both in the large lounge, people enjoyed these very much. However, no activities were held in the small lounge. One person we spoke with who was in their room watching television was brought into the small lounge, staff said, "For a change of scenery." The television was on in the small lounge but no sound. The activity coordinator and other care staff told us people who sat in the small lounge were predominantly living with dementia, there was no meaningful activities provided for people living with dementia and when activities took place they were left out.

This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives we spoke with also told us there could be more activities that included everyone. One relative said, "They [the staff] don't have time to chat there is not a lot of stimulation or one to ones, these people in here are the people with dementia they are the quieter ones in this room who don't really know what's going on but there's nothing for them."

Another relative said, "The activity coordinator is a bubbly personality and the carers are really nice. But need more stimulation and outings."

We found that people's views were captured but ideas raised had not yet been acted upon. We saw a survey

in the service user guide which was available in the reception area. Six surveys had been completed and returned by relatives and one by staff. We were told by a visitor that there had recently been a 'Relatives meeting' they attended and said it was really relevant. However the minutes were not yet completed. There were minutes available of a meeting on February 2017 and nine people who used the service and three relatives attended. At this meeting the attendees were asked what trips they would like, and requested Coast Trips, Parks, Cafes, Garden Centre. There was a note about a mini bus that could be borrowed. We asked relatives if this had happened and they all said there had been no outing that year.

The activities Coordinator told us that only two wheelchairs were allowed on the bus and it seems unfair to leave the home to just take two people out. Therefore no one had been taken out. They also told us that it was only recently that they were given an activities budget before the staff used to fund raise to provide this. They said it would be easier to arrange activities and outings now they had a budget and did not have to solely rely on fund raising.

The registered provider had systems in place to receive and monitor any complaints that were made. We saw that when a complaint was made appropriate action was taken. People and their relatives we spoke with all told us they were confident any concerns would be dealt with.

Relatives were welcomed to the service and could visit people at times that were convenient to them.

People maintained contact with their family and were therefore not isolated from those people closest to them. During the lunchtime service we observed family members being asked if they would like to join people for lunch.

The manager told us they had an 'open door' policy where people living at Whiston Hall, their visitors, and members of staff could approach them at any time to discuss any complaints or concerns they had.

Requires Improvement

Is the service well-led?

Our findings

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. However, a new manager had been appointed and had been in post three weeks at the time of our inspection. They had commenced the process to register with CQC.

The people we spoke with were aware there had been a change in management. People who used the service knew the new manager by sight.

Although some relatives told us they had attended a meeting, there were no minutes available and one relatives we spoke with was not happy with the communication as they felt they had not been kept informed of what was happening. They said, "There is a lack of feedback, manager's change and staff leave and no one tells us anything."

During our inspection we identified some areas that required attention that had not been picked up by the quality monitoring system. However, the new manager was aware that there were areas that had not been looked at as part of the quality monitoring system and knew because of this there were issues that had not been identified.

Since our inspection the manager has sent us a consolidated action plan of all the required actions, who is responsible for completing them and clear timescales. This gave us confidence that the new manager recognised the areas where improvements were required to address the concerns we identified on our inspection. However, the quality monitoring system needs to be fully developed and implemented and embedded into practice.

Staff told us they were well supported and worked well as a team. They told us they have regular team meetings and communication is good. All staff we spoke with said the new manager was very good. One staff member said, "Things are much better with the new manager." Another care worker said, "[The new manager] is quite calm and relaxed, but organised." Another care worker said, "The new manager is lovely. She is available if we need her and very approachable."

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

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where 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 9 HSCA RA Regulations 2014 Person-centred care People did not receive care that was person centred, met their needs or reflected their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People were not fully consulted about the care and treatment. Where people lacked mental capacity legal requirements were not always followed

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not receive safe care and treatment, were not protected against the risks associated with the management of medications or infection control.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers and deployment of staff did not ensure peoples needs were met in a timely way.