Care Quality Commission

Country Court Care Homes 2 Limited

Summer Lane nursing home

Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

The inspection was unannounced and took place on 20 October 2014.

The home provides care and accommodation for up to 90 people. Waverley Unit within the home provides specialist care for people with dementia.

The home had a registered manager in place. 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 theservice is run.

During our inspection, we found breaches of regulations that meant people in the home were not always safe. We found there were insufficient levels of sufficiently skilled staff to meet people's needs. People, relatives and visitors to the home all expressed concern about staffing levels and how this impacted on people's care. People told us; "I can't get them to help me so I don't bother asking any

Summary of findings

more" and "It's hopeless expecting any help. You just have to get on with it and do the best you can on your own. Some people are in bed all day so I'm lucky. They just haven't got enough staff for us all". We made observations during a lunch time meal that showed people's needs were not being met at this time due to the insufficient numbers of staff.

We found there was a system in place where newly recruited staff were able to shadow shifts in the home before their Disclosure and Barring System (DBS) checks were complete. This is a check that providers are required to undertake to support them in making safe recruitment decisions. No risk assessment had taken place in relation to this. This meant that people were at risk from staff whose suitability to work with vulnerable people had not been fully checked. The provider also told us there was a period of time when company recruitment procedures had not been followed. This had been identified through the provider's quality and monitoring procedures and action taken promptly to address the risks that this presented.

Procedures to prevent cross infection were not followed consistently because staff did not always wash their hands when necessary.

People were not fully protected against the risks associated with medicines because there was not always accurate information kept about the use of PRN 'as required' medicines.

Staff were positive about the training they received and told us they felt able to ask for additional training when required. Nurses and care staff demonstrated knowledge and understanding of caring for people who were at risk of pressure ulcers.

People were protected against the risks of malnutrition because they were assessed using a standard tool and this was repeated regularly to support staff in identifying when further specialist input was required. Staff were aware of the Mental Capacity Act 2005. We saw people's capacity had been assessed and best interests decisions documented in relation to issues such as bed rails and the type of diet a person required. Action was being taken to ensure that people were not unlawfully restricted.

People were supported to see other healthcare professionals when necessary, such as GPs, district nurses and chiropodists.

Feedback about how caring staff were was mixed. Some people were unhappy and told us; "I don't feel you can talk to staff as they are so busy. They can be very curt with me and I feel I am a nuisance", whilst others told us; "we've got some lovely staff, we're very happy here" and "we enjoy it here, we'd have a job to find fault".

We found that people weren't always treated with dignity and respect. We observed staff use language that did not reflect a respectful or personalised approach to caring for people. We heard staff use terms such as; "she's a feed" and "she's dementia".

People told us that staff made arrangements to protect their privacy when delivering personal care, such as ensuring curtains were closed.

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.

There were insufficient numbers of sufficiently skilled staff to meet people's needs.

The risks relating to newly recruited staff shadowing shifts prior to pre-employment checks being completed had not been fully assessed.

Procedures for the prevention of cross infection were not always followed.

Information about PRN (as required) medicines was not always clear in people's support plans.

Inadequate

Is the service effective?
The service was not always effective.

Documentation was not always completed in order to fully protect people and to allow staff to monitor people's care.

Care was not always delivered in line with people's support plans.

Staff received training to support them in their work and had knowledge of the Mental Capacity Act and DoLS.

Requires Improvement

Is the service caring?
The service was not always caring

We received mixed views about how well cared for people felt.

We heard language being used by staff that did not reflect a respectful and personalised approach to people.

People and their representatives were encouraged to be involved in planning their care.

Requires Improvement

Is the service responsive?
The service was not always responsive.

There were insufficient opportunities provided for people to engage in activities that reflected their personal interests.

Staff showed knowledge of the importance of treating people as individuals with their own individual preferences.

There were processes in place to respond to complaints.

Requires Improvement

Is the service well-led?
The service was not always well led.

Requires Improvement

Summary of findings

We found breaches in regulations during our inspection. There was an action plan in place to improve the home; however quality assurance systems had not been fully effective in identifying breaches of regulations.

Staff and people in the home did not always have confidence in raising issues of concern and that they would be acted upon.

Summer Lane nursing 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.

The inspection took place on 20 October 2014 and was unannounced. This was the first inspection under the current provider.

The inspection was carried out by four adult social care inspectors and an expert by experience in older people's care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed complaints received by the commission and any notifications. A notification is information about important events which the service is required to send us by law. This inspection took place in response to concerns shared with the Commission about people's safety and the quality of care they were receiving.

We spoke with nine people who use the service, five relatives or friends, three visiting healthcare professionals, six staff and the registered manager. We made observations and reviewed records. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

The feedback we received during our inspection raised concerns that there were insufficient numbers of staff to ensure that people's needs were met.

Comments from people in the home included; "No I don't feel safe, I feel abandoned. No one comes when you ring the bell, you can wait over an hour or more and sometimes they don't come at all. I lost my neck alarm over a month ago I've asked again and again for a new one, but nothing happens". Other people told us; "I can't get them to help me so I don't bother asking any more" and "It's hopeless expecting any help. You just have to get on with it and do the best you can on your own. Some people are in bed all day so I'm lucky. They just haven't got enough staff for us all".

Overall, opinion varied amongst staff on how well the staffing levels worked. Nurses in particular reported that they felt staffing levels were sufficient. The registered manager of the home and the managing director of the company both reported that staffing levels were appropriate and sufficient for the number of people in the home. No concerns regarding staffing levels had been highlighted as part of their own quality and safety monitoring. We were provided with meeting minutes to show that staff sickness had been identified as an issue and that new ways of managing this were being introduced.

We were also provided with information about people's dependency levels in the home. We read that of 45 people, living in the ground floor of the home, at least 23 required two members of care staff to support them with their care routines. The ground floor was split in to three areas, with two care staff in each and two nurses overall. No further analysis of how people's needs were able to be met had been completed to plan for and demonstrate that there were sufficient staff.

We observed a lunch time meal in the home and found during this time not everyone's needs were met. Two people were supported with their meals and both were interrupted during this time whilst staff were required to attend to other people. One person waited 20 minutes for support with their meal to resume. A number of people experienced cold meals due to them not receiving their meals promptly. Staff told us that when they were going to assist people to lunch, they were finding that they needed further support with their continence needs and this increased the time it took to support everyone to be ready for their meal. There were insufficient staff to meet people's needs over lunchtime.

Staff also told us there was not always time to offer people morning drinks because they were so busy. During our inspection, staff told us that by lunchtime, not everyone had received their personal care to get washed and ready for the day. Staff reported that they were still carrying out morning personal care at 4.30pm.

This is a breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

The registered manager told us there was a system in place, whereby as part of the recruitment process, applicants would shadow shifts prior to their full Disclosure and Barring System (DBS) checks being completed. These checks are used to help employers assess a person's suitability to work with vulnerable adults. There was no risk assessment in place in relation to this even though the registered manager confirmed that all aspects of care would be shadowed including personal care. This meant people using the service were at risk because people who had not been fully checked in relation to their suitability for the role were shadowing shifts and observing personal care.

The provider also told us there was a period of time when company recruitment procedures had not been followed and that staff had begun working in the home without full suitability checks completed. This had been identified through the provider's quality and monitoring procedures and action taken promptly to address the risks that this presented.

This is a breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

The provider had policies and procedures in place for the prevention and control of infection. We saw the provider had a schedule of audits which planned for infection control to be audited every three months. We looked at the most recently completed audit which was dated May 2014. We saw in accordance with the home's policy a registered nurse had been delegated the role of infection control lead by the registered manager.

We found during our visit that there were offensive odours in the home, particularly in the area for people living with

Is the service safe?

dementia. Staff members we spoke with told us these odours resulted from issues relating to people's continence. We were told this was a particular problem during the night because staff did not have enough time to clean the floors properly. Staff told us that carpets were being replaced by hard flooring in some rooms to try to eliminate this. We saw contractors were at the home carrying out this work on the day of our visit.

We observed that staff did not always follow practices to reduce the risk of cross infection. For example, during the medicines administration round we saw a member of staff did not wash their hands before or after applying people's eye drops or ointment. They explained that they washed their hands before beginning the medicine round, as we observed. However, guidance from NICE (National Institute for Clinical Excellence) states that good hand hygiene should take place before and after such administration of eye preparations to avoid cross-infection. During lunch, we saw two care staff removing the footplate from a wheelchair. Both staff resumed serving meals and helping people to eat without washing their hands.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

Medicines, including controlled drugs, were stored securely in purpose-made cabinets or lockable mobile trolleys. We saw staff locked the trolley if they left it to give someone their medicines, and locked the medicines storeroom if they left the area. There was also a lockable refrigerator solely for medicine storage. Daily minimum and maximum temperatures were recorded for the fridge and the storeroom. These showed medicines had been stored at appropriate temperatures to ensure their effectiveness.

Stocks of controlled drugs that we checked were as indicated in a register kept specifically for these medicines. We saw two staff had signed the book as well as the Medicine Administration Record (MAR) each time to confirm the medicine had been administered. These practices were in line with current guidance.

Some medicines were prescribed for use 'when required' (PRN), such as pain-relief or laxatives. Staff had not always made entries on MARs to show that these medicines had been offered to the person. We saw no further guidance with MARs or in people's care plans for the use of such medicines. For example, the reasons for giving the medicine, how much to give if a variable dose had been prescribed and what the medicine was expected to do.

We were shown a blank template form relating to the use of PRN medicines but this was not used consistently. A nurse confirmed that one person's PRN medicines were prescribed for end of life care, but we found there was no care plan in place about this aspect of the person's care. This meant that there was no clear guidance in place to guide staff in meeting this person's needs.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

We saw that several issues in relation to medicines were identified during a visit to the home by a manager within the organisation as part of their monitoring of the service. The provider had already put an action plan in place in relation to this.

Staff understood their responsibilities to safeguard people from potential abuse. Everyone we spoke with said that they would report concerns to a nurse or a registered

Requires Improvement

Is the service effective?

Our findings

We saw staff used a form with relevant prompts for recording, describing, grading and monitoring wounds as well as recording any dressings being used. Nurses told us they also photographed wounds, to help with the monitoring. The forms were not always fully completed or updated. This created a risk that appropriate care and treatment might not be provided to support healing and ensure people's needs were met.

We also saw that recording forms were in place in relation to monitor people's fluid intake. Daily totals had not been recorded on any of the forms we saw. Therefore it was not clear how effectively people were being supported to have enough to drink. However, staff told us they were informed at handover at the start of their shift, by the person in charge, if anyone needed greater encouragement because they hadn't eaten or drunk sufficient so far that day.

This was a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

Nurses told us they had been trained to provide compression bandaging by local NHS specialist community nurses. They confirmed that their practice was reassessed at intervals. This ensured they continued to use required techniques, to promote healing and avoid harm to the individual through incorrect practices. We spoke with a care assistant who demonstrated they had knowledge about caring for people with pressure ulcers in line with current guidance.

Nurses were able to describe the risk factors that might lead to someone developing a pressure ulcer. This meant they would be aware of who was more likely to be at risk as well as the factors that could be acted on to prevent people developing pressure ulcers. For example, they told us they ensured the use of barrier creams on relevant skin areas if people had continence needs, to promote the health of their skin. They also used a nationally recognised risk assessment tool, which guided the support people received, such use of equipment.

Staff were positive about their training and demonstrated understanding of how to ensure good skin care. However, we observed that this was not always put into practice effectively. In one example, we saw that a person had a pressure relieving mattress that was not set at the correct setting for the person's weight. This meant that the person was not fully protected from the risks of developing pressure ulcers. We saw turn charts were completed; however the times of turning had been extended beyond the required times in many cases.

Staff we spoke with all said there was a good selection of meals available and that people were able to make choices. Alternatives were available if preferred. Meals specifically for people with diabetes were also available. Two people told us they ate their lunch in their own rooms. They said; "It's brilliant food" and "If you want anything different they'll do it for you". However, not all feedback was positive; we also received comments about food being cold. One person told us; "they serve us our dinners last if we have them in the rooms and they're cold, so I always ask for the salad then it doesn't matter" another person told us; "the food varies but on the whole its pretty good. It suits me anyway. There are problems though if you are fussy because they're supposed to come round with the menu the evening before so you can choose something, but they rarely do so they haven't always got enough of the things you like and you have to have something else". Nurses completed a nationally recognised malnutrition risk assessment for each individual. Most of those we saw had been repeated monthly. A nurse explained that if an individual's risk level changed in a specific way, they referred the individual to a dietician for fuller assessment and advice on supporting the person. This meant that people were protected against the risks associated with malnutrition.

Most staff were positive about the training they received and said; "we're trained up when anything new is introduced" and "training gives us the skills to do our jobs." Staff said; "we do manual handling, food hygiene and dementia training" and "we are observed after training and it's discussed in supervision." All staff told us they could ask for additional training if they wished.

Two people who required the use of a hoist to meet their needs told us that staff managed this well. They said staff handled them gently, explained what they were doing and didn't rush.

Care staff told us they had completed Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training (MCA/DoLS). This is legislation to protect people who may not be able to make decisions for themselves. Staff said; "we show them different things to give them choices, we can see from body language and their eyes what they want" and "we

Is the service effective?

give them choice by showing them their clothes and they choose". This showed that staff had knowledge and awareness of how to support people to make decisions about their own care.

We saw evidence of the MCA being put in to practice through a documented best interests decision about the use of bed rails. We also discussed DoLS and saw evidence of an application in relation to one person in the home who required DoLS authorisation to keep them safe. We observed throughout the day that some people were being stopped by staff from leaving particular areas in the home and that there were keypads in place on various doors. We discussed this restriction on people's freedom with the registered manager who told us they would be reviewing other people in the home who may require DoLS authorisation, in relation to recent changes in guidance. It was recorded in a provider report from September 2014 that the manager in the home had discussed DoLS applications with an advisor in the local authority who had discussed how people in the home should be prioritised for referral.

We saw records of professional healthcare visits to people including opticians, G.Ps and chiropodists. We saw that one person had been referred to a speech and language therapist (SLT) because of concerns about their swallowing and possible risks they might choke. Advice from the SLT had been added to the person's care plan, and we heard staff discuss thickening the person's drink as indicated. We saw a best interest decision had been recorded, about giving the person pureed food as recommended by the SLT, which involved the person's GP. This was because the person had been assessed as lacking the capacity to decide for themselves if they wanted this type of diet.

We recommend that the systems in place for promoting good health of the skin are reviewed to ensure that they are implemented effectively and are consistent with relevant guidance.

Is the service caring?

Our findings

We found that people weren't always treated with dignity and respect. We observed staff use terms that did not reflect a personalised approach to caring for people. We heard staff use terms such as "she's a feed" and "she's dementia".

During our inspection we also observed one person who had been asked to vacate their room for the day due to work being done in the room. This person was asked to sit in a corridor with all their personal effects around them. The person concerned told us that they felt embarrassed by this. One person also raised a concern that staff did not always change the stained clothes of the person they visited. We saw several people in their bedrooms with the door wide open. One of these people told us staff didn't ask them if they wanted their door open; "they just leave it open" - and chose to have it shut when we left them. They confirmed that staff shut their curtains to ensure their privacy when receiving personal care.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

Feedback from people and their relatives was mixed with some people telling us they were happy in the home and others who were not happy with their experiences. One person told us; "I don't feel you can talk to staff as they are so busy. They can be very curt with me and I feel I am a nuisance". One visitor told us that when they arrived, the person they had come to see hadn't been washed and dressed as expected. Other people were more positive and told us; "we've got some lovely staff, we're very happy here" and "we enjoy it here, we'd have a job to find fault".

Staff told us; "We talk to people and try to make everyone feel part of the family" and "If we think people can do something, we let them."

We heard staff asking one person if they had enjoyed their meal and another person about a recent musical event, with positive responses about both. In the area of the home for people living with dementia, we saw one person being approached by staff in a respectful manner to carry out personal care. When the person demonstrated that they did not want to go, the member of staff respected their wishes. Shortly afterwards another member of staff approached the person again and encouraged them in a kind way to have their personal care attended to. This showed staff were aware of the ways in which this person communicated their consent and acted accordingly.

One person told us staff asked their views about their care and choices on a daily basis. Another person told us about the care records filed in their room. They said staff had told them they could read their record and had done so. We saw evidence that the representative of a person, who had communication difficulties, had been invited to be involved in planning their care.

As part of the provider's quality monitoring, we found people's opinions were sought through surveys and resident meetings. This helped ensure that people were able to raise any concerns or issues that they had. We saw a report from September 2014 where a senior manager in the organisation had visited the home and as part of their visit, had spoken with people to gain their views.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with told us that a member of staff responsible for activities had recently left and since that time opportunities to get involved in social activities had reduced. Comments included; "there's nothing downstairs but we can go and join in the activities upstairs if we want." Another person told us; "we have a little clique of us who play cards in the lounge and we're running a little shop now, it gives us something to do". We found that in some files there was a lack of information about people's likes and dislikes and their hobbies or interests. One relative that we spoke with expressed concern about the lack of activities that met the needs of people living with dementia.

Staff told us about the importance of treating people as individuals with their own likes and preferences. Nurses told us; "residents are kept at the centre of care, care should be beneficial and in the best interest of the resident". Care staff told us; "people are all different, no-one is the same" and "people can have choices, for example one person had a shower when they wanted". However, our observations showed that people's individual needs were not always met.

We observed that there were significant periods of time when people were not involved in activities that met their personal needs. We observed that for a period of one hour in the area of the home for people living with dementia two people were clearly awake and alert but were not provided with any activity that supported their personal interests. When staff did interact, conversations were brief as staff passed through the area on the way to other areas of the home.

On one occasion we also observed a person sitting alone in the lounge, positioned in front of the television which was turned off. Staff only put the television on for this person when prompted to do so by inspectors.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

The provider told us they were in the process of recruiting a new member of staff to coordinate activities in the home. This would help improve the range of opportunities and activities for people to take part in.

People's support plans contained clear descriptions of how they should be supported. The information was reviewed monthly to ensure the information was current and accurate. Staff told us the care files gave them the information they needed to be able to provide appropriate care. Daily notes were maintained separately and were kept in people's rooms.

People were given opportunity to maintain relationships that were important to them. During our inspection, we saw one person was supported to get ready to go out with an expected visitor. Other relatives told us they visited the home regularly. One couple that were living together in the home told us they were very happy there.

We saw a record of complaints was kept and evidence that the registered manager had contacted the complainant to discuss the issues raised. Prior to the inspection, the Commission received complaints which we had shared with the provider. These were acted upon and investigated with a full response shared with the Commission within an agreed timescale. The response showed that issues highlighted in the complaints had been fully investigated and action had been taken in relation to the findings of the investigation. This showed that the provider responded to complaints and took action arising from investigations where necessary.

We saw that complaints were monitored through the provider's quality monitoring systems to ensure that procedures were being followed.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in place, however for a period of three months prior to the inspection, they had not been in day to day charge of the home. This meant they had not had a daily overview of how the service was performing. During this three month period there was a manager in place but they had not registered with the Commission.

We were shown reports that evidenced how other senior staff in the organisation were monitoring the performance of the home. We saw a report dated September 2014 where a number of issues were highlighted and an action plan put in place for improvement. We saw that progress had been made in meeting the action plan. For example, it was noted that flooring was to be replaced in areas of the home to help address the issue of odours. This was being actioned during our inspection. A further action point was to complete a nutritional risk assessment for everyone in the home. During our inspection, we found assessments that had been completed and repeated monthly. This showed that issues identified through quality monitoring were acted upon.

However, we found a number of shortfalls during our inspection that reflected how the service was not yet performing in a way that met people's needs. Whilst we found evidence that improvements were being implemented; the quality assurance systems had not been fully effective in identifying the breaches of regulation identified during our inspection.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

Prior to our inspection we had received concerns about how some staff were being treated in the home. These concerns were shared with the provider and action was taken to investigate them. The investigation showed that staff were given opportunity to raise any concerns that they might have and were encouraged to be open and honest. This showed a commitment by the provider to be transparent. However, we found that a culture of openness was not yet fully embedded in the home.

Staff we spoke with had mixed views about how well their concerns would be listened to if they approached the registered manager or senior managers within the organisation. Some staff told us they felt confident about raising their concerns whilst others told us "we're unable to raise concerns, we're not listened to". This mix of views was also reflected in the comments from people and relatives. Comments included "yes the service is well-led. We have good carers and good nurses" and "the manager is doing their best and is kind and helpful". Another relative told us "we can go to the management but nothing gets done". This showed that not all staff, people and relatives had confidence in bringing their concerns to the attention of the provider, and that they would be acted upon.

All staff confirmed that they had staff meetings, although some staff expressed that they didn't feel able to give their opinions in these meeting as they were worried about the repercussions of doing so.

We spoke with the registered manager about the current situation in the home and they were aware that staff morale was low and there were staffing issues they needed to work on. The managing director told us that Human Resources personnel were being brought in to the home to try and work on some of these concerns.

We saw that resident and relative meetings were advertised around the home to help ensure people were kept informed of when they could attend. This showed the provider was willing to engage with staff and people to try and resolve concerns.

The registered manager understood their responsibilities in relation to their role. For example, we saw that notifications to the Commission were made when required to do so.

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 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **There were not sufficient numbers of suitably skilled staff available at all times to meets the needs of people in the home.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **Staff shadowed shifts as part of their recruitment procedure before DBS checks had been completed. No risk assessment was in place.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **Staff did not always follow effective procedures to minimise the risks of cross infection.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **People were not always protected from the risks associated with medicines because clear guidance was not always in place.**

Regulated activity	Regulation

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 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **Clear records were not always kept in relation to care of wounds and fluid intake.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **People were not always treated with dignity and respect.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **Quality assurance systems were not fully effective in identifying breaches of regulation.**