Bramblings (Kent) Limited

Bramblings Residential Home

Inspection report

Bramblings Residential Home
Bramblefield Close
Hartley
Kent
DA3 7PE

Tel: 01474702332

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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?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 24 October 2016 and was unannounced. Bramblings Residential Home is a 42 bed care home for older people that does not provide nursing care. There were 41 people living at the home at the time of this inspection. When we last inspected the service on 13 September 2013 the provider was meeting the required standards. At this inspection we found that the provider was not meeting the required standards.

The home had 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.

Staff were knowledgeable about the risks associated with people`s daily living and routinely mitigated some of these identified risks. However there were very few risk assessments developed with management plans to offer guidance for staff in what steps were needed to mitigate the risks.

People who had a diagnosis of dementia or had a confused state of mind had no mental capacity assessments in place to establish if they had capacity to understand and take informed decisions regarding the care and support they received from staff. Best interest processes were not followed to ensure the care and support people received was in their best interest.

Where people had restrictions applied to their freedom in order to keep them safe, the registered manager has not applied for Deprivation of Liberty Authorisations (DoLS) to ensure they were depriving people of their liberty lawfully.

People had their medicines administered by trained staff; however they did not always receive their medicines as intended by the prescriber. Staff failed to ensure that people had their medicines available in sufficient quantities.

People had little opportunities to participate in activities or pursue their hobbies and interest. When activity staff were absent there were no alternative arrangements in place to ensure people were provided with an activity programme of interest to occupy their time.

People told us they were involved in decisions about their care, however, some people could not recall having been involved and their consent was not always accurately reflected in their individual plans of care. Care plans were not personalised to reflect people`s likes, dislikes and preferences about the care they received. These had not identified and detailed all the care needs people had and did not offer sufficient guidance for staff to understand and deliver care and support in a personalised way. People`s care plans were not always reflective of their current needs.

People who lived at the home were positive about the skills and abilities of the care staff. Staff received induction training when they started working at the home and yearly refresher training in key areas such as safeguarding, infection control, manual handling and first aid. However the registered manager could not evidence to us that agency staff working at the home received any training or if they were suitable to work and deliver care to people. Staff told us they had regular supervisions and felt supported by the home management team.

The quality assurance systems were not effective. The regular audits carried out by the registered manager and the provider were not comprehensive enough and had not identified all the issues and concerns we identified at this inspection. Care records were not up to date and not always reflective of people`s care needs.

People were cared for in a kind and compassionate way by staff who knew them well and were familiar with their individual needs, preferences and personal circumstances. We saw that staff had developed positive and caring relationships with people who lived at the home. They provided care and support in a respectful way promoting people`s privacy and dignity.

There were sufficient numbers of suitable staff available to meet people's needs consistently across all areas of the home. Safe and effective recruitment practices were followed to make sure that staff were of good character and had the experience and qualifications necessary for the roles they performed. Staff were knowledgeable about the risks of potential abuse and knew how to report any concerns they had internally and externally to local safeguarding authorities.

At this inspection we found the service to be in breach of Regulations 12, 11, 9 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked 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 consistently safe.

Risks to people's health and well-being were not always identified, recorded and plans were not developed to give guidance to staff in how to manage these.

People did not always receive their medicines as intended by the prescriber.

Agency staff working at the home had not been asked to provide their profiles by the registered manager to ensure they were trained and suitable to work at the home.

There were sufficient numbers of staff available to meet people's needs at all times.

Staff recognised and knew how to respond to the risks of abuse and how to report to local safeguarding authorities.

Safe recruitment practices were followed to ensure staff were of good character and suitably qualified for their role.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The principles of the Mental Capacity Act (MCA) were not always followed to ensure people received care which was in their best interest.

People had restrictions applied to their freedom; however the registered manager has not submitted applications to the relevant authorities as required by the law.

People told us their health needs were met and they were supported to access health and social care professionals when necessary, however details from the professional's visits were not recorded.

People were supported to eat a healthy balanced diet that met their needs.

Is the service caring?

Good

The service was caring.

People told us they were involved in their care and this was delivered as they liked it.

People were cared for and supported in a way to promote their dignity.

People who lived at the home told us staff were respectful, kind and caring.

People`s care records and personal information was kept confidential.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive personalised care from staff.

People were not always provided with opportunities to pursue social interests and take part in meaningful activities relevant to their needs.

Complaints were recorded however not always responded to appropriately. Lessons to be learned were not always shared with staff to help improve the service.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The quality assurance and governance systems used by the registered manager and the provider were not always effective in identifying areas for improvement.

Records relating to people`s care were not always up to date and did not provide staff with sufficient guidance in how to meet people`s needs safely and effectively.

Staff felt supported by the registered manager and the provider. They were clear about their roles and responsibilities.

Bramblings Residential 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 met 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 under the Care Act 2014.

The inspection was carried out on 24 October 2016 and was unannounced. The inspection team consisted of one inspector and an expert by experience. An expert by experience is someone with personal experience of having used a similar service or who has cared for someone who has used this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that requires them to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed other information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we spoke with 12 people who lived at the home, one relative and four staff members including the deputy manager. We also spoke with the registered manager and the provider. We reviewed the commissioner's report of their most recent inspections.

We viewed care plans relating to four people who lived at the home and four staff files. We also looked at other documents central to people's health and well-being. These included staff training records, medication records and quality audits. We carried out observations in communal lounges and dining rooms and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us due to complex health needs.

Requires Improvement

Is the service safe?

Our findings

Risks to people`s well-being were not always identified and appropriately managed. Staff were knowledgeable about people who were high risk of falls and they told us they were closely monitoring people at risk, however there were no risk assessments to detail any preventative measures used or in place to mitigate and lower the risks falls. For example one person had two falls in June 2016 and five falls in August 2016. This person`s care plan had a fall risk assessment tool which placed them at high risks of falls. There was no detailed management plan for staff to follow in how to mitigate the risks and if any measures were taken to keep this person safe. The registered manager told us the person had been seen by their GP and they were referred to specialist falls clinics, however there were no records of these visits or what actions should be taken to lower the risks of falls for the person.

The person`s records detailed that they were independently mobilising with their walking aid and often they were found walking around in a confused state of mind and not knowing what was happening around them. There was no assessment for any aids which could have alerted staff when this person was getting up from their bed or chair and may have been in need of help. This meant that the person was at continuous risk of falls.

Staff were using tools to determine the risk levels for people regarding their skin integrity and falls, however these tools were not completed correctly and did not provide staff with guidance on what measures they had to take if people were identified at high risk of developing pressure ulcers or high risks of falls. For example we saw that when staff completed a Waterlow assessment (this is an assessment to identify if people were at risk of developing pressure ulcers) for a person they recorded a score of 22. There was no guidance for staff what this score meant and what measures they should consider to prevent pressure ulcers developing. Staff could not tell us what the score meant, they told us if people were at risk of developing pressure ulcers the District Nurse Team ordered special mattresses for people to use. Staff told us they reported to managers in case they noticed any read areas on people`s skin.

Staff were not using any tools to establish if people were at risk of malnutrition. They told us they routinely referred people to their GP and dietician where they noticed a weight loss above three kilograms in a month. However staff had not considered people`s Body Mass Index (BMI) when they monitored people`s weight loss. This meant that people could have been at risk of malnutrition if they constantly lost weight over time but their weight loss was not grater then the three kilograms this would not have been actioned by staff. Staff told us they communicated with the GP who visited the home on a weekly basis if they observed people were not eating well and they asked for food supplements to promote a good nutritional intake for people. However records had no detail about why the GP visited people, the outcome of their visit or if any actions were agreed following their visit.

We found that people could not be weighed between the 04 and 14 October 2016 because the scale was out of order. The deputy manager told us they were waiting for the new scale to arrive so they could weigh people. However this meant that for the people who were losing weight and had to be weighed regularly in order to monitor their weight loss this was not possible. For example a person was identified by staff as

losing weight. They were assessed to be weighed twice a month. We found that they continued to lose weight. On 22 August 2016 they were 63.8KG, on 07 September 2016 they weighed 61.6KG and on 19 September 2016 they were 59 KG. After the 19 September 2016 they could not be weighed due to the scales being broken. This meant that staff was not able to identify if the person continued to lose weight in this period and involve the person`s GP or a dietician in their care. This was a potential risk to people`s health.

We found that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as risks to people's health and welfare were not sufficiently mitigated to keep people safe.

People had their medicines administered by trained staff; however we found that people had not always received their medicines as intended by the prescriber. People`s medicine administration records (MAR) were not always completed accurately. For example hand written entries on MAR charts were not signed by two staff members to ensure the information written was correct.

We found that staff administering people`s medicines were not always signing the MAR after they gave people their medicines, we noted several gaps in the records and these gaps had no explanation given as to why and if people had or not received their medicines.

Staff were not proactively reconciling medicines for people to ensure there were enough medicines in stock and as a result we found that on occasion's people had run out of their medicines. For example one person who was prescribed a medicine to help them eliminate water went without their medicines for one week and another person had no antidepressant tablet for four days. The manager told us that for the first person the GP had increased the dose of the water tablet and this was the reason they run out of medicines. They told us they have requested the prescription from the GP and then asked the pharmacy to prepare and deliver these; however it took a few days for the medicines to arrive. We found no records to check on what date the medicines were requested from the GP. This meant that people`s health could have deteriorated because they had not received their medicines.

We looked at a random selection of medicines and found that stock levels were not always correct. We found inaccurate quantities of tablets, there were either more or less tablets remaining in the opened boxes. This meant that people did not always receive their medicines as intended by the prescriber.

We found that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were safe and robust recruitment processes in place to make sure staff employed were able, fit and suitable to work with vulnerable people. Appropriate checks had been undertaken before staff started work including written references, satisfactory Disclosure and Barring Service clearance (DBS), employment history and evidence of the applicants' identity. However there were no checks done by the registered manager or the provider for agency staff used to work at the home. There were no agency profiles requested from the agency for the registered manager to be able to identify agency staff and to check the training agency staff received prior of them working in the home. The registered manager and the provider told us they relied on the agency to send agency staff who had the right qualifications, skills and the right to work in the home. The registered manager told us they were going to request the profiles from the agency following the inspection for all the agency staff who were going to work at the home.

People told us there was enough staff to meet their needs effectively. One person told us, "I can just press my red button and help will come." Another person said, "I had a fright in the middle of the night and rang

my bell and help arrived as prompt as you like." There were enough staff on duty on the day of the inspection to meet people`s needs promptly. We observed call bells being answered in a timely way and people`s needs were attended to promptly throughout the day.

People told us they felt safe living in Bramblings Residential Home and they trusted staff. One person told us, "I have no worries here, I feel safe." Another person said, "I am happy here. I am safe and I like being here. I would leave if things were any different."

Staff were trained and knowledgeable about the risks of potential abuse and knew how to report any concerns they had to the relevant local safeguarding authority, which included by way of 'whistleblowing' if necessary. One staff member said, "I would report all my concerns to the manager or deputy manager. I know what to do if I suspect abuse."

Requires Improvement

Is the service effective?

Our findings

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. We found that mental capacity assessments were not carried out for people who had a diagnosis of dementia and they may have lacked capacity to take decisions regarding their daily care needs.

There was no best interest decisions documented to evidence the process of options considered before a decision was made in people's best interests. For example staff told us about a person who occasionally displayed threatening behaviour towards other people living in the home. Staff took the decision to keep the person in the sitting room and assist them to eat and not take them into the dining room at meal times. When we asked staff why they took this decision they told us that the person was disruptive and disturbed other people, however we could not be sure that this was also in the person`s best interest.

People can only be deprived of their liberty 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). We found that people had restrictions applied to their freedom without having DoLS authorisations in place for these. For example some people were not able to leave the building on their own and the front door to exit from the building had been secured to prevent people from leaving and unauthorised access in the home. We also heard a person saying, "I want to go home" several times throughout the day but they were not able or allowed to do so. We asked the registered manager if they submitted applications for DoLS authorisations and they told us they did not. They sent us an e-mail following the inspection to inform us they have submitted 11 applications to the local DoLS authorities to ensure they were lawfully applying restrictions on people`s freedom.

People told us staff asked them for their consent to care before they carried out any tasks. One person told us, "They [staff] always ask do you want this or that. I am very happy." Another person told us, "Everything I want to know they [staff] tell me and they ask me if I am happy." However consent from people was not recorded in relation to matters such as, sharing their personal information with other professionals; consent to agree the care needs they had. For people who lacked capacity there was no record or evidence as to who held lasting power of attorney (LPA) for their care and welfare or if they had an advocate to agree that the care they received was in their best interest.

The lack of appropriate arrangements to seek people's consent and to act in their best interests was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were happy with the way staff offered support and care to them. They felt staff were skilled and knowledgeable. One person told us, "Staff are good, they know what they need to do." Another person said, "Oh yes, they are lovely and they know what I need."

Staff members told us, and records confirmed that they had been provided with the training relevant for their job roles and refresher updates were done regularly. One member of staff told us, "Training is good and we can ask for training as well which is great." Another staff member told us, "We are offered plenty opportunities to do training. I have recently done dementia training. I really enjoyed it." Newly employed staff confirmed they had induction training and shadowed a more experienced staff member for a period of time until they were confident working unsupervised.

Staff we spoke with told us they felt supported by the managers they had regular supervisions where their performance and development was reviewed. A staff member said, "I feel supported by the managers. They supervise and observe how we work and give us constructive feedback." Another staff member said, "I do have regular supervision and I feel supported by managers."

People we spoke with had mixed views about the food. Some people told us they found the food being good others said there were not enough choices. One person said, "Vegetables are sometimes so hard I cannot bite them and we do not get nice gravy and it is always really the same choice." Another person told us, "The food is above average. Very good."

On the day of the inspection there were plenty of drinks available and people in their rooms had drinks at hand. Staff regularly offered people snacks and hot and cold drinks throughout the day. One person said, "I always ask for biscuits, banana and milk and they arrive."

We observed people having lunch in the dining room area. Tables were not laid to give a purpose to the room and prompt people to sit and have their meals and there was no interaction in the dining area, no music playing. People were left sitting around a long table for 15 minutes with a glass of orange squash in front of them before their meal was served. The meals, although chosen by people in the morning, were plated up by staff and no choice of portion size or preferences to vegetables were offered to people. There were no menus on the table to remind people what they have chosen.

We observed two staff members assisting people to eat their meals in the lounge area. They assisted people at their own pace and were attentive to the needs of the people they supported however; there was minimal conversation with anyone at the table. The staff did not facilitate any conversation between themselves and people they were supporting.

People were referred to health care professionals if there was a need for it. One person told us, "I was so pleased when I came back after my operation; they looked after me and came to me when I rang the bell and was worried about my hip, they even dialled 111 and a doctor came to visit me."

The dates when health and social care professionals visited were recorded in people`s care plans. However there were no details about the purpose of these visits or a record about the outcome. The registered manager and staff told us they knew the purpose and the outcome of recent visits from professionals however they agreed that by not recording these in time they would not be able to recall all the details.

Good

Is the service caring?

Our findings

People told us staff were kind and caring towards them. One person told us, "Staff are helpful, kind, pleasant and approachable". Another person told us, "I could not be happier here. The staff are lovely and kind." One relative told us, "We are very happy with the staff and [person`s] care here."

We saw that staff developed positive and caring relationships with people who lived at the home. They called people by their first name and were respectful when talking to people. People told us they felt comfortable to approach any of the staff and were not afraid to ask for help at any time of day or night. The staff interacted politely with people and we observed people smiling and being cheerful when staff entered their rooms.

People were supported to maintain positive relationships with friends and family members who were welcomed to visit them at any time. One person said, "I can have my visitors any time. I can even go out with them."

People who lived at the home did not recall having been involved in planning or reviews of their care plan and most knew little about what their own care plans contained. However they told us they were happy with the care. One person said, "Everything is as I want it. I will soon tell them if not." Another person said, "I do what I like here and they [staff] do what I want them to do, so I am quite happy."

People were treated in a way that protected their privacy and maintained their dignity. People we saw in their bedrooms and communal areas were dressed appropriately, well-groomed and looked comfortable and content. When people were assisted with personal care this was carried out away from people, behind closed doors, and sensitively to ensure people`s privacy was maintained. We observed one person who required assistance with their continence needs. One staff member noticed this and discreetly sought the support of a colleague who then quickly and quietly took the person to their room and assisted them and not drawing attention to their needs.

Private and confidential records relating to people's care and support were securely maintained in lockable offices. Staff were able to demonstrate that they were aware of the need to protect people's private and personal information. This helped ensure that people's personal information was treated confidentially and respected.

Requires Improvement

Is the service responsive?

Our findings

People told us they were bored most of the time and there was not much for them to do all day. One person said, "They [staff] organise some events or other things at times but nothing much so I just watch TV. Sometimes it's boring but my family visits regularly." Another person said, "There`s not much to do here but we at least have each other to chat with."

The deputy manager told us that there were two activity coordinators for the home, however one was on long term leave and the other was absent. They told us the activity coordinators organised events in the home and outside entertainers visited the home occasionally. However, we observed that there were little items of interest readily available for stimulation or entertainment. None of the people were partaking in any form of activities throughout the day of the inspection. People who came out from their bedrooms were shown to chairs in the lounge before and after lunch and they were left to sit with the television left on at the end of the room.

Staff told us that activities were happening when the activity organiser was on shift; however there were no arrangements in place to cover for their holidays or absence and staff had no time to spare for activities. One staff member told us, "We don't really have time to do activities with people. We wanted to do bingo today but by the time we could nobody wanted to join in."

We found that although a significant number of people in the home lived with dementia there were very limited activities or stimulation available to meet their needs. The environment offered no stimulation or object of interest for people to occupy their time.

We found that people had low expectations regarding the care and support they received. Most of the people we spoke with lived at the home for several years and got used to follow a set routine not necessarily because they preferred it. We spoke with a person who told us they lived in the home for a long time and they did not expect a lot from the service. They told us, "What can I expect when I live in a care home. I go along with everything and I got used to it." Another person we spoke with told us they liked their door closed when they moved in the home; however they now left their door open because everyone including staff just walked in after a short knock not waiting for a response. They said, "It`s no point to close the door. People just walk in." Other people`s comments included, "I press the buzzer at around ten past eight and I am answered very quickly, I tell them that I would like to get up and they explain how long I will have to wait before they can wash me and help me out of bed ", "Past seven forty five they [staff] put me to bed and take out my hearing aids so I cannot watch any evening television. Then they get me out of bed at six in the morning every day but I don't mind even if I do find my bed comfortable in the mornings."

For people who were not able to verbalise their preferences due to their level of dementia their care plans did not consistently or accurately reflect their life histories, personal circumstances or preferences. This meant that new and temporary staff members who were less familiar with people did not always have access to the information and guidance necessary to help them provide person centred care and support.

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

Most people told us that they never complained and could not give us feedback if their complaints would be listened to. One person said, "Naturally sometimes you don't like things but generally it is very good, I can't complain, I actually can't complain about anything." Another person said, "I don't complain. I tell them what I need and they [staff] usually is very helpful. Everything I want to know they tell me." There was a system and procedure in place to record and investigate complaints. However we found that complaints were not always answered and responded appropriately and we found no evidence that lessons were learned and shared with staff to improve the service. For example we saw a complaint recorded by the registered manager; however their response to the complainant was recorded on the complaint form. There was no detail about any investigation or any lessons learnt and shared with staff to improve the service.

Requires Improvement

Is the service well-led?

Our findings

We found that the service was not consistently well-led. The registered manager and the provider were not up to date with current legislation requirements. They had not submitted DoLS applications to the local authorities as required by law for people who had restrictions applied to their freedom in order to keep them safe.

People's care records were reviewed by staff regularly, however the information contained in them was not detailed enough around people`s mental capacity, mobility needs, skin integrity, behaviour management, risk management or person centred care. Daily care records evidenced people`s changing needs; however the care plans and risk assessments were not promptly updated to reflect these changes. For example we found that for one person staff recorded for several weeks prior to the inspection that the person`s mobility needs changed. They required two staff`s assistance to mobilise as their legs were weak. However the mobility assessment in their care plan still said they required supervision from just one member of staff and they were mobilising with a walking aid.

Tools used by staff to establish the level of risk people had to develop pressure ulcers or risk of malnutrition and falls were not used to develop risk management plans to detail what measures staff was required to take to manage risks safely. Professional visits were not appropriately logged to detail the purpose of their visit and what actions were agreed following these.

Incidents and injuries were recorded and information about numbers of falls were kept by the registered manager, however they told us they were not analysing these to try and identify trends and patters. There was no falls management plan developed for people who had significant number of falls. For example one person had 8 falls in one month, another person had 7 falls. The registered manager had not investigated these to find if these were random falls or if a pattern could be identified. They were not using any aids to monitor this people`s whereabouts in order for staff to be able and offer support quickly if it was needed. The registered manager told us people were referred to their GP and falls clinics and had physiotherapist input, however they could not evidence these visits as there were not recorded.

People whose behaviour may have been difficult to manage on occasions had no behaviour management plans in place for staff to recognise any triggers which could have predicted this behaviour. We found that staff only recorded on Adverse Behaviour Charts (ABC) when an incident occurred. The registered manager informed us at the beginning of our inspection about the signs and symptoms and the triggers of this person`s behaviour, however they had not developed a plan for staff to follow in how to manage this.

Regular audits of key areas of service delivery had not been effective in identifying all the concerns found following this inspection. The registered manager and the provider told us they made significant improvements at the service in the last year after the previous manager left. However they had no service improvement plan in place to accurately measure the quality of the work done.

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

2014.

Staff told us they felt supported by the management, they had regular supervisions where they could discuss their development, however staff meetings were not held regularly. Staff told us they relied on the handovers at the beginning of each shift to be updated on what was happening in the home. One staff member told us, "We have regular supervisions but not staff meetings. We have handovers for each shift and that`s how we find out what is going on."

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 The provider failed to ensure that the care and support people received was personalised and took account of their likes, dislikes and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure that appropriate arrangements were in place to seek people's consent and the care people received was in their best interest.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health and welfare were not sufficiently mitigated to keep people safe. The provider failed to ensure that there were sufficient medicines available for people and that people received their medicines as intended by the prescriber.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to monitor and mitigate the risks relating to the health, safety and welfare

of people.

People`s care records were not always accurate or contemporaneous in reflecting the care and treatment they received.

The provider`s quality assurance systems were not effective in identifying all areas in need of improvement.