Cumbria Care

Croftside

Inspection report

Beetham Road
Milnthorpe
Cumbria LA7 7QR
Tel: 01539 563325
Website:

Date of inspection visit: 1 September 2015
Date of publication: 12/11/2015

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**

Overall summary

This unannounced inspection took place on 1 September 2015. We last inspected Croftside in December 2013. At that inspection we found the service was meeting all the six regulations that we assessed.

Croftside is a residential home located in the village of Milnthorpe and is close to all the local amenities and services. The home has three units, the one on the ground floor provides care and support for people living with dementia. The home provides accommodation on two floors for up to 34 people. The first floor is accessible by a passenger lift and all the bedrooms are for single occupancy. At the time of our visit there were 33 people living in the home.

The service had a registered manager in post. 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 and associated Regulations about how the service is run.

Summary of findings

We found at this inspection that there was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were not sufficient numbers of support staff at night time to meet the assessed needs of people living in the home and in emergency situations.

There was a breach of Regulation 13 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014. This was because the registered provider had not made sure that suspected or alleged abuse had been acted upon quickly and in line with local safeguarding arrangements to keep people safe.

There was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the assessments of people's care, treatment and support needs were not always in place, planned in detail and reviewed to support person centred care and did not always show how some risks were to be managed.

The Care Quality Commission (Registration) Regulations 2009 require that the registered provider notifies the Commission without delay of allegations of abuse and accidents or incidents that had involved injury to people who used this service. This is so that CQC can monitor services responses to help make sure appropriate action is taken and also to carry out our regulatory responsibilities. The sample of people's records that we looked at showed examples of incidents and accidents that had occurred that should have been reported to CQC.Our systems showed that we had not received these notifications. The failure to notify us of matters of concern as outlined in the registration regulations is a breach of the provider's condition of registration and this matter is being dealt with outside of the inspection process.

You can see what action we told the provider to take at the back of the full version of the report.

We spoke with people who lived at Croftside and they made positive comments about their home and told us they felt it was a safe place to live. They told us that staff were "kind" and "helpful" and helped them to do things for themselves. People living there told us that care staff respected their privacy and treated them with respect. We saw that the staff on duty approached people in a friendly and respectful way and everyone we spoke with told us that they felt safe living at the home.

We spent time with people on all the units. We saw that the staff offered people assistance and took the time to speak with people and take up the opportunities they had to interact with them and offer reassurance if needed.

They service had safe systems for the recruitment of staff to make sure the staff taken on were suited to working there. On the day of the visit there were sufficient care staff available to support the people living there. We saw that care staff had received induction training and ongoing training and development and had supervision once employed.

Medicines were being safely administered and stored and we saw that accurate records were kept of medicines received and disposed of so they could be accounted for.

People knew how they could complain about the service they received and information on this was displayed in the home. People we spoke with were confident that action would be taken in response to any concerns they raised.

We have made a recommendation about obtaining information on best practice in relation to providing evidence of who holds PoA for individuals and ensuring the annual review of DNACPR forms and decisions.

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 safe.

The registered manager had not always followed local guidelines to refer possible abuse to the appropriate safeguarding agencies.

There were not sufficient numbers of care staff at all times to meet the assessed needs of people living in the home and in emergency situations.

Medicines were being handled safely and people received their medicines correctly.

Is the service effective?

Requires improvement

The service was not effective.

There was not evidence of best practice in relation to providing evidence of who holds PoA for individuals and ensuring the annual review of DNACPR forms and decisions.

The requirements of the Deprivation of Liberty Safeguards had been followed to ensure legal authority had been obtained to restrict a person's liberty where needed.

We could see that training had been provided for staff relevant to their roles to help them understand and support people living in the home.

Is the service caring?

Good

The service was caring.

People told us that they were being well cared for and we saw that the staff were respectful and friendly in their approaches.

Staff demonstrated good knowledge about the people they were supporting, for example information on their backgrounds and preferred activities.

We saw that staff maintained people's personal dignity when assisting them. Staff also offered explanation and reassurance about what they were doing

Is the service responsive?

Requires improvement

The service was not responsive.

Staff did not always have accurate information to refer to in care plans and some people did not have appropriate risk assessments in place to inform their care planning and the support they needed from staff.

There was a system in place to receive and handle complaints or concerns raised.

Summary of findings

Support was provided so people could follow their own interests and faiths and to maintain relationships with friends and relatives and to have local community contact.

Is the service well-led?

Requires improvement 

The service was not well led.

Some notifications of accidents and incidents required by the regulations that should have been submitted to the Care Quality Commission (CQC) had not been notified.

Checks of care plans and reviews used to assess the quality of care planning were not ensuring that people's care plans always had the required information.

People who lived in the home and their visitors were given some opportunities to give their views of the service.

Croftside

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 inspection took place on 1 September 2015 and was unannounced. The inspection was carried out by two adult social care inspectors.

As part of the inspection we also looked at six care records and care plans relating to the use and storage of medicines. We looked at their individual care records and risk assessments to help us see how their care was being planned with them and delivered by the staff. We also looked at the staff rotas for the previous two months, staff training and supervision and recruitment records. We also looked at records relating to the maintenance and the management of the service and regarding how quality was being monitored within the home.

During the inspection we spoke with 10 people who lived in the home, five care staff, a member of domestic staff, the two supervisors on duty, the registered manager and the home's operations manager. We also spoke with two visiting relatives and a GP. We observed care and support and staff interactions in communal areas and at breakfast and lunch time.

Before our inspection we reviewed the information we held about the service. We looked at the information we held about notifications sent to us about accidents and incidents affecting the service and the people living there. We looked at the information we held on safeguarding referrals, concerns raised with us and applications the manager had made under Deprivation of Liberty Safeguards (DoLS).

We had not received a Provider Information Return (PIR) from the registered manager. 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 are aware of the reason why it was not done.

Requires improvement

Is the service safe?

Our findings

Everyone we spoke with who lived at Croftside had positive things to say about life in this home and told us that they felt "happy" and "safe" living there and that they were well looked after by the staff. One person told us, "All in all it's pretty good here, I am happy here. I enjoy my own company but if I need help they [staff] come quickly". All those we spoke with told us that the staff came to help them when they needed assistance. One person told us "There are usually enough staff, sometimes they are shorthanded but they cope very well and some do extra shifts. There has always been someone here to look after me".

We spoke with a visiting relative and they told us that "I feel [relative] is safe here and someone is always around to help, the staff are helpful but they do have a lot to do". Another visitor we spoke with told us "There have been times when there's not been enough staff about and [relative] has been left in the toilet a while. That's not deliberate; they [staff] are all very kind they just had to deal with other things".

Staff also told us that they had been short staffed on some days because of holidays and sickness. They told us that they prioritised other work to make sure the people living there were cared for before anything else such as laundry or cleaning. We could see that there were adequate care staff available to support people on the day of the inspection. There were two supervisors on duty during the morning. There were six support staff working with the people who lived there during the day. We looked at the records of the staff rotas over the last two months and these indicated that the service had struggled with staff shortages over the summer months as some staff had left, with leave and others on sick or maternity leave.

We could see from the frequent changes to staff rotas that staff levels had fluctuated and that the registered manager, supervisors and staff were working extra shifts, coming in on days off and moving around the home to try to maintain effective and safe staff levels for the people living there. Staff told us, "We all pull together" and we are "a good team". They told us that supervisors had come in early to work with them and told us "We all want to make sure people are properly looked after".

Recruitment was underway but new staff checks would not be completed for another month. As a consequence the service was not taking permanent admissions, except for pre-arranged respite stays, until the staffing problems had been fully resolved.

We spoke with the registered manager about how staffing levels were monitored to make sure the staffing levels in the home to meet the needs of the people living there. The registered provider did not have formal dependency tools for staff to use to monitor the effect on staffing needs as people's dependency altered. However staff had kept a record of the work activities of night staff and the increasing needs of some people living with dementia who needed more support and supervision at night. This was to illustrate the need for an additional member of night staff. This need had been accepted by the registered provider and the manager was recruiting staff.

The rotas showed there were still only two support staff on night duty at the present time to support the people living on the three units. The registered manager told us they hoped to have the recruitment of the new staff member completed within a month. In the meantime night shift staffing levels remained below the number needed to meet people's assessed needs and keep them safe at night.

We saw from accident records kept in the home for the last four months that there had been 15 unobserved falls during the night shift. We also looked at people's personal evacuation plans in the event of fire in the home. One plan indicated that a person would require one of the two night staff with them all the time in the event of fire. If that person was supported as their plan stated that would effectively leave one support worker to support and assist everyone else. We discussed with the manager and operations manager that given the needs of people that had been identified, the requirements of the evacuation plans and the number of unobserved falls occurring during the night there were still insufficient staff on night duty.

This indicated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were not sufficient numbers of support staff at all times to meet the assessed needs of people living in the home and in emergency situations.

We found that accidents, incidents and near misses that affected people living in the home had not always been

Requires improvement

Is the service safe?

reported correctly or to the appropriate agencies. For example we found daily records indicating a person had been found on the floor with no apparent injuries but there was no record in the accident book.

All the staff we spoke with told us that they had received training on recognising possible abuse and knew what action to take if they felt someone needed to be safeguarded from abuse or possible abuse. They told us they would report it to the supervisors or registered manager to look into and pass on to social services. Staff were also aware of the procedures for reporting bad practice or 'whistle blowing' and told us they would report poor practice if they saw it. Training records indicated that all care staff had received this training within the last 12 months including domestic and kitchen staff.

We found that two incidents of aggression between two people in the home had not been referred to the local authority safeguarding team. We also saw records of person with bruising of unknown origin that had not been reported either. An enquiry by a safeguarding team allows all evidence of an incident to be assessed and to put plans in place to protect vulnerable people. We found that the registered manager had not always taken appropriate action when there had been incidents that had affected the safety and wellbeing of people who lived there. The sample of people's care records that we looked at had information on incident and accidents that should have been reported or 'notified' to CQC but had not been.

This was a breach of Regulation 13 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014. This was because the registered provider did not have robust systems in place to make sure the service notified the correct agencies and followed local safeguarding arrangements to keep people safe.

We looked at staff recruitment records of the newest staff to see that checks had been done to help ensure staff working in the home were only employed if they were suitable to work in a care environment. We saw required Disclosure and Barring Service [DBS] checks had been done and references obtained. However one staff member who had previously worked in social care settings did not have a reference from their last social care employer but from one they had worked with eight years previously with four employers since then. The registered manager told us that this was because they had not been able to get reference from the others. This had not been followed up with this person to find out why.

During this inspection we looked at the way medicines were managed and handled in the home. We observed the administration of oral medicines by the supervisor. The supervisor explained to people what the tablets they were taking were for. We observed some good practice for example in hand hygiene before starting medicines and the use of gloves when administering eye drops. Protocols and guidance were in place for 'as required' medicines so that people received these safely and appropriately when they were needed.

We saw that the staff administering the medicines had received appropriate training to do so and that they gave people the time and the appropriate support needed to take their medicines. We looked at the handling of medicines liable to misuse, called controlled drugs. These were being stored, administered and recorded correctly.

We found that the home was tidy and there were no lingering unpleasant odours. The moving and handling equipment we saw in use, such as hoists, were clean and being maintained under contract agreements and that people had been assessed for its safe use. We noted that there were areas of the home that needed some redecoration for damaged and chipped woodwork in bathrooms and on corridors and damaged plaster. These things distracted from the general environment and made surfaces harder to keep clean.

Requires improvement

Is the service effective?

Our findings

People we spoke with who lived at Croftside told us that the staff supporting them knew them well. We were told, "They [staff] know what I want doing, they're very helpful and listen to me" and "They [staff] have never done anything without asking me first". We were told, "The food is excellent, always a choice and seconds if you want them". We were also told "The food is very nice, I can choose what I have" and that there were alternatives if they did not like something. Visitors we spoke with told us their relatives enjoyed the food provided.

We looked at care plans to see how decisions had been made and recorded around 'do not attempt cardio pulmonary resuscitation' (DNACPR). We saw that GPs had made clinical decisions as to whether or not attempts at resuscitation might be successful. No one living there had an advance directive to indicate particular treatment preferences in the event of not being able to make a decision.

We found that the information on the completed DNACPR form for resuscitation was not always supported by other information . For example, there were DNACPR forms that had been completed by doctors that stated a team discussion had taken place around this or following a 'best interests' process of the Mental Capacity Act 2005 (MCA). However, there were no names on the form of who it was that had been involved in the discussions.

We also noted that some DNACPR forms had been completed by a doctor with the review date being put down as "indefinite". This indicated that the forms may not be reviewed annually to ensure that they remained current and appropriate documents. Assessments and treatment decisions require review throughout a person's care and treatment to ensure they are still relevant

We noted that the information around who held Power of Attorney for a person was not always clear in people's care plans and there was not always evidence seen of the authority. Powers of Attorney show who has legal authority to make decisions on a person's behalf when they cannot do so themselves and may be for financial and/or care and welfare needs. It was not always clear which of these applied. As a result it was difficult for care staff to know who held legal authority to make decisions or be consulted about health and welfare on someone's behalf or if this was just for finances.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and the MCA. The MCA and DoLS provide legal safeguards for people who may be unable to make decisions about their care. The registered manager knew when a Deprivation of Liberty Safeguard was required to protect an individual's rights. We saw that the registered manager had raised potential restrictions with the managing authority to make sure they were acting in line with the legislation and supporting people's rights.

Training records showed that he registered manager and supervisors had received training on MCA and DoLS but care staff had not. However the care staff we spoke with demonstrated an awareness of the codes of practice and the processes involved. Staff said they would take concerns about someone's ability to make a decision or give consent to the supervisor to deal with.

We looked at the staff training matrix and what training had been done and what was required. We saw that staff had done induction training when they started working at the home and they received regular supervision with their supervisors. We could see that training had been provided for staff on dementia awareness to help that understand this and support people living with the condition. A refresher course on this was also booked for the following month. The home had two keyworkers in the safe moving and handling of people to train and support staff. We could see that staff had received this training within the last year.

We saw that people had nutritional assessments in place and that their weights were being monitored. We saw that advice had been sought from the speech and language therapist (SALT) on choking risks for individuals. There was also information on specific dietary needs such as diabetic diets and soft and pureed meals as well. This meant that people were receiving support with maintaining a healthy diet and that their hydration needs were being met.

We recommend that the service consider finding out more about best practice in relation to providing evidence of who holds PoA for individuals and ensuring the annual review of DNACPR forms and

Requires improvement

Is the service effective?

decisions. This is so that if the registered provider has any concerns that a person's health has improved or there are errors on the form they can query this with whoever signed it.

Good

Is the service caring?

Our findings

We spoke with people living in the home about how they were cared for and how staff supported them to live as they wanted. We were told by people living there "I always have a choice about what I do" and "I am happy here, the carers are very good with me" and "They [staff] don't come in without knocking first" and also "I am very well cared for here and looked after well". All the people we spoke with said they felt they were well supported and looked after.

Relatives we spoke with told us that staff were "helpful" and kept them informed of any changes affecting their loved ones. We spoke with a visiting medical practitioner who told us they had always found the staff and supervisors and the registered manager in the home to be "friendly" and "helpful" and had never noted anything that concerned them about the way staff cared for people. They told us "In my experience they [staff] provide very good care" and also "I have never seen anyone be unkind".

We saw that people's privacy was being respected and that staff protected people's privacy by knocking on doors to private rooms before entering. People told us that the supervisor got the doctor when they wanted them and that doctors and district nurses saw them in their bedrooms for medical examination or any discussions.

We saw that staff maintained people's personal dignity when assisting them with equipment and when helping transfer people from a wheelchair to an easy chair. Staff also offered explanation and reassurance about what they were doing. During our observations we saw that staff took the time to speak with people and took opportunities to chat and interact with them and offer reassurance if needed.

We saw that people had been able to bring some personal items into the home with them to help them feel more comfortable with familiar items and photographs around them. All bedrooms at the home were used for single occupancy. This meant that people were able to spend time in private if they wished to. A person told us they saw their relatives "As and when I please".

We spent time in different communal and dining areas of the home throughout the inspection and at breakfast and lunch time. We saw that meals were relaxed and informal times. People who required support with eating received this with staff helping and prompting people with their meals and chatting with them. We saw that people had a choice of food and that staff asked them what they wanted and if they wanted 'second helpings'. We saw he staff took up opportunities to engage positively with people and we saw people enjoyed talking and joking with the staff.

Records indicated that staff and supervisors had not received training to support people at the end of life. However the care staff we spoke with understood the importance of providing good care at the end of a person's life and told us how they worked with the district nurses and GP to provide this support if needed.

There were organisational policies in place to help staff deal with the personal aspects of supporting people at the end of their lives and their families. There was a procedure to allow staff to discuss this or 'debrief' if they had found this aspect of care difficult.

Requires improvement

Is the service responsive?

Our findings

During our inspection we received positive comments from the people living there about their daily life in the home. We were told that daily routines were flexible depending on what they wanted to do. We were told, by one person "They [staff] know what I want; they're very good and helpful. They do listen and have never done anything without asking me first".

We were told by people living there " I have not had to complain really, I would tell the supervisors if I was worried and my family" Another told us, " I have no complaints at all, they [staff] ask if everything is OK and if I am a bit off colour they get the doctor".

We looked at care plans for six people. We saw that people's needs and risks were being assessed and identified but not consistently. Some people did not have appropriate risk assessments in place to inform their care planning and the support they needed from staff. For example risk assessments for falls were missing for some people and body maps had not been completed for some people to reflect an assessed need. One person had a risk assessment in place in relation to a specific medical condition but no plan in place with regard to the risks from the condition and its subsequent management.

One body map was for a person with skin care needs and they had prescribed medication for skin care but had no information about this need in their care planning or on their body map. Care plans did not contain details on the management of some people's medicines, such as anticoagulants that were required to prevent blood clots developing. Two of the care plans we looked at had risk assessments in place about choking risks when a person was eating in bed. The risk was noted but the care plans did not include information on the management of the risk.

Care plans had been reviewed but some information in them was missing or not up to date. Care management plans did not always reflect the strategies and actions needed to support for more complex care needs. These were needed so staff knew what level of care to provide. For example, a care plan documented that a person could refuse care and "sometimes be aggressive" but there was no formal behaviour monitoring being recorded or what actions staff should take in response to this behaviour. Where people refused care there were no strategies for staff to follow to persuade and support them to accept personal care. It was documented that one person had "episodes" but their plan did not say what these "episodes" were or how they were to be managed and treated.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the assessments of people's care, treatment and support needs were not in place or sufficient detail to support person centred care and did not include all their needs and possible risks that needed to be managed

People's health and support needs had been assessed before admission and we saw that people had access to appropriate health care professionals to meet their individual health care needs. We saw records in the care plans of the involvement of the community mental health team, district nurses and specialist nurses as well as opticians, chiropodists and dental services.

We saw that people had a 'hospital passport', this had information about the person, their health and care needs, medication and what they needed in order to support them. This was to help make sure that should a person need to transfer to another care setting quickly all the relevant information would be available.

The service had a complaints procedure that was on display in the home for people living there and visitors to refer to. Some of the people we spoke with were not aware of it but told us how they would raise a complaint if they needed to. People living there and their relatives we spoke with confirmed they had confidence in the registered manager to listen to any complaints they might have and deal appropriately with them. A relative we spoke with said when they had raised a concern about poor communication it had been addressed by the manager.

There were some organised activities available to people living there. We spoke with some people in the lounges that were playing Scrabble who told us about attending exercises classes one day a week and doing quizzes and bingo on another and having the hairdresser visit each week . One person showed us the art work they had been doing and these were on display in the home. People living there told us about forthcoming events such as the cheese and wine party that was being incorporated in Halloween events.

Requires improvement

Is the service responsive?

People told us about the monthly religious services they could attend if they wanted to and also their weekly singing sessions. People living there told us they were able to follow their own faiths and beliefs.

One day a week some people were supported to go out to a 'dementia café' at the local church. This gave people the opportunity to take part in different activities with other people in the local community and meet up with people from outside the home.

Requires improvement

Is the service well-led?

Our findings

People who lived in the home said they knew the registered manager of the service and saw them and the supervisors "most days" to talk with. People told us that they felt that the home was being well run for them and they were asked individually and at 'residents meeting' how they wanted things done in their home. We were told that there was a "friendly atmosphere in the home". We looked at the minutes of the last 'resident's meetings' and saw that people had discussed a range of issues about what they wanted in their home, such as meals.

We found that the registered provider had not ensured that CQC had been notified of incidents and accidents in the home that they were required to inform CQC of under the regulations. We looked at records for the last six months and found that there had been a failure to notify CQC about injuries people had sustained following falls and not reporting two possible safeguarding incidents. This meant CQC had not been able to check that the registered provider had taken appropriate action at the time of these incidents and accidents so that, if needed, action could be taken to protect the person or their rights. We told the registered manager they needed to do so.

The failure to notify us of matters of concern as outlined in the registration regulations is a breach of the provider's condition of registration and this matter is being dealt with outside of the inspection process.

We spoke with the registered manager and the operations manager about this failure and the breach of regulation. We informed them that that we would deal with this breach separately and take further action if future notifiable incidents were not reported to CQC without delay.

There were systems to assess the quality of the service provided in the home. An annual audit was carried out by the registered provider on health and safety in the home in July 2015. The registered manager had requested action to fulfil the areas identified by the audit for improvement. This included work needed to make smoke seals on fire doors safe and effective. A maintenance person arrived during the inspection to complete this work. The manager had identified environmental and maintenance work that was required and had requested this work be carried out.

The operations manager also visited the home on a monthly basis to do service checks and monitor quality. We saw that some internal auditing did take place for example an infection control audit had been carried out by the registered provider. However we found that the checks of care plans and reviews used to assess the quality of care planning were not ensuring that people's care plans always had the information on the care and management of individual's needs and on decision making. The internal auditing system and monitoring put in place by the registered provider had not identified that care records were not detailed or up to date or that some notifications had not been made.

There had not been a satisfaction survey sent to people living in the home this year. We looked at the last survey from 2014 and the comments had been positive.

The home had a registered manager in place as required by their registration with the Care Quality Commission (CQC). We saw during our inspection that the supervisors and the registered manager were accessible and spent time with the people who lived in the home and engaging in a positive and open way with them. All the staff we spoke with told us that they had regular staff meetings, formal supervision and felt they were supported in their work.

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 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	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: Assessments of people's care, treatment and support needs were not in detail to support person centred care and did not include all their needs and possible risks that needed to be managed. Regulation 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: The registered provider did not have robust systems in place to make sure the service notified the correct agencies and followed local safeguarding arrangements to keep people safe. Regulation 13 (1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: There were not sufficient numbers of support staff available at all times to meet the assessed needs of people living in the home and in emergency situations. Regulation 18 (1)