Care Quality Commission

Strathmore Care

Meyrin House

Inspection report

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Date of inspection visit:
03 July 2017
05 July 2017

Date of publication:
26 October 2017

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Meyrin House provides accommodation and personal care for up to 18 older people. An unannounced inspection was carried out on 3 and 5 July 2017. Some people living at Meyrin House had care needs associated with living with dementia. At the time of our inspection, 13 people were living at the service.

The home did not have a registered manager in place. However prior to the inspection taking place we had received an application from the current home manager. 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.

Arrangements in place to keep the provider up to date with what was happening in the service were not effective. As a result, there was a lack of positive leadership and managerial oversight.
The manager could not demonstrate how the service was being run in the best interests of people living there. Systems in place to identify and monitor the safety and quality of the service were ineffective, as they either did not recognise the shortfalls or when they did there was a lack of action to rectify them.

Views about staffing levels were mixed and some people felt that there was not enough trained and experienced staff available to meet their needs. We also found that people or their families were not fully involved in planning and making decisions about their care. We found the service not to be responsive in identifying and meeting people's individual care needs.

Staff did not have the skills and experience, and they were not deployed effectively to meet the needs of people. We found that staff did not always have enough time to spend with people to provide reassurance, interest and stimulation. There was a lack of knowledge around supporting and caring for people living with dementia including understanding how it affected people differently and how each individual should be cared for to promote their wellbeing as far as possible.

The dining experience was varied as it did not meet all the people's individual nutritional needs. As a result, the manager was unable to demonstrate that people had enough to eat and drink to support their overall health and wellbeing.

Although some of the relatives told us that staff treated people with kindness and were caring, we found the way the service was provided was not consistently caring. Staff did not always demonstrate a caring attitude towards the people they supported and some failed to promote people's dignity or show respect to individuals. The majority of interactions by staff were routine, task orientated, and we could not be assured that people who remained in their bedroom received appropriate care to meet their needs. This also meant they were socially isolated as opportunities provided for people to engage in social activities were limited.

Whilst we were concerned that some staff did not always recognise poor practice, suitable arrangements

were in place to respond appropriately, where an allegation of abuse had been made. Systems in place to deal with people's comments and complaints were not effectively being used. Records we reviewed confirmed this.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not always protected against the risks associated with medicines because the manager did not have appropriate arrangements in place to manage medicines safely.

Although staff knew how to recognise and respond to abuse correctly and there were arrangement in place to keep people safe, not all people felt safe. People's individual risks had not always been correctly assessed and identified.

The recruitment process was robust which helped make sure staff were safe to work with vulnerable people. The deployment of staff was not appropriate to meet the needs of people who used the service.

We found people's medicines were managed and stored safely.

Is the service effective?

Inadequate

The service was not effective.

The dining experience for people was variable and not always appropriate to meet people's individual nutritional needs.

Improvements were required to ensure that staff's training was effective and good practice was embedded through their everyday practices with people who used the service.

Is the service caring?

Requires Improvement

The service was not caring.

Not all care provided was person centred, caring and kind.

People and those acting on their behalf were not always involved in the planning of their care.

People were not always treated with dignity and respect.

Is the service responsive?

Inadequate

The service was not responsive to people's needs.

People were not always engaged in meaningful activities and supported to pursue pastimes that interested them, particularly for people living with dementia.

Not all people's care records were sufficiently detailed or accurate.

Staff were not consistently responsive to people's needs.

Arrangements were in place for the management of complaints however they had not proved effective.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of managerial oversight of the service as a whole.

The quality assurance systems were not effective because they had not identified the areas of concern.

Care Quality Commission

Meyrin House

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 registered manager was 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 the 3 and 5 July 2017 and was unannounced. The inspection was undertaken by two inspectors on the 3 July 2017 and one inspector on the 5 July 2017.

Prior to our inspection, whistle-blower concerns were raised that people using the service may be at risk of abuse. Due to the severity of the concerns and conversations with the Local Authority we carried out an urgent inspection.

We reviewed other information that we held about the service such as notifications. These are the events happening in the service that the service is required to tell us about. We used this information to plan what areas we were going to focus on during our inspection.

As part of the inspection we spoke with one person who used the service, two relatives and five members of care staff, and the home manager and care supervisor. We also spoke with the Local Authority's contracts, safeguarding team and the police.

Some people were unable to communicate with us verbally to tell us about the quality of the service provided and how they were cared for by staff. We therefore used observations, speaking with staff, and relatives, reviewing care records and other information to help us assess how people's care needs were being met. We spent time observing care in the communal areas and 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.

As part of this inspection we reviewed six people's care records. We looked at the recruitment and support records for three members of staff. We reviewed other records such as medicines management, complaints and compliments information, quality monitoring and audit information and maintenance records.

Inadequate

Is the service safe?

Our findings

In May 2016, our inspection raised concerns about the numbers of staff available to meet people's needs safely and therefore the service was rated Requires Improvement. We carried out a follow up inspection in November 2016 where we found improvements had been made and the service was rated Good. However, at this inspection we found these improvements had not been sustained and maintained.

The manager was unable to confirm how staffing levels at the service were calculated to determine the number of staff required. The manager confirmed that the dependency levels for each person were assessed and recorded each month. However, we found that there was no systematic approach to analyse the results so as to determine the number of staff required, to ensure that the deployment of staff met people's changing needs and circumstances. The manager advised that staffing levels for the home were decided by the head office and there was very little involvement from them in relation to the decisions made for this process. Manager added "Every week I send the dependency outcomes for every person to the head office/provider who then advise me on the staffing levels for the service". On reviewing people's dependency assessments we found the service had two contradictory assessment tools in place for each person. It was not clear which information was being used to ascertain staffing levels for the service. After the inspection, the provider wrote to us informing us that this system was being reviewed.

Staff's comments about staffing levels were varied. Although some told us that levels were acceptable and they could meet people's day to day needs, others informed us levels were inadequate and that this could be stressful especially during busy periods of the day. Staff told us that the impact of this was that people could not always go to bed at the time of their choosing and/or preference. Whilst some staff recognised the importance of interaction with people using the service, others were task orientated so their views may also be a concern. The manager informed us that when they started working in the service it was run on 'three plus two' ratio for 12 people this being, three members of staff during the day and two members of staff at night. However, on reviewing staff rotas we found that on the 01 July 2017 there were 13 people living at the service and staffing levels had not been reviewed and remained the same. We were informed by the manager and night staff that a person who came to live at the home recently had been pre-assessed as being at risk of waking up and being disorientated at night. This required regular checks to ensure their safety. Since being in the home they had sustained an unwitnessed fall. However the manager failed to demonstrate that appropriate measures had been put in place to mitigate future risk.

Where people required close monitoring due to high risk of falls or becoming anxious and distressed towards other people, there was not always a member of staff available to monitor or support people. Our observations during a period of one hour showed that for a 20 minute period there were no staff in the main lounge where most of the people were, as they were either supporting people with personal care or medication.

All the findings above were highlighted when we inspected the service in May 2016, despite a period of improvement during the November 2016 inspection the service has failed to sustain the improvements.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff knew the people they supported and some risks were identified and recorded relating to people's health and wellbeing. For example, the risk of poor nutrition, poor mobility and the risk of developing pressure ulcers. However this was inconsistently applied. Where risks were identified, suitable control measures were not put in place to mitigate the risk or potential risk of harm for people using the service. The majority were not up to date to reflect people's current needs or updated following hospital discharge or from the outcomes from visiting doctors and district nurses. For example one person sustained a fall on the 11 May 2017 which resulted in a broken wrist. There was no indication on how staff were to support the person with transfers. Information contained in the care plan with regards to mobilising was contradictory. One record stated the person could mobilise with a walking frame and the assistance of one carer, while another record stated they were to mobilise with a wheelchair as they could no longer walk long distances. We also noted that during the period of the plaster cast being on, their assessed risk level had remained the same despite the person requiring the use of the wrist when mobilising with a walking frame.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service uses an electronic medication management system to ensure staff who administer medication, can easily document medication administration, along with other observations that are logged so to maintain a clear and accurate audit trail. We observed a staff member during their medication administration duties which they did so safely, ensuring that people received their prescribed medications as required and in a timely manner. Staff administered medicines to people in a way that showed respect for their individual needs, for example, they explained what was happening, sought people's consent to administer their medication and stayed with them while they took their medicines to ensure that it had been administered safely. Staff had received training in administering medicines and had their practice checked periodically. We reviewed medication administration records for 13 people and found these to be in good order. Medication was stored and disposed of safely.

Staff had a good knowledge of how to keep people safe and protect them from potential harm. They were able to indicate how people may be at risk of harm or abuse and how they would go about protecting them and ensuring their safety. Staff told us that they would escalate their concerns to the manager. If the concerns were about the manager staff stated they would contact the provider and/or other external agencies, such as, the Local Authority. Staff knew about the provider's whistleblowing policy and procedures. Staff had all the information they needed to support people safely.

The service ensured that it employed suitable staff because a clear recruitment process was followed. This made sure that staff were suitable to work with people in a care setting. Relevant checks had been carried out including obtaining at least two references, ensuring that the applicant provided proof of their identity and undertaking a criminal record check with the Disclosure and Barring Service (DBS).

Inadequate

Is the service effective?

Our findings

At our inspection in May 2016 we noted that most staff had received training to carry out their role however had not received any refresher training nor had their competencies been assessed.
At our inspection in November 2016 the then manager informed us that they had been looking at available training dates, however at this inspection we found that several of the staff had still not received refresher training.

Staff told us that they had received training from the local authority and provider on how to meet the needs of the people they supported. However records we viewed were not up to date and did not demonstrate that staff were competent in their roles. In one staff folder we found the member of staff last received training in subjects such as Safeguarding, Mental Capacity Act and manual handling in 2015. Training records did not show that the staff had been offered or attended yearly refresher training despite this being highlighted at our inspection in May 2016. The care supervisor informed us that the current training being provided needed to be improved and was in the process of being overhauled. One member of staff informed us, "The only training I have done recently was for the new medication system." The managing director wrote to us after this inspection informing that a new training program was set to be rolled out in the very near future, as they had also identified this was an area, which needed to be improved. We are concerned that the new system had not been rolled out over a year after our last inspection and there was no indication when it would be introduced.

Staff records showed that several of the staff working in the home had not received any formal supervision since December 2016 with some staff going back to February 2016.The manager and care supervisor informed us that informal supervisions with staff were undertaken however, this was not recorded and could not be evidenced. The manager also added that since they had commenced employment at the service January/February 2017 they had not received any formal supervision or progress review to assess how they were progressing in their role. The manager and care supervisor informed that they had held informal conversations with each other but the manager was yet to have a formal and recorded conversation with the provider to demonstrate that the provider had given them the support they needed.

This was the case when we inspected the service in May 2016, despite a period of improvement during the November 2016 inspection the improvements had not been sustained.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to this inspection the commission asked the provider to ensure that appropriate action was taken in regards to heatwave guidance provided by the department of Health. This guidance asked providers to carry out risk assessments in relation to the risks involved to people's safety. The local authority had also highlighted this guidance to the provider.. We found the manager had pinned the guidance in the corridor and although this information was accessible to everyone in the home, they had not carried out an individual risk assessment on people using the service and there was no proof that staff had read the

guidance. This was a concern to us as observation during the inspection on the first day we found staff were not always encouraging people to take in fluids outside of meal times. We observed two sets of visiting relatives assisting two people with fluids. We spoke to a visiting relative about what we had observed and they informed, "This is what we have to do, staff are not always around so we are left having to make sure our relatives have had a drink especially in this hot weather." The temperature at the time of our observations was 31 Degrees Celsius. We also found fluid charts in the 'Ongoing Care Record Booklet' (OCRB) were not always totalled and did not give a true reflection of people's fluid intake and output. In light of our observations we were concerned that people using the service may be at risk of dehydration. We wrote to the provider after our visit and they assured us that guidance from the Department of Health would be followed and sister homes would also ensure that appropriate risk assessments were in place.

The service needed to improve the way mealtimes were organised and how choices were offered to people, including offering clear support and explanations to people as to which meal choices were available. In the lounge, we observed people eating their lunch sat in a comfortable chair or in the dining room. We saw staff supporting people to eat in the lounge and one person in their bedroom. Staff were seated next to, or in front of the person they were assisting or encouraging to eat. Although staff were heard asking if the food was satisfactory and people were offered some encouragement to eat, there was no explanation nor description of what people were eating.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We looked at whether the provider had considered the MCA and DoLS in relation to how important decisions were made on behalf of the people using the service. Details on how to involve the person in decision-making according to their individual levels of understanding and preferred communication methods were included in each person's care plan. In addition an Independent Mental Capacity Advocate (IMCA) was available when required to advocate for people, to ensure that people's rights in this area of their care were protected.

The manager had an understanding of the principles and practice of the Mental Capacity Act 2005 [MCA] and Deprivation of Liberty Safeguards [DoLS]. The manager informed us that they worked hard to ensure that people's needs and rights were respected. Appropriate applications had been made to the Local Authority for DoLS assessments.

We found that everyone's capacity assessments had been recently reviewed and people's ability to make an informed decision had been assessed and appropriate support plans were in place. For example, one person needed support with their medication, it had been identified that the person did not understand why they were taking the medication however, staff would explain it to them and encourage them to take it. Our observation of the medication round confirmed this.

In general, people had received effective support to care for their healthcare needs from the GP, District

nurse and end of life care team who visited people requiring support on a regular basis. However information provided by healthcare professionals was not always used to update people's care plans. Records we reviewed confirmed this.

Requires Improvement

Is the service caring?

Our findings

Although some people and their relatives told us staff were caring and kind, our observations showed this was not always consistently applied. Most of our observations noted that staff were mainly communicating with people when they were offering to support people with personal care or offering meal provision. This suggested that the care provided for people was task and routine based rather than person-led.

Staff did not support people in a person centred way, their responses and interactions with people were often task led and routine based. For example, people at times had to wait long periods of time before being supported. Staff engagement with people was poor as staff did not always spend time speaking with them or acknowledging them as individuals. We observed one person repeatedly calling out however staff did not provide any reassurance as they were assisting others and could only afford them time as they walked past the person and would tell the person that they would get back. Staff did however return to the person but 30 minutes had lapsed.

Not all people who used the service received interaction with staff other than being given a drink. Most people in the main lounge spent time either asleep or looking ahead without engaging in their surroundings. Throughout our inspection we observed one person trying to engage with staff but repeatedly staff walked past them and did not make any eye contact or attempt to respond to them despite the person holding their hand out to staff that were walking past them.

We noted that people were smartly dressed. Staff informed us that people's well-being and dignity was very important to them and ensuring that people were well-presented was an important part of their caring role. People were able to maintain contact and continue to be supported by their friends and relatives. People's relatives told us that they were able to visit the service at any time without restrictions.

We found advocacy information displayed within the service. An advocate provides support and advice to people and is there to represent people's interests. However, when we spoke to people and relatives about who they would turn to should they need external support they had very little knowledge of whom they would speak to.

Inadequate

Is the service responsive?

Our findings

At our inspection in May 2016, we found people did not always receive care in a person centred way because the deployment of staff meant staff's approach was mainly task and routine focused. This meant that interactions between staff and people using the service were primarily focused around the provision of drinks and meals. During the inspection in November 2016 we also found that people's care was not always planned and assessed to ensure people's safety and welfare. Care plans were not fully reflective or accurate about people's care needs. Some people's care plans did not contain sufficient relevant information on how their dementia affected their day-to-day living and how they were to be supported by staff.

Prior to the inspection, we had received concerns that the night staff were waking people up in the early hours of the morning (between 4-5am) as this would help the day staff. We carried out an early morning visit and our findings confirmed the concerns we had received. We arrived at 04.35am and found that three people were up and dressed in the main lounge with a hot drink in front of them however they had all gone back to sleep. On reviewing every person's care plans we could not find anyone who had a preference of being up before 6am.

One staff member informed us, "Some of the people like to get up early so we assist them to get up and make them a hot drink." However, our observations showed that despite staff saying people liked to get up, they had gone back to sleep and hot drinks provided by staff had not been drunk. Staff added, "On the night shift it is very busy as we have to do the laundry, hoovering, clean and set the tables and disinfect the chairs. We also have to complete room checks and pad changes." This meant that people did not always receive care in a person centred way because the deployment of staff meant staff's approach was mainly task and routine focused.
We observed one person become anxious or distressed. Staff supporting the person did not appear to know how to calm the person down. The person's care plan did not contain any information on how staff would manage the person's behaviour. In addition, assessments of the behaviours observed and the events that preceded and followed the behaviour were not consistently robust, completed or easily accessible to provide a descriptive account of events including staff interventions. The manager intervened however also found it difficult to support the person who was very insistent on leaving the home. On reviewing the person's risk assessment, we could not find any information on how to best support the person when they became anxious.

Despite healthcare visit logs indicating that, people were having regular visits from healthcare professionals this information was not always being transferred or used to update people's care plans. For example, one relative informed us during the inspection that staff in the home had told them that their relative had been assessed as end of life however, the manager of the home had told them otherwise. We advised the relative to contact their relative's GP to get clarity as this would be essential in ensuring the person was receiving appropriate care. We also found one person who had been prescribed cream, instructions on the marchart stated that this was to be applied for a three-week period; however we could not find any information within their skin integrity care plan as to the rationale for this being prescribed. The person's care plan stated that their scalp was very sensitive due to a serious medical condition and should be kept moisturised and they

were to wear a cap at night to try to prevent them from scratching. A recent letter from a healthcare professional suggested mittens and/or a helmet to stop them from touching their scalp. However there was no care plan in place that specifically focused on the care required to manage this healthcare needs. Our observations also saw that the person was not wearing any protective covering or mittens during the night to protect their scalp. The scalp looked dry and brittle and was not moisturised to prevent itching. Their mobility care plan was out of date. It stated they required a stand aid and small sling to assist with moving, however the person was no longer able to mobilise and the stand aid was out of action. Documentation had not been revised to reflect current needs and how these were to be managed safely. This was discussed with the manager and we were advised this would be reviewed.

There were no meaningful activities for people living with dementia. Staff informed us that since the company's activities co-ordinator had left the service's employment (Dec 2015/Jan 2016) the home staff had to do and plan social activities. They told us this was not always possible as there was not always enough staff on duty. In addition, there was no indication that reminiscence, including memory boxes, objects of reference and 'life story work' was used to help trigger memories or enable people the opportunity to independently entertain themselves. Our observations throughout the inspection showed there were few opportunities provided for people in regards to planned social activities. There was a lack of meaningful engagement and people were not supported to pursue their interests or hobbies. There were no activities in the afternoon on both days. A staff member informed us, "When we get time we will sit down and talk to people, however most of the time we put a music DVD on, the television".

Improvements were needed to ensure that all the people living at the service received support to engage in their favourite pastimes and live an active life. We found that people's care plans clearly identified their interests and likes in regards to social activities, however on looking at people's care plans and observations it was not clear as to how people were being encouraged to have their needs met.

After the inspection we wrote to the provider to ascertain who was responsible for planning and arranging activities. The provider informed us that they were in the process of recruiting an activities co-ordinator however at present the responsibility lay with the manager and their staff.

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

People and their relatives told us that if they had any concern they would discuss these with the management team or staff on duty. People told us that they felt able to talk freely to staff about any concerns or complaints. There was a policy and procedure in place, however we found people's concerns had not always been acted upon despite staff taking written statements. For example, one relative spoken with during this inspection informed us that they had lost faith in the manager and did not feel that concerns or complaints brought to their attention would be dealt with. They had recently been given conflicting information about the health and welfare of their relative as staff informed them that their relative was on end of life care however, the manager said that they were only being cared for in bed.

Inadequate

Is the service well-led?

Our findings

At our inspection in May 2016 conditions were imposed on the provider's registration which centred around the provider having effective governance systems in place to ensure the quality of the care. At this inspection we found that these systems were still not in place and the provider was not regularly and effectively reviewing the quality of the service. Opportunities to sustain and build on improvements from November 2016 had therefore been missed. We are therefore seriously concerned about how the provider ensures that its senior leadership communicates, monitors and audits the service to ensure that it is meeting the fundamental standards of care and raising the quality overall

At the time of the inspection the service did not have a registered manager. The manager informed that an application to be formally registered with the Care Quality Commission had not been made. We found the service had a lack of clear leadership in regards to who was managing and running the service. The current manager in post did not to have the necessary support to improve a service that had been failing. As they had not been made aware of the services past compliance history and outstanding actions mentioned in the paragraph above.

Although some systems were in place, they were ineffectual and had not highlighted the areas of concern we had identified at this inspection. There was no evidence to show that the provider's quality assurance systems effectively analysed and evaluated information so as to identify where quality or safety were compromised, to drive improvement or respond appropriately. In addition systems in place did not mitigate risks relating to the health, safety and welfare of people using the service. For example, quality assurance checks were in place to monitor and make sure that an analysis of accidents and incidents or falls were completed at regular intervals to identify and analyse the data or to establish what caused them. However, the accident records for two people were viewed and these showed over a period of several months that they had experienced several falls or sustained an injury. No analysis of the information was in place to monitor potential trends, for example, the frequency of falls, the specific circumstances surrounding the fall and the actions to be taken, such as, referral to the local falls team or a discussion with the person's GP to review their medication.

Records relating to staff employed and people using the service were not properly maintained. This related to staff training, induction and supervision. Where the provider had completed an internal audit and areas for improvement had been highlighted, no evidence was available to show where these had been completed or required to be followed-up. For example, the audit for December 2016 highlighted that care plans for all people using the service required completion and risk assessments required review. Our evidence at this inspection showed that these remained outstanding and had not been completed.

The provider did not have an effective system in place to review staffing levels to ensure that the deployment of staff was suitable to meet people's needs. It was apparent from our inspection that the absence of robust quality monitoring was a contributory factor to the failure of the provider to recognise breaches or any risk of breaches with regulatory requirements sooner. The provider was unable to demonstrate how they intended to comply with the regulations as set out in the Health and Social Care Act

2008. This showed that there was a lack of provider and managerial awareness and oversight of the service as a whole as to where improvements were required.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care was not always delivered in a person centred way. People were not supported to express their preferences and care was not designed with a view to achieving service users' preferences and ensuring their needs were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Where risks were identified, suitable control measures were not put in place to mitigate the risk or potential risk of harm for people using the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurances processes were ineffectual and had not highlighted the areas of concern. The provider's quality assurance systems did not effectively analyse and evaluate information so as to identify where quality or safety were compromised, to drive improvement or respond appropriately.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received regular training and supervision.

Staffing levels at the service was not maintained at safe levels at all times