Mr Frederick Bilsland

St George's Residential Care Home

Inspection report

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Date of inspection visit: 23 March 2015
Date of publication: 06/07/2015

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?	Good
Is the service well-led?	Requires improvement

Overall summary

This unannounced inspection took place on 23th March 2015. We last inspected St. George's Residential Care Home in January 2014. At that inspection we found the service was meeting all the regulations that we assessed.

St George's Residential Home provides accommodation and personal care for up to 41 older people and is situated in the conservation area of Millom. The home was originally a vicarage to which a substantial purpose built extension was added, which provides the majority of bedrooms with ensuite facilities and private telephone systems. Capital expenditure in recent years has seen the provision of additional car parking and ambulance facilities and creation of a dementia friendly sensory garden to help provide stimulation in a safe environment for people living in the home.

There were 26 people living at the home at the time of our inspection.

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

Summary of findings

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.

People living at St George's told us that they felt safe and were happy living in this home.

Staff demonstrated sufficient knowledge of people's needs in regard to medicines. We found one medication record that indicated that there had been a prescribing error with a controlled medicine [a medicine liable to misuse] made by the GP. This error had not been picked up by staff on checking the medicines into the home or noticed the error on their stock checks. Staff had administered the correct dose despite the incorrect prescription but had not raised the error with the GP.

We found that the service did not have information in place to ensure that people received 'as required' medicines in a consistently person centred way.

We saw that the accident reporting systems in place did not always operate effectively. We saw that an accident had occurred involving a person living there but action had not been taken promptly to make sure they received appropriate care and treatment following an injury.

We found that the service had not always given thorough consideration to some of the equipment in place to support people's safety. We saw this, for example, where door alarms and movement sensors were being used to monitor people's movements on a best interest's basis. Applications had not always been made to a supervisory authority where there was doubt about a person's liberty being restricted in some way.

There were systems to assess the quality of the service provided in the home but we found that some quality checks or 'audits 'had not been effective, such as with medicines. Areas of improvement identified at audit had not always been followed up to make sure they had been addressed promptly and reviewed.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 that corresponds to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to medicine management, providing consistently appropriate and person centred treatment, restrictions on a person's liberty and effectively monitoring the quality of service provision.

There was information in care plans that showed the staff had discussed with people if they wished to be resuscitated should their health conditions change. The service had policies in place in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). However in practice these safeguards were not always being consistently applied.

We looked at staff training and development records and found that there were lapses in the provision of some training. We saw that training had been scheduled to take place to bring staff training up to date in these areas.

People we spoke with who lived in the home told us that they made decisions about their daily lives. We saw that people who needed support to eat and drink received this in a supportive and discreet manner.

We found that people living at the home were able to see their friends and families as they wanted. There were no restrictions on when people could visit them. We could see that people were able to follow their own faiths and beliefs and take part in activities in the home if they wanted to.

The registered provider had systems in place to make sure people living there were protected from abuse. They also had safe systems for recruitment to make sure the staff being employed were suited to working with the people living there.

The environment of the home was welcoming and the communal areas were decorated and arranged to make them homely and relaxing. Records indicated that the mobility equipment in use had been serviced and maintained under contract agreements and that people had been assessed for its safe use.

People knew how they could complain about the service they received and told us they were confident that action would be taken in response to any concerns they raised. All the visitors we spoke with told us that staff made them welcome when they came to visit or when they wanted to speak with them.

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

Summary of findings

We have made a recommendation about staff appraisals being carried out in line with the service's policy for providing annual appraisals of its employees.

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?
The service was not safe.

Appropriate arrangements were not in place to consistently ensure the proper and safe management of medicines within the home.

We found an occasion when appropriate care and treatment had not been provided following an accident.

Staff had been recruited safely. Staff we spoke with in the home knew how to recognise possible abusive situations and how it should be reported.

Requires improvement

Is the service effective?
The service was not effective.

We found that the service had not always given sufficient consideration to some of the systems in place to support people's safety that could be interpreted as continuous control and supervision.

Staff appraisals had not been undertaken although the service had a policy in place for providing annual appraisals .Supervision records were available and it was evident that staff had been supervised on a regular basis.

People reported the food was good. They said they had a choice of food at mealtimes. We saw people were provided with appropriate assistance and support and staff understood people's nutritional needs.

Requires improvement

Is the service caring?
The service was caring.

People told us that they were well cared for and we saw that the staff were caring and people were treated in a kind and respectful way.

People were treated with respect and their independence, privacy and dignity were promoted.

Information was available on access to advocacy services for people who needed someone to speak up on their behalf.

Good

Is the service responsive?
The service was responsive.

Systems were in place to assess people's needs and we saw evidence that people's needs were regularly assessed. Care plans and records showed that people were being seen by appropriate professionals to meet their physical and mental health needs

People told us a range of activities were available and they were able to access the community and see their families as they wished.

Good

Summary of findings

People living at St George's told us that staff respected their choices and also helped them take part in activities and pastimes they enjoyed.

Is the service well-led?

Requires improvement

The service was not well-led.

Although there were systems to assess the quality of the service provided in the home we found that not all aspects of care had been effectively monitored.

There was insufficient clarity about the lines of accountability within the home. Leadership monitoring within the home may not be effective in monitoring staff performance.

The provider had formal and informal systems to gather the views of people who used the service.

St George's Residential Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 23 March 2015 and was unannounced. The inspection was carried out by two adult social care Inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During the inspection we spoke with 10 people who lived in the home, six visiting relatives, four care staff, domestic staff, the senior carer on duty and the registered manager. We spoke with two nursing and medical professionals who were visiting the home to see people living there. We observed the support provided in communal areas, observed activities taking place and the lunch time meal. We spoke with the people living in the home and with visitors in private and in communal areas.

We also spent time looking at records, which included looking in detail at six people's care plans and risk assessments to help us see how their care was being planned with them and delivered. We also looked at the staff rotas for the previous two months, staff training and supervision records and records relating to accidents, incidents and complaints. We looked at the records of premises maintenance and records regarding how quality was being monitored.

As part of the inspection we also looked at administration records and care plans relating to the use of medicines.

Before our inspection we reviewed the information we held about the service and information provided to us by health care professionals coming into contact with the service. We looked at the information we held about notifications sent to us about incidents reported to us affecting the service and 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).

Requires improvement

Is the service safe?

Our findings

People we spoke with who lived at St George's made positive comments about their life in the home. They told us, "I feel very safe in the home" and "I have everything I need" and "I am being looked after well". We were also told that "I trust the staff and feel very safe and comfortable living here". Relatives who visited the home told us that they did not have any concerns about the safety or welfare of their relatives. "We were told "I have never had any concerns" and also "You hear terrible stories about homes but honestly I have never felt that here, the manager keeps it very good". We were also told by a relative that the home was "Always clean and tidy with no smells".

During our inspection we looked at accident and incident records and found that reporting systems were in place to report these. However we identified that appropriate actions had not been taken following an accident experienced by a person who lived at the service. Their care records did not provide evidence that senior staff on duty had taken action to make sure that person received appropriate care and treatment following a fall related injury. The events recorded in the person's care plan indicated that a medical assessment was appropriate action to ensure the injuries were not putting the person at further risk. There were no records of a visit from the GP to check the person over. Although we could see the person had not come to any harm the systems in place did not operate effectively to make sure that the proper steps were always taken to ensure that people in the home were provided with treatment that was appropriate to their need.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people using the service could not be sure appropriate care and treatment would be provided following an accident.

As part of this inspection we looked at medicines records, supplies and care plans relating to the use of medicines. We found that a 'controlled medicine' [a medicine liable to misuse] had been incorrectly prescribed by the person's GP. This prescribing error had gone unnoticed over several days and whilst the correct dosage had been given the error had not been picked up by the home's quality monitoring systems or noticed on stock checks This raised concern around the safe administration procedures. Action to alert the person's GP to the error was undertaken by staff on the day of the inspection.

We found that the service did not have information in place to ensure that people received 'as required' medicines in a consistently person centred way. Staff demonstrated sufficient knowledge of people's needs in this regard however records did not always support this. Medication records also showed omissions in recording detail for medicines prescribed with variable doses.

The service had effective systems in place for ordering and receiving medicines, staff confirmed that a good relationship was maintained with the pharmacy provider. We noticed that procedures in place for destroyed and refused medicines mid-month were not consistently thorough and clear records were not maintained to support audits.

Storage of medicines was found to be secure; however the service did not have a procedure in place to monitor the room temperature for where medicines are stored. The manager began to address this during the visit. We observed that staff maintained hand hygiene and the security of medicines throughout the observation.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because appropriate arrangements were not in place to ensure the proper and safe management of medicines within the home.

We found that there were procedures in place to help protect people from abuse. The care staff we spoke with could tell us the actions to take and said they would be confident reporting any safeguarding concerns to a senior person in the home. There was also information for staff on how to raise concerns about poor practice or concerns they had about the care people received. The registered manager provided evidence to confirm that referrals had been made to the Local Authority Safeguarding Team and we noted that there was an on-going safeguarding investigation underway.

We found that the home was clean and tidy and was being well maintained. Records indicated that the mobility equipment in use had been serviced and maintained under

Requires improvement

Is the service safe?

contract agreements and that people had been assessed for its safe use. We observed that people were assisted to move safely. Staff we observed demonstrated confidence when supporting people to move and communicated effectively whilst supporting them.

There were records of monthly maintenance checks on fire alarms, fire extinguishers and emergency lighting and records indicated that fire drills and training took place. There were contingency plans in place to manage foreseeable emergencies and people had individual emergency plans in place to appropriately support people if the home needed to be evacuated. This helped to make sure that people were kept safe living in the home.

Staffing levels were being assessed using a tool based upon the dependency levels of people living at the home. We asked people living there about the support available to them from the care staff and we were told by people living there, “The staff come very quickly if I require them in the night” and “My room is very comfortable, I spend a lot of time there and the staff are about when I need them”. A relative told us, “There are staff coming out of the woodwork” and another that “There are staff around when they’re wanted or if I need to ask something”.

There were 26 people living in the home during our visit and there were five care staff and a senior carer on duty to provide personal care support during the day. This was as stated on the rota. We saw that people’s request’s for support during the inspection were responded to in a timely manner. A medical professional we spoke with during the visit told us that “There always seems to be enough staff around when I come”.

There were two care staff on duty to provide personal care and support at night and there was an ‘on call’ system to access support from senior staff at night. We saw that there were enough kitchen, cleaning and maintenance staff available to support the care staff in their work. There was also designated activities staff working with people living in the home and they were in the home five days a week.

Three new care staff had recently been employed in the home. We saw safe recruitment procedures were in place to help ensure staff were suitable for their roles.

Requires improvement

Is the service effective?

Our findings

People told us the staff who supported them knew how they liked to be supported and provided this promptly. People living there told us, "I trust the staff" and "They [staff] are well trained and my care here is good". A relative told us "I can't fault the care. I have every confidence in them [staff] to do their job".

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA). The Mental Capacity Act (MCA) and DoLS provide legal safeguards for people who may be unable to make decisions about their care. We looked at care plans to see how decisions had been made around their treatment choices and 'do not attempt cardio pulmonary resuscitation' (DNACPR). The records in place showed that the principles of the Mental Capacity Act 2005 Code of Practice were used when assessing an individual's ability to make a particular decision.

We spoke with staff to check their understanding of MCA and DoLS and found that staff demonstrated basic knowledge of requirements outlined by the Mental Capacity Act 2005. Staff training records evidenced that over 50% of the workforce had received Mental Capacity Act training within the last three years, as required under their own policies. However in practical terms the application of the DoLS safeguards was not fully understood.

We found that the service had not always given thorough consideration to some of the systems in place to support people's safety that could be interpreted as continuous control and supervision. We saw this, for example, where door alarms and movement sensors were being used to monitor people's movements on a best interest's basis. Applications had not always been made to a supervisory authority where there was doubt about a person's liberty being restricted in some way.

Where measures are in place to limit people's liberty in any way it is the registered manager's responsibility to make the appropriate applications to a supervisory body are made. This helps ensure that a person's rights are upheld and their liberty respected.

We saw that the registered manager had applied to supervisory authority under DoLS where this had been clearly indicated for a person to limit their liberty and promote their safety. The approach being taken was one that aimed to protect people's rights but was not being consistently interpreted and applied.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because applications had not always been made to a supervisory authority where there was doubt about a person's liberty being restricted.

We looked at staff training and development records and found that there were lapses in the provision of training in relation to safeguarding adults. It also included first aid training for some senior staff and care workers to help ensure they had the skills required to identify an emergency situation and so provide effective first aid. The health and safety training records also evidenced that this was overdue for renewal and was this was not in line with the service's own training policy.

We discussed these gaps in training records with the registered manager. It was confirmed to us that following a recent training audit these areas had already been identified. We saw that training had been scheduled to take place to bring staff training up to date in these areas. The registered manager provided confirmation of the planning and organisation of training in these.

We looked at records of what training staff had received to support them in their roles such as dementia awareness as some people in the home were living with dementia. We saw that staff providing personal care had received this training although they had not had any recent updates to help keep them up to date with current best practice.

The registered manager told us that staff appraisals had not been undertaken although the service had a policy in place for providing annual appraisals of its employees. Supervision records were available and it was evident that staff had been supervised on a regular basis. We could also see that staff had received induction training when they had started work in the home.

All of the care plans we looked at contained a nutritional assessment and a regular check on people's weight for changes. We saw that if someone found it difficult to eat or swallow advice was sought from the dietician or the speech

Requires improvement

Is the service effective?

and language therapist (SALT). Where the home had concerns about a person's nutrition they had involved appropriate professionals to help make sure people received the correct diet.

We observed how people in the dining areas of the home were supported as they had their lunch and saw that it was a social and relaxed occasion. We were told by one person we spoke with who lived there that they felt their health needs were being met and "I have my food pureed because I cannot swallow very well but it is always well presented and looks appetising".

We saw that care staff assisted people who needed help to eat their meals in an unhurried and sensitive way and also prompted and encouraged people with their meals. We saw that some people used specially adapted cutlery to eat their meals as this allowed them to remain independent with eating their meals. There was a choice of food at all mealtimes and we saw a choice of hot and cold drinks was made available during the day. One person told us "We have a very good chef".

We recommend that the registered manager holds staff appraisals in line with the service's policy for providing annual appraisals of its employees.

Good

Is the service caring?

Our findings

The people who lived in the home we spoke with told us they were “happy” and “very satisfied” with the care and support they received. People living there spoke positively about the care staff and we were told, “They [staff] are very kind to me” and “I am being well looked after” and also, “The staff are all very caring when they do things for you”.

One person told us, “They [staff] are very caring and they help me keep my independence” and also. “When they help me to shower they do all they can to respect my privacy”. We were also told, I have been asked but I don’t mind a male carer so long as he does the job efficiently”. People told us that the staff knew them well and that “I know the names of all the staff looking after me”.

Relatives we spoke with were positive about the care their relatives received. We were told by a visiting relative, “The staff are always kind and considerate to [my relative] and the standard of care is very good here”. Friends of a person living there who visited them regularly told us, “The staff are always very friendly when we come to visit. There is always a cup of tea for us to have with [friend]”. People living there and relatives told us that there were no restrictions on visiting.

We observed people in communal areas of the home. We saw that people who could not easily tell us their views were comfortable and relaxed with the staff that were supporting them. We saw staff talking to people in a polite and friendly manner. They called people by their preferred names as stated in their care plans.

Some people used items of equipment to help them maintain their independence. We saw that the staff knew which people needed pieces of equipment to support their independence and provided these when they were required. During the visit we observed people being assisted to move from wheelchair into an easy chair using a hoist. We saw that the care staff used the equipment confidently and spoke to the person throughout and that as a result the person remained calm and reassured. However modesty could have been even better promoted if a blanket had been put over the person’s knees on transfer.

We saw that staff protected people's privacy by knocking on doors to private rooms before entering them. All bedrooms at the home were used for single occupancy and this meant that people were able to spend time in private if they wished to. Bedrooms we saw had been personalised with people’s own belongings, such as photographs and ornaments to help them to feel at home with familiar and valued things.

We found that information in leaflets and booklets was available for people in the home and on notice boards to inform people about services inside and outside the home. This included information about the registered providers, the services offered and about support agencies such as bereavement and advocacy services that people could use. An advocate is a person who is independent of the home and who can come into the home to support a person to share their views and wishes if they want support.

The care staff we spoke with understood the importance of providing good care at the end of a person’s life. Care plans contained information about people’s care and treatment wishes should their condition deteriorate. We could see that personalised end of life and emergency care plans had been developed to communicate clearly what people’s wishes were to all those who may be involved in their care. Training records indicated that five care staff were currently undertaking training in end of life care and that over half of the staff had done so. This helped to make sure staff would have the right skills to support people and families at the end of life.

Good

Is the service responsive?

Our findings

We found that the service had procedures in place to allow people to raise a complaint. Records were available and demonstrated management responses and resolution where possible. The registered manager updated us on complaints that were still being investigated. The complaints procedure was available on the home's notice board for people to refer to. We were told by people living there that "I am able to speak to the management and staff at any time" and "I know who is on duty and they are very good. I have nothing to complain about".

A relative who visited regularly told us "[Relative] has nothing to complain about the staff are all very good and will do anything for us, you only have to ask". We were given an example by a person's relative of an occasion when a complaint had been made and how the registered manager had acted on this. The person told us they were "a lot happier now". Relatives told us that they had the opportunity to take part in helping to develop life histories and comment on their relative's social and cultural preferences.

A range of organised activities were available for people and were led by the home's activity coordinator who worked in the home five days a week. There was a second activities person who did armchair exercises and was available to take people out and spend time individually with people.

We could see in care plans that people's social preferences and interests had been discussed with them and their families so people could be supported to continue with these if they wanted. This included supporting people so that they were able to follow their own beliefs and faiths. We were told by one person "We have a church service once a month when the vicar comes in". They told us they enjoyed this and another person said, "We can attend the church service if we wish and I always try to".

During the visit we observed activities going on in the communal areas. There was a quiz going on during the morning where everyone could join in and in the afternoon there was a 'Memory Lane' activity going on involving reminiscence. Activities were advertised on a large board in the communal area and also which staff were on duty that day. Visiting health care professionals commented on the wide range of activities on offer to people and also the community involvement. We saw from the entertainments that had been planned that religious festivals were given emphasis in line with the beliefs of the people living there. Social events such as a 'pie and pea supper' night involved families and friends in the social life of the home.

We could see in people's care plans that the service worked with other health care and medical professionals and support agencies such as mental health teams and social services. The care plans and records that we looked at showed that people were being seen by appropriate professionals to meet their physical and mental health needs. Care plans also showed that management plans were evaluated and had been reviewed on a monthly basis. This was to help make sure that they were up to date about people's needs and preferences.

We could see that a process was underway to review all residents and their care needs. The registered manager was aware that the increasing complexity of some people's personal care needs could have the effect of compromising the care of other people living there and overstretch the staff resources and skills. Therefore an internal review was being done to make sure the service was still able to meet everyone's needs or if they needed to seek advice from other agencies to help make sure people had the right support.

We spoke with visiting health care and medical professionals visiting the home and they were positive about the personal care and support being provided. We were told "I have never seen anything that has caused me any concerns about people's care, it's well run and there are staff available to come with me". We were told that the staff "Managed diabetic's well" and "Always ask us to document what we have done or want doing in their diary". We were also told that when treatments or management of care altered that the staff followed instructions "to the letter" and that staff "Seek advice and medical help quickly" and that people's medication needs were subject to review. We could also see in care plans where the staff had implemented management plans for pressure area care on the guidance of the district nurses.

Requires improvement

Is the service well-led?

Our findings

People living there told us that they knew who the registered manager was and saw them to speak to as they went around the home. The relatives we spoke with also knew who the registered manager was and that they could speak with them if they wanted to.

There were systems to assess the quality of the service provided in the home but we found that some quality checks or 'audits 'had not been effective. For example, we saw that an incorrect drug dosage had not been found during medicines checks and records had not been properly maintained in regard to destroyed and refused medicines to enable auditing processes.

The last medication audit carried out in January had identified some inconsistencies in medication management that needed to be addressed to maintain safe and effective medication practices. This audit had identified issues we found at this inspection. For example the lack of plans for the use of 'as required' medicines, lack of care records of variable dose medicines, the lack of a lock on the medicine refrigerator door and temperature monitoring. No timescales had been put on these to make sure they were addressed or whose responsibility it was to do so. Therefore these matters had not been followed up to make sure the shortfalls had been addressed.

We could also see that omissions in prescribed treatment had been identified by senior workers but not reported upwards and investigated. We also found that senior care staff had not always reported accidents and incidents to the manager appropriately. This indicated to us that there was insufficient clarity about the lines of accountability within the home. Senior care staff we spoke with about incident reporting did not demonstrate confidence in understanding what their responsibilities were. It also indicated that leadership monitoring within the home may not be effective in monitoring staff performance.

However where the manager was aware of incidents they had been subject to analysis and discussion at staff meetings.

These examples demonstrated a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the systems being used to assess the quality of the services people received and to protect them had not been effective in identifying, following up and continuously monitoring where improvement had been required.

The home had a registered manager in place as required by their registration with the Care Quality Commission (CQC). People who lived in the home told us that they were asked for their views about the service and had been asked to complete surveys to give feedback on their experiences. People living there and relatives told us about the 'relatives and resident's meetings in the home where people could give their views on the service provision and make suggestions. We could see that action had been taken on comments made about more variety at mealtimes and also for more staff.

The registered manager also sought the views of the care staff working in the home. There had been action taken on issues raised in the staff survey around staffing and conditions of service. The registered provider also made regular visits to the home to monitor service provision and records were kept of these visits. At the last visit the training had been audited and revealed that there were gaps in the training required by staff and this was being addressed.

Survey's had also been sent to nursing and medical professionals who came into contact with the service. This was so the registered manager could get their views and suggestions on service improvement.

The Registered Manager provided evidence to confirm that referrals had been made to the Local Authority Safeguarding Team, it was noted that an on-going safeguarding concern had not been promptly communicated to CQC by the service. We discussed with the manager the importance of prompt notification for future reference.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: People who use services were not protected against the risk of inappropriate treatment because the registered manager had not ensured action was always taken to make sure that people received appropriate care and treatment following an injury. Regulation 9 (1) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Arrangements were not in place to ensure the proper and safe management of medicines within the home to ensure people were protected from the risks associated with medication. Regulation 12 (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The systems being used to assess the quality of the services people received and to protect them had not been effective in identifying, following up and continuously monitoring where improvement had been required. Regulation 17 (1)

This section is primarily information for the provider

Action we have told the provider to take

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: People using the service were not consistently having their rights considered by a supervisory authority in relation to possible limitations on their freedom. Regulation 13 (5)