Olympus Care Services Limited

Southfields House

Inspection report

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Tel: 01604499381

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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 unannounced inspection took place on 28 March 2017. This residential care home is registered to provide accommodation and personal care for up to 46 older people. At the time of our inspection there were 45 people living at the home.

There was a registered manager in post however at the time of the inspection they were on a period of extended leave and an acting manager was supporting the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People did not always receive their medicines from competent and skilled staff. People were rushed to take their medicines and they were not always given them in the correct format, for example dissolved in water. The systems in place to ensure people received their medicines safely required improvement as they were not always given at regular intervals, or with sufficient lengths of time between each medicine. People's medicines were not always ordered and received in sufficient time, resulting in people not always being able to take their medicines as required.

There was not enough staff to meet people's needs in a timely and person centred way. People that were unable to get out of bed until they received staff support did not have their preferences respected and spent longer in bed than they would choose. At mealtimes there was insufficient numbers of staff to support people to have their meals without delay, and with a person centred approach.

Improvements were required to ensure that existing staff had the appropriate skills and competencies in all aspects of people's care. Existing members of staff had significant gaps in their training records and timely action was not taken to rectify this. Care staff had a lack of knowledge about the Mental Capacity Act and the principles around providing safe care to people, however the management team ensured that people's mental capacity had been assessed and appropriate support systems were in place.

Staff had not always received the guidance and support they required to ensure they were performing to the best of their abilities. We found that these systems were improving and staff were beginning to receive regular supervision.

Staff required support to ensure people received adequate nutrition and fluids to meet their needs. People did not always have access to drinks and people's nutritional needs were not always sufficiently monitored and assessed. People's healthcare needs were not always well managed and there were occasions that people's relatives became involved to ensure they were sufficiently supported.

There were limited opportunities for stimulation and meaningful interaction. People had very little options

to vary their day and follow their interests or have new experiences. People and their relatives were not involved in reviewing their care plans following their initial review when they moved into the home. Each person had a care plan in place which helped explain the care each person required.

The home had experienced changes in the management over a short period of time and there had been times when there had not been sufficient leadership in place. Quality monitoring systems were not always effective at identifying where improvements were required and when issues had been identified they had not always been actioned in a timely way. There were a lack of effective systems in place for people, their relatives and the staff to provide feedback about the service.

People praised the caring nature of staff and the friendly approach they had. Staff were knowledgeable about the people they cared for and were reassuring and supportive to people when they were anxious or distressed.

People were encouraged to express their views about day to day matters and staff understood the need to respect people's confidentiality. Advocacy services were available for people that required additional or independent support and visitors were able to visit people when they wished.

We identified that the provider was in breach of four of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). The actions we have taken are detailed at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were not always supported to take their medicines safely and when they were required.

There were not always enough staff to meet people's needs in a timely and person centred manner.

People had risk assessments in place which reflected how people's risks could be supported.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported by staff that had not had regular and up to date training.

People were supported to provide consent for the care they received however staff were not always knowledgeable about the Mental Capacity Act, 2005 (MCA) and the impact this had for people.

Improvements were required to ensure that people had timely support to manage their nutritional needs.

Is the service caring?

Good

The service was caring.

Staff had a good knowledge and understanding about the people they cared for.

People were encouraged to express their views on the day to day choices in their lives.

People had access to advocacy services if they were required.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had little stimulation and engagement beyond task led activities related to their care.

People and their relatives were not involved in reviewing the care people received.

People had care plans in place which provided guidance to staff about people's care requirements.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Improvements were required to monitor the quality and safety of the support people received at the home.

A registered manager was in post however there had been difficulties in providing consistent and strong leadership.

Effective systems were not in place for people, relatives or staff to provide their feedback about the home.

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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 28 March 2017 and was unannounced. The inspection was completed by one inspector and one expert by experience. An expert by experience is a person who has personal experience of using a service like this, or has experience of caring for someone who uses a service like this.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. At the time of the inspection they had not completed this document.

We reviewed the information we held about the service, including statutory notifications that the provider had sent us. A statutory notification provides information about important events which the provider is required to send us by law. We also contacted health and social care commissioners who place and monitor the care of people living in the home.

During our inspection we spoke with 14 people who used the service, three relatives, eight members of care staff, the acting manager and the provider.

We looked at care plan documentation relating to three people, and three staff files. We also looked at other information related to the running of and the quality of the service. This included quality assurance audits, training information for care staff, staff duty rotas, meeting minutes and arrangements for managing complaints.

Requires Improvement

Is the service safe?

Our findings

There were not enough staff deployed to meet people's needs in a timely and person centred way. At our last inspection we identified concerns that people were unable to get up at the time they wanted to. At this inspection we found that this was a repeated area of concern, and had deteriorated further with more people unable to get out of bed when they wished. We saw that at 10.15am there were 12 people who were waiting for staff to help them get out of bed. People were patiently waiting for staff and told us they understood that the staff were busy. One person said, "I do like a lie in but I am ready to get up now. I'll just keep waiting. She (the staff member) told me she would be back in a minute." Relatives told us they did not feel there were enough staff to meet people's needs. One relative said, "They need more staff. The staff levels are too low. There is never more than one member of staff on this unit and it's not enough. The ones here, you can't fault them but they have too much to do."

Staff told us they did not feel there were enough staff and they tried to manage as best they could. One member of staff said, "It's always difficult for the people that need two members of staff to help them get out of bed because it takes a long time for another member of staff to come here because they're busy helping other people. I have tried to get people washed and dressed in their beds to help speed things up. At the moment I have three people washed and dressed in bed and I'm waiting for someone to help me so now I'll go and start on the people that only need one member of staff." Another member of staff said, "I am here on my own. We do struggle; I am not going to lie especially this week when we have been very short some days. Mornings are the worst – there are supposed to be two floaters [two members of staff that are not allocated to staff any specific unit but are available to provide additional support to the six units] about here somewhere but I never see them."

The layout of the building had six different units with between five and eight people in them. In addition to individual bedrooms, each unit had its own kitchen and lounge area for people to spend their time. The building itself was relatively large and spacious with three of the units not within close proximity to each other. Staff had access to an electronic paging system to request assistance, although there was a reluctance from staff to utilise this. Each unit had one dedicated member of staff assigned to it, with two other care staff on duty and expected to help all six units where required. There were also two senior members of staff who were available to help but were often required to administer medication and therefore unable to offer additional assistance for example in the morning to help people out of bed or with their personal care needs.

Mealtimes were another area of concern as people were not given adequate support to eat their meals in a timely and person centred way. We observed that one member of staff who was supporting seven people in one unit to eat their meals was rushing around to try to meet everybody's needs but being unable to do so. The member of staff served everyone their meal choices, and then attempted to support somebody who required full assistance to eat their meal. During this time, one person required assistance to use the bathroom and the staff member left the person who required support to eat their meal. The other five people in the unit had already finished their meals and were waiting for their puddings. The staff member returned and then left the unit to go and get people's chosen puddings. People appeared bored and

frustrated with the lack of timely support and one person commented, "We might get some pudding sometime today might we?!"

We spoke with the acting manager about the staffing arrangements and the way they were managed. The service did not use an accurate dependency tool to assess their staffing arrangements and the acting manager had underestimated the number of people that required two members of staff to support them with their mobility. The acting manager believed that there was adequate staffing to meet people's needs but felt that they had been insufficiently deployed at key times of the day. On the day of the inspection the service was not understaffed as per their own requirements and had additional help as two trainees were also shadowing staff. There were no immediate plans to increase the number of staff.

This was a breach of Regulation 18 (1) Staffing

Staff did not always show that they were able to support people in a safe and competent way. We observed that not all of the staff had the required skills to provide medicines to people in a person centred way which reflected their choices and abilities to take them in their preferred way. For example, people were rushed to take their medicines and were not given sufficient drinks to swallow their tablets. We saw that one person was unable to eat their breakfast as the member of staff wanted to give them their medicines first. Another person was given a dispersible aspirin undissolved which clearly caused them difficulty. This member of staff had passed a competency assessment to administer medication which caused us concern and we asked the acting manager to make a safeguarding referral regarding our concerns about this member of staff's performance.

We also found that staff had failed to recognise that two people had been left without access to their call bell in their bedroom, and one person who required staff support did not understand how they could use it. We found one person in their bedroom stating that they did not feel very well but did not know how to tell care staff about this. Their call bell was out of reach and when we gave this to them they said, "What do I do now?" We had to show them how to use their call bell to request staff assistance. We saw that when people were willing and able to use their call bell, staff usually came quickly but there were not always sufficient checks on people that could not use this without support.

This was a breach of Regulation 12 (2) (c) Safe care and treatment

We spoke with people who required medicines and they told us they got them regularly but weren't sure on the timings. One person said, "They seem to bring medication around morning, noon and night. I don't know what time I should get it but only the early morning one seems to be at the same time." We spoke with staff regarding people's medicines and they said, "There is a lot of dispensing to do – it takes a long time to get to everybody, but it's much worse at the weekends when there is only one of us on giving out the medication. At least in the week there are two of us, although it still takes ages." We saw that the morning medication took a significant amount of time for the two members of staff to complete, with some people receiving their morning medication just after 11am. We were concerned that people were not given sufficient time between each of their medicines as people's lunchtime medicines began just after 12pm and we noticed that this had finished by 1.45pm; this meant that people were having their daily medicines within a one to three hour time period.

We reviewed people's medication records and found that there were a number of occasions when the records had not been correctly completed. It was unclear if people had always received their medicines as they had been prescribed as there were gaps in the records and there had been no investigation into these omissions. In addition, we saw examples of people not being offered their homely remedies such as

paracetamol because new prescriptions had not been ordered in time. One person who had paracetamol on an 'as required' basis had not been offered this for three days because the prescription had not arrived.

This was a breach of Regulation 12 (2) (g) Safe care and treatment

There was a risk that that people were not always supported by staff that were suitable to work in the care industry. We saw that for new members of staff the provider checked on staff's employment history and obtained references for people before they commenced work. The provider also completed criminal background checks on new members of staff when they were initially employed. The provider had a policy that required existing members of staff to complete annual declarations to confirm they had no criminal convictions within the previous year. However these were not always completed and no further checks were made on people's backgrounds to ensure they were still suitable to provide care and support for vulnerable people.

Improvements should be made to ensure staff could recognise and act on concerns when people may be at risk of harm. Staff had an understanding of safeguarding procedures and had an understanding of their responsibilities to report any concerns. They could recognise obvious signs of harm such as physical or financial harm but needed further support to understand more subtle types of harm such neglect or institutional harm. Staff told us they would feel confident to report their concerns. One member of staff said, "I would find the manager and tell her – I would also write down what was said to me or what I saw so that it was in writing." We saw that safeguarding referrals had been made to the relevant authorities and full investigations had been completed when concerns were identified.

People had individual risk assessments in place which recognised when they may need additional support to keep them safe, however we say examples of people's risks not being fully recognised or adequately managed. For example for people that were unsupported whilst in their bedrooms there were not always adequate systems to ensure that they could receive staff assistance in a tiemly way. Staff understood most people's risks and when they had changed. For example, staff were able to explain the additional support people had needed when they returned from a stay in hospital to help them mobilise safely. Staff also understood their responsibility to identify new risks, for example, if people's behaviours or health changed. We saw that most people's care plan records had detailed guidance around their known risks and these were updated as required.

The management team monitored and reviewed when people had fallen. The acting manager ensured that people's care and support was sufficient, and when necessary full reviews of their care was arranged. People were supported with additional equipment to keep them safe, for example if people had experienced a fall whilst they were trying to get themselves out of bed, consideration was given to whether a sensor mat to alert staff to people's movement may help to give people better support and assistance.

Requires Improvement

Is the service effective?

Our findings

Improvements were required to ensure that existing staff had the appropriate skills and competencies in all aspects of people's care. The provider arranged for new staff to complete an induction programme which provided training and guidance about how people should be supported with their care. However existing members of staff did not have a sufficient knowledge or competence in key areas. For example, the care staff had a limited knowledge of the Mental Capacity Act and the requirements this had on them. There were significant gaps in a number of areas of training for staff which included first aid, safeguarding and fire awareness. This had been identified as an area which required improvement by the acting manager and provider two months earlier however timely action had not been taken to make these changes. Staff told us that training was sometimes hard to cover due to a lack of staff and some training was held at an external venue which was not always easy to get to. The acting manager told us that training had been booked for after the inspection.

Staff had not always received the guidance and support when they needed it. One member of staff said, "It has been difficult in the past to talk openly to the management but it is getting better. The new manager is really friendly and supportive." We saw that staff had not received regular supervisions or appraisals for a significant amount of time; however the acting manager had implemented a system to facilitate this. They confirmed that staff should receive regular supervisions and regular observations about their practice. In addition, the acting manager had an open door policy and made every effort to be available for staff.

Improvements were necessary to ensure people's nutritional needs were fully assessed and regularly monitored. For example, we found that the staff had identified concerns with one person's nutritional intake and had made a referral to the nutritionist. However, staff had failed to continue to monitor this person and follow the advice of the nutritionist, for example by weighing them on a weekly basis. Staff did not have access to clear guidance to help recognise when people may need additional or professional support to improve their diets, for example, when people were losing weight there was an inconsistent approach to when further support would be offered to the person.

People told us they were satisfied with the food and drink that was on offer. One person said, "It's good. Well ok most days. We do get a choice at both lunch and tea time. Not just sandwiches which I like." Another person said, "It's alright. Some things are not to my taste but the carer girls look after me and get me something from the kitchen. They know when I don't like the food on offer –so no complaints really." We saw that people were able to eat and drink at mealtimes, albeit people did not always receive timely staff support, however we found that improvements were required to ensure that people drank sufficient fluids throughout the day. We spoke with one person in their bedroom and they told us they were hot and needed a drink. They did not have any water or other drinks in their bedroom and were unsure how to use their call bell to request staff assistance. We saw that another person in their bedroom did not have access to a drink. They told us they would like a drink but would wait for staff to offer one to them.

Improvements were required to help manage people's healthcare needs. One relative was exasperated with the lack of support from their relatives GP and stated that they had to take on extra responsibilities to get

the healthcare support that was required. They had felt obliged to take a day off work as they were not confident that the staff at the home would resolve their concerns with the doctor. Another relative said, "The G.P. has only been in once when I got so frustrated I shouted at them on the phone. I insisted he came in. It's not good enough." The acting manager recognised that people at the home received an inconsistent approach regarding their healthcare and was working to build relationships with the local surgeries so people could see an improvement to the care they received.

Other aspects of people's healthcare were generally well managed. One person said, "I have just had some new glasses. The chiropodist visited us last week. I need to see a dentist. My son is on the case, not sure when he will come but I haven't seen one yet." Another person said, "I saw a chiropodist a few weeks ago, I have never seen a dentist here – I have not got many of my own teeth left but I would like to see one soon. My daughter is trying to get me one." People's healthcare records showed that people usually saw a chiropodist and optician on a regular basis however not everybody was supported to regularly see a dentist, and some people confirmed that they would like to see one.

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 Mental Capacity Act 2005 (MCA). We checked whether the service was working within the principles of the MCA and we saw that they were, but found that the care staff lacked a knowledge and understanding around this. The 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.

The management team were aware of their responsibilities under the MCA and of the requirements to obtain people's consent for the care they received. We saw that when appropriate, a DoLS (Deprivation of Liberty Safeguard) application had been made to support people with limited mental capacity with their personal care. At the time of the inspection the local authority were considering the applications that had been made.

Good

Is the service caring?

Our findings

People appeared relaxed and comfortable in the company of staff and people told us that the staff treated them well. One person said, "They are very good staff. They're kind and patient. They're lovely staff. They make it good for us here." One relative said, "The girls here [the staff] are all very good. They can't do enough to help them."

Staff demonstrated a good knowledge and understanding about the people they cared for. People had developed positive relationships with staff and they were able to provide reassurance and warmth when people were unsure or were distressed. For example, we saw that one person who showed signs of anxiety, was frequently comforted by members of staff. There was a team approach, with household staff, care staff and senior staff all making time to speak to the person and offer reassurance. However, staff were unable to spend great lengths of time with anybody as they were required to support the other people within each unit. Whilst staff showed a good understanding of people's needs there was some frustration that they were very busy and most interactions with people were task led.

People were encouraged to express their views and to make their own choices and staff responded to the manner in which people communicated with them. One person said, "I decide where I want to go. Sometimes I like to go to my room." People were supported to wear clothes they liked and staff explained that if people were unable to access the wardrobe independently they supported them to make their own choices.

Staff understood the need to respect people's confidentiality and understood not to discuss issues in public or disclose information to people who did not need to know. Any information that needed to be passed on about people was placed in a confidential document or discussed at staff handovers. Staff respected people's privacy and ensured that people's personal care was supported discreetly and with the doors closed. Staff usually supported people to maintain their dignity and offered support to people to adjust their clothing, or keep them covered up when this was compromised.

There was information on advocacy services which was available for people and their relatives to view. Staff demonstrated their understanding of decisions that may require support from an independent advocate which included decisions around handling their money or moving home. The acting manager had the contact details of an advocate and recognised the support they could provide.

Visitors, such as relatives and people's friends, were able to visit people at the home. The management had recognised that visitors may require quiet or private areas to spend time with their loved ones and had created a homely room for this purpose.

Requires Improvement

Is the service responsive?

Our findings

People were limited with the level of engagement and interaction they had in their day. People told us there was not always much time for staff to be able to talk to them beyond providing their care and people had limited access to any meaningful activities. One relative said, "There are no activities at all for them. Staff don't have any time to sit and chat to them. They're always rushing about." Staff told us they were encouraged to provide activities or tasks people enjoyed however this was often not possible due to the high level of support people required on a daily basis and the limited number of staff that were available to support people. We observed that beyond the television, there was little opportunity for engagement. We saw that staff made efforts to engage with people as they were completing their tasks but there was a clear lack of positive engagement with people to help stimulate their wellbeing.

People and their relatives were not involved in reviewing their care planning. One person said, "They [the staff] don't really talk to me about what happens, but they do ask sometimes if I want a bath." One person's relative said, "I've not seen it [the care plan] and as far as I know nor has my husband. We did come into a meeting when [name of relative] first came in but not since." Another relative said, "I had a talk with them right in the beginning and they wrote a few bits down. I have signed their plan for them but I don't have any input or reviews into it now." Staff told us they were unaware of people or their relatives having much involvement with deciding on their care after people had moved in. We saw that there were significant gaps of people and their relatives reviewing their care, despite the provider's policy expecting this to be reviewed every three months. The acting manager acknowledged that these reviews had not been carried out and had identified that this was an area that needed to be improved however at the time of the inspection no plans had been put in place to address this.

People's care and support needs were assessed before they came to live at the home to determine if the service could meet their needs. People were able to visit the home if they could, to gain an insight into whether they wanted to come and live at the home. People and their relatives were also able to visit the home during the decision making process. We saw that the management team gathered as much information and knowledge about people during the pre-admission procedure from people themselves if they were able to communicate, and from relatives, advocates and professionals already involved in supporting each person. This ensured as smooth a transition as possible once the person decided they would like to move into the home.

People had care plans in place which helped staff to understand how people liked their care and what was important to each person. For example, they contained information about how people needed help to mobilise or walk, and staff had a good understanding of people's care needs. One person said, "I do get myself washed and dressed, they come with me to the bathroom. They like to keep an eye on me and then they help me get out and dried which is really nice of them." Staff were happy that they understood how people liked their care. One member of staff said, "I know what support each person on my unit needs, to walk, to eat or where they like to spend their time, although sometimes it changes."

A complaints procedure was in place which explained what people or their relatives could do if they were

unhappy about any aspect of the home. Staff were responsive and aware of their responsibility to identify if people were unhappy with anything within the home and understood how they could support people to make a complaint. We saw that the acting manager took a proactive view to complaints and addressed people's concerns quickly.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in post at the service, however at the time of our inspection they had been on a significant period of leave. In the interim, an experienced acting manager had taken on management responsibilities but had unexpectedly had to take leave from the service for a short period of time. People were unclear who the manager was and often referred to one of the team leaders as the manager. Relatives also told us they had found the lack of management very difficult. One relative said, "The lack of real management on the premises has been the biggest problem for me with [name of relative]. I feel I am battling the system without any support." The acting manager expressed their own frustration at being absent and had tried to keep as involved as possible whilst they were on leave. We asked if the provider had maintained a strong presence during this period and whilst the acting manager felt very well supported there was a lack of evidence that the management of the home had strong leadership during this challenging period.

At our last inspection we identified concerns with inadequate staffing arrangements and at the failure to support people in a timely way at key times of the day. Despite this issue being highlighted previously, ineffective management action had been taken to resolve this, and this had deteriorated further. There were ineffective quality monitoring systems in place to review if people received the care they preferred, including the time of day they got out of bed and how they preferred their personal care.

Quality monitoring systems were in place; however they were not always effective at identifying where improvements were required. For example, medication audits were in place but they failed to identify when errors had been made, and failed to adequately investigate, resolve and record the outcome. In addition, all staff administering medication had recently been assessed as competent to do so; however we found this not to be the case during the inspection. In addition, when the auditing systems did identify that actions were required to make improvements to the service, these were not completed in a prompt manner. For example, there had been several months when training had been identified as needing to be completed, and it being organised for staff to attend.

Effective systems were not in place for people, their relatives or staff to provide their feedback about the service. One member of staff explained that it had been difficult to provide honest feedback about the service in the previous 12 months as they felt the management team had been unapproachable and they felt they would not be listened to. They told us that they felt that things had improved since the acting manager had arrived and were more forthcoming with their views however they were no established structures in place for people, staff or relatives to provide their feedback. The acting manager was aware that this was an area that needed to improve.

This was a breach of Regulation 17 (2) (a) (e) Good governance

The culture of the home had started to change to encourage staff to be open and honest and be confident that there was not a blame culture. One member of staff said, "It's got a lot better recently. I do feel like we can talk to the [acting] manager. Their door always seems to be open and morale does definitely seem to be

getting better." We spoke with the acting manager and they explained that they were aware that staff morale could be improved, and were keen to listen to them for new ideas. They said, "One of the things that staff have told me is that they felt in the past sometimes changes were made quickly and without any explanation so I am keen to take things slow and discuss any changes I want to make, to make sure I get it right."

The home had policies and procedures in place which covered all aspects relevant to operating a care home which included safeguarding and recruitment procedures. The policies and procedures were detailed and provided guidance for staff. Staff had access to the policies and procedures whenever they were required and staff were expected to read and understand them as part of their role. However, the management team needed to ensure that the policies and procedures that were in place were followed and adhered to, for example, the supervision policy. The management team had submitted appropriate notifications to the CQC when required, for example, as a result of safeguarding concerns.

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 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: Staff did not have the competencies to provide people with their medicines in a person centred manner. Regulation 12 (2) (c). Satisfactory systems were not in place to ensure people received their medicines at the time they required them. 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: There had been insufficient leadership in the home at times. Quality monitoring systems were not always effective at identifying where improvements were required and when issues had been identified they had not always been actioned in a timely way. There were a lack of systems in place for people, their relatives and the staff to provide feedback. Regulation 17 (2) (a) (e).

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: Inadequate arrangements were in place to ensure that people received the care they

required at the time they required it. Regulation 18 (1).