Care Quality Commission

Centenary care Homes Limited

Centenary House

Inspection report

70 Charlton Road, Shepton Mallet, BA4 5PD
Tel: 01749 342727
Website: www.centenarycare.co.uk

Date of inspection visit: 16 and 17 October 2014
Date of publication: 14/04/2015

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

This unannounced inspection took place on 16 and 17 October 2014. This inspection took place because of concerns we had received.

The last inspection of Centenary House was carried out in February 2013. No concerns were raised at that inspection.

The care home is registered to provide accommodation and personal care for up to 23 people. It specialises in the care of older people.

There is a registered manager in post. 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.

Although people told us they felt safe in the home we found a number of concerns. People were not always receiving the care and support they needed because staff were not available to respond and assist people when required. There was a lack of appropriate arrangements for recruiting staff and a failure to undertake the required checks when employing care staff.

People told us they received their medicines when they needed them. However, we found the arrangements for

Summary of findings

the management and stock control of medicines were inadequate. There were medicines being kept for a long period, some of which had been prescribed for people who were no longer in the home.

People told us they found staff "caring and kind" and there was a warm and friendly atmosphere in the home. However there were some areas which needed addressing to ensure people received a caring service in respect of basic care needs. For example making sure people were wearing appropriate clothing.

People had access to a range of health care professionals to make sure their needs were assessed and they received appropriate support and treatment. However there was no system for the assessment, monitoring and review of people's nutritional needs. Although risk assessments had been completed to reduce the risks to people, we found there was no written guidance about how people were to be kept safe in the event of an emergency.

There were inconsistencies in the care planning information about moving and handling tasks. There was a potential for people to receive inappropriate or unsafe care through staff not being told accurate information about how to support individuals safely.

Whilst there were some activities they did not always meet people's preferences or reflect their interests. People were enabled to make choices in how they lived their lives. There was a welcoming environment and relatives spoke of friendly and approachable staff.

People were confident talking with the registered manager about any concerns and felt they would be listened to however there was no sense of people being fully involved in the development of the service. People were given very little opportunities to comment on the quality of care and make suggestions about improvements.

There were inconsistencies about the approach of the registered manager in how they managed the home, supported staff and how they ensured there was an environment where staff were valued and respected.

From what we were told the registered manager was committed to caring for the people who lived in the home. However they had failed to undertake important aspects of their role and responsibilities. Specifically in identifying areas for improvement and failures in care arrangements such as management of medicines, aspects of care planning and in undertaking safe recruitment practice.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

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?

Inadequate

The service is not safe.

People were not protected from possible abuse because the required criminal record and other required checks for employees had not taken place.

People told us they felt safe in the home and relatives said they were confident the people they represented were safe.

Staff had some understanding of abuse but had not completed any vulnerable adults or Mental Capacity Act 2005 training to ensure they had a thorough knowledge and understanding of these areas of practice.

There were inadequate arrangements for the safe storage and management of medicines.

Is the service effective?

Requires Improvement

The service was not always effective.

There was no system in place for the assessment and monitoring of people's nutritional needs.

Staff received training but there was a failure to provide support and review staff performance through individual supervision.

People had access to a range of healthcare professionals to meet their individual needs.

Is the service caring?

Requires Improvement

The service was not always caring.

People were able to make choices about their daily lives but not consistently involved in decisions about their care arrangements.

People were supported by staff who were kind and patient and generally had respect for people's dignity and privacy and how people wanted to lead their lives.

People were supported in a caring and sensitive way when receiving personal care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were potentially at risk because care plans failed to provide consistent and accurate information about some aspects of people's care.

People did not always receive a personalised service and the activities were not always meaningful to the individuals in the home.

Summary of findings

People felt confident about voicing their views and concerns.

Is the service well-led?

The service was not well led. There were significant shortfalls in how the service was managed and people were protected.

There was not a consistently open and supportive environment where staff were empowered and felt valued.

There was a failure to undertake quality monitoring of the service in order to identify areas for improvement.

People receiving the service found the management of the home approachable and accessible.

Requires Improvement

Centenary 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 16 and 17 October 2014 and was unannounced. At our last inspection of the service we did not identify any concerns with the care provided to people.

The inspection was carried out by an adult social care inspector. The inspection had been undertaken as a result of concerns we had received about the staffing, management of the home and the quality of care people were receiving. Before the inspection we looked at the information we held about the home and spoke with local authority commissioners.

During the inspection we spoke with five people who used the service, three relatives and five staff. We spent time with the registered manager discussing their views about how they managed the service and the quality of the care provided. We looked at a number of records relating to individual care and the running of the home. These included four care plans, medication records, recruitment, training and records of accidents and policies and procedures. We also observed staff interacting and supporting people and how people were supported to have meals.

Inadequate

Is the service safe?

Our findings

Although people told us they felt safe in the home we found a number of areas of concern. One person told us "Nobody takes advantage of you here, I certainly feel safe". We asked this person what they would do if something did happen i.e. spoken to harshly or disrespectfully and they told us they would tell the registered manager "and she will do something about it". Another person told us "I like it here; I am safe here and get the help I need."

People were at risk of abuse because the provider had not checked staff were suitable before they commenced employment. Records of staff recruitment showed four of the seven staff records had not had a current criminal record check. Two had not had relevant information about their last employment requested when they were employed. There was also no evidence staff members, where applicable, had the necessary paperwork to work in this country. The provider's policy on recruitment said "All offers of employment are made on condition that two satisfactory written references are obtained" and "When recruiting new staff the home will refer to the Protection of Vulnerable Adults register and will perform a full police check". We saw this policy had not been followed.

This is a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 19 of the Health and Social care Act 2008 (regulated Activities) Regulation 2014.

We asked staff about their understanding of abuse and how to protect people from possible abuse. They were able to give us some examples of what is seen as abuse and told us they would report any concerns to the registered manager. However, when we looked at staff records we saw staff had not completed safeguarding vulnerable adults training and this was confirmed by the registered manager. The registered manager told us it was discussed as part of staff induction but by not receiving specific training, staff may not have had the depth of knowledge and skills to protect people from the risk of abuse.

Medicines were stored in locked cupboards and a trolley in a corridor of the home. However, there were inadequate arrangements for the storage and management of some medicines. A fridge, located in the corridor, used for medicines was unlocked in the morning and remained unlocked until the afternoon when we informed a member of staff. At the time, the only medicine held in the fridge was insulin. However this should be securely stored. There were a number of bags in the office which held medicines to be returned to the pharmacist. The registered manager told us they had been waiting "some time" for the bags to be collected by the pharmacist and had contacted them on more than one occasion. The office was not locked during our visit which meant anyone could have had access to this medicine.

There was a medicines storage cupboard. There was a significant level of medicines in stock some of which dated to June 2013. It held a number of medicines for a person who had died in May 2014. There were also medicines dated 30 June 2014 for an individual who had moved to another care home. This demonstrated that there were not effective systems in place to dispose of medicines after they were no longer required.

The evidence above, relating to medicines, demonstrates a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 (f) & (g) of the Health and Social care Act 2008 (regulated Activities) Regulation 2014.

People's individual risks were considered and managed. For example, there were risk assessments about people's daily living skills, such as moving around the home, leaving the building and behaviour which may challenge staff or others. There was a risk assessment about one individual who could be challenging towards others. When asked, staff were able to tell us how they responded to this person's behaviour.

However, there were no personal evacuation plans or risk assessments in the event of emergencies such as a flood or fire. This meant staff and the emergency services would not have had written guidance to ensure people were kept safe in the event of an emergency. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 9 (3) (b)-(h)of the Health and Social care Act 2008 (regulated Activities) Regulation 2014.

Prior to the inspection we received concerns about the number of staff available to support people. At the time of our visit there were 11 people using the service. The registered manager confirmed there were nine care staff employed. From staffing records we noted only one of these had been employed for longer than a year. The

registered manager acknowledged there had been a number of staff leaving over the past year. A healthcare professional told us they had concerns about the continuity of care and the knowledge base of staff. Another healthcare professional told us they were concerned the provider wanted to care for people who were not suitable to live in the home, or that they had the staff available to meet people's needs.

The registered manager worked 9am-5pm weekdays. There was one cook and one domestic on duty, care staff undertook laundry duties. Staff told us they worked 14 hour shifts and rotas showed there was two care staff on duty 8am to 3pm and 8am to 10pm with one additional staff working 3pm to10pm.

There was two night staff one of whom was sleep-in from 10pm to 8am. This meant there was one staff to respond to people's needs unless they called the sleep-in staff for help. We noted how one person had been assessed to be repositioned hourly because of risk of damage to their skin and pressure wounds. Care records showed repositioning had not taken place hourly during the hours 10pm to 8am. We discussed this with the registered manager who told us during this time the staff member on duty would not reposition the person. However they would move the person off areas of their body which were at risk for 60 seconds to relieve pressure. We questioned how effective this was in alleviating the risk of pressure wounds. After our inspection we spoke with a health care professional who told us they would have concerns about this practice. We then spoke with the manager who told us since our inspection the person had been re-assessed and was now being repositioned 4 hourly. However, this would require two staff available at night to reposition this person.

Staff took breaks of up to ten minutes during their shifts. On these occasions there was only one staff member available to respond to people or provide care. Staff told us how busy the service was and how at times there was "Just not enough time". One told us "Another staff member would provide us with time for people". They told us of an individual who walked around the home and did not always get the attention they needed. Another told us they were not rushed and "always have the time". During the inspection a relative told us how they had visited the home at 10:30am on one occasion and their relative was still in bed. They said their relative did not normally stay in bed until this time. They told us "I would say they need more staff." They told us how the basic care was not always available. For example, making sure their relatives clothes were changed, on one occasion when going out their relative had not been wearing socks".

We observed the availability of staff to respond to people and provide support or assistance. During the morning of our visit, on a number of occasions, for periods of up to ten minutes, we observed staff were not available to support or assist people in the lounge area of the home. On these occasions people were either restless, calling out for help or wanting assistance. On two occasions lasting ten minutes the cook responded to one person who was repeatedly asking for something to eat. Whilst this was provided, staff were not available to sit with this person and spend time with them.

During lunchtime two care staff were available to support and assist people with getting and having their meal. People were spending up to ten minutes sitting waiting for their meal; one person continually got up from the table and another was asking where their meal was. At one point a staff member left the dining area and went to sit with another individual helping them with their meal. Whilst this may have been necessary, it left one staff member to support the other eight or nine people who were waiting for their meal, some of whom needed some form of assistance. This meant people were restless and had to wait a considerable time before receiving their meal. The atmosphere during the meal was not relaxed or well managed. In the afternoon availability of staff improved with staff being visible and available through most of the time we were observing. We saw staff were able to spend time sitting with people or engaging in an activity.

We asked the registered manager how they decided on the level of staffing. They told us they made a judgement based on people's dependency needs being low, medium or high. At the time of our visit there were two people who were high. They were either cared for in bed, needed all care, with limited or no mobility and required hoisting. There was no record demonstrating how the assessment was made as to people's level of dependency or if these assessments were reviewed. They told us they had raised with the provider about additional care staff being employed and reviewing the salary in an attempt to improve retention and recruitment. We noted some comments made by staff in a provider's visit report of 24

Inadequate

Is the service safe?

July 2014. Comments included; “will be happier when we have more staff”, “we have some new staff but they have not stayed” and “we need another weekend staff”. One comment said “good staff team”.

This lack of staffing to respond to people’s needs is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 18 (1)of the Health and Social care Act 2008 (regulated Activities) Regulation 2014.

Requires Improvement

Is the service effective?

Our findings

We found people were not protected from the risk of inappropriate care and treatment because people's records lacked the information needed. For example, there were no systems to assess people's nutritional needs and no information about how to meet and monitor their nutritional well-being. One person had a variable diet and at times ate very little whilst on other occasions ate well. There was no nutritional assessment or nutritional care plan for this person to identify how to meet this person's nutritional needs effectively.

Where some people required the use of bed rails there was no assessment of their mental capacity to consent for their use. Care plans did not have a record of how people had consented to the care and treatment they received. For some people DNACPR (do not attempt cardiac pulmonary resuscitation) had been completed by a GP and relative but there was no evidence in the records to show if the person's mental capacity had been assessed.

The lack of appropriate information is a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 (2)(d) of the Health and Social care Act 2008 (regulated Activities) Regulation 2014.

Staff told us they had received training including infection control, moving and handling, first aid and medicines. We looked at records of six staff who had been employed for longer than three months. For four there was no evidence of regular individual supervision. One member of staff told us they could not recall when they last had individual supervision. Their records showed one supervision session in May 2014. The provider's policy on staff supervision said "All care staff should have supervision at least six times in 12 months" It said "Staff supervision is essential in developing and maintaining high care standards and in supporting and developing care staff".

Staff told us they had not received any training about the Mental Capacity Act 2005 (MCA). They were not aware of the Deprivation Of Liberty Safeguards. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant.

However staff were able to tell us about how they involved people in decisions about their daily lives. These ranged from when someone wanted to get up to where they wanted to be in the home. We observed staff asking people where they wanted to sit. One person told us they felt they were able to make choices about their daily life. They said "It is up to me what I do and the staff respect it is my choice".

One person was being deprived of their liberty under the Deprivation of Liberty Safeguards (DoLS) set out in the MCA. DoLS provides a legal process (authorisation) by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. The registered manager was aware of recent changes which determined when a person may need to be deprived of their liberty. The registered manager was also aware of the need to review the authorisation to ensure it was still legally valid.

Care staff were aware of the restrictions made on this person's freedom of movement. One care staff told us how they tried to make sure the individual was regularly able to go into town under supervision. Staff recognised how the person's lifestyle before moving to the home had been very different to their lifestyle now they were living in a care home and had restrictions placed upon them. As a consequence staff wherever possible made sure the person had access to the outside space at all times.

People had access to a range of community health services such as chiropody and dentist. One person told us "I can see my doctor when I want I only have to say and staff arrange for me to see them". Another person said "If ever I am unwell they are very quick to get a doctor". One person told they were going to the local optician. Records showed people received regular visits from their GP. Where people required community nursing support this had been arranged and this was confirmed by care records. We spoke with a healthcare professional who told us they were visiting to support staff and as part of monitoring a person's health needs and wellbeing.

People told us they enjoyed the meals and there was always a choice of meal. One person told us "There is always something you will like". Another person said "I enjoy the meals here, the food is always good". A third person said "I like the food they seem to know what I like and don't like.

Requires Improvement

Is the service caring?

Our findings

People told us they found staff "caring and kind". One person told us "this home is very caring and carers are loving". Another person said "You cannot fault the staff they really try to look after you". We read a comment from a relative which described the home as "such a caring environment". They also said how they were made to feel welcomed as did another relative we spoke with.

However we found areas to make sure people's dignity was respected required improvement. For example, one relative told us of a matter of concern which we, with their agreement, discussed with the registered manager. This was about an occasion when they took their relative to their home and found they were not wearing underwear only a continence pad. This was not dignified for the person. The registered manager said they would look into this and talk with the relative. Another relative said how staff did not always make sure their relatives clothes were changed when this was needed and on one occasion when going out their relative had not been wearing socks. We also read minutes of a staff meeting. One of the subjects raised was specifically about ensuring people's dentures were cleaned and laundry was washed and cared for appropriately.

Some people told us how they had been asked about their care needs and also knew of their care plan. One person told us "I know they talk about my care and sometimes I am asked if everything is all right". People told us how they were able to make choices about whether they sat in their room or in the lounges, what time they got up and went to bed and generally how they spent their time. One person told us how they were not really interested in the activities which were arranged and staff respected their decision "They don't try and make me go to the lounge for activities they know most of the time it is not for me". Another person told us they felt their privacy was respected. They said "Staff respect my choice and don't try to impose things on me. I try to be as independent as possible and staff know I want to be independent."

We asked staff what they understood by caring. They told us: "it is treating people as individuals", "being sensitive when supporting people with personal care", "being respectful and treat people with dignity and remembering people's dignity". We observed staff interacting with people in a caring, dignified and supportive manner. On one occasion we saw staff supporting a person using a hoist whilst transferring. They did so thinking of their dignity and explained what they were doing. On another occasion a care staff asked a person if they wanted to use the toilet and they did so in a quiet and sensitive manner. When staff spoke with us about people they did so in a respectful manner and were very conscious of people's disabilities and how this affected their lives.

We observed staff supporting an individual who was distressed. They did so in a calming and reassuring manner without demeaning the behaviour. The person asked the same question repeatedly and staff were patient in their response, reassuring the person and then able to re-direct them to the lounge.

Requires Improvement

Is the service responsive?

Our findings

People were potentially at risk because records failed to provide consistent and accurate information about some aspects of people's care. We had also received information of concern about the arrangements for supporting people with moving and mobility and about the instructions and information available. We found there were assessments of people's care needs such as moving and handling and mobility but there was inconsistent information about how to support people. For example one person's care plan stated they "walk with a zimmer frame". However we were told this person was no longer mobile and required the use of a hoist for all transfers. The care plan did not provide this updated information which meant staff reading the care plans would not have the information required. The same care plan also stated the person was bathed using a bath lift however we were told they were now being given a "bed bath". For another person the care plan stated "mobilises with four wheel zimmer frame encouraged with two carers" however in another section of the care plan it stated the person required "minimal assistance".

There was no written evidence of how people were involved in decisions about their care arrangements or if they attended, if they wished, reviews of their care arrangements.

There was also little information about people's personal circumstances and history, preferences, routines and interests. Staff were able to tell us about some aspects of people's likes and dislikes such as how one person liked to have their bath, one person's interest in sports and what clothing people liked. However they knew little about people's histories and personal circumstances such as interests and occupation. This meant there was no information available to staff to make sure people received a personalised service which recognised people as individuals.

This lack of up to date and accurate information in people's records is a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 (2)(d)of the Health and Social care Act 2008 (regulated Activities) Regulation 2014.

We asked people about the activities which were available. There were varying views with one person saying "there are plenty of activities" whilst three other people said: "not really much going on", "one thing missing here is activities, very little activities", and "not much entertainment, we used to get music people coming to the home". One person told us how they attended regular communion services in the home whilst another said the activities were "not my thing". There was an activities record and this showed activities such as crafts, skittles, dominoes and sing-along had taken place. We were told about one person who had an interest in flower arranging and had undertaken a flower arranging activity. One staff member told us they were completing a life story book with one person. A staff member told us they wished there was more time to spend with people. One staff member said "Another staff member would provide time for people." another said "people should be more involved with more activities".

People told us how their relatives were always "made to feel welcome" when they visited the home. One person told us "My relative often visits and says how nice it is to come and see me with staff that are so friendly". Relatives told us they were able to visit at any time and one said how they "always felt informed and involved". Another said they visited often and "It is never a problem, they always keep us informed as well which is so nice". There was a small lounge which was used by relatives rather than people having to go to their rooms.

People told us if they had any worries or concerns they would discuss them with the registered manager. They were confident they would be listened to and "she would do something". People told us they knew they could make a complaint if they wanted. One person said "I suppose I could complain but have never needed to. I express what I have to say and they listen to me".

Requires Improvement

Is the service well-led?

Our findings

During this inspection we found a number of areas which required improvement. For example, record keeping, recruitment processes, management of medicines, managing some areas of risk and staffing arrangements. We asked the registered manager about how they monitored the quality of the service. The registered manager confirmed they had not completed any audits or quality monitoring recently. The last monthly house check, normally completed by the registered manager had not been completed since July 2013. This meant there was no effective system to monitor the quality of the service or identify areas of concerns or risk and drive improvement in the service.

Although the provider undertook monthly visits to the home and produced a report with recommendations. We found the report did not include exploring the registered manager's quality assurance systems and performance. There was an opportunity for people to talk about their views of the service with the provider and we noted people had spoken positively about the staff and care they received. These visit reports also looked at the premises in terms of decorative state and any need for repairs. A visit in May 2014 had identified some actions regarding the premises and improvements; however there were repeated actions when another visit had taken place in June 2014. These included repairs and updating parts of the home. The registered manager told us they were aware of these actions and was in the process of arranging contractors to undertake some work. For example repair of lighting fixtures in a shared bathroom. They told us there was no maintenance person employed to undertake day to day tasks.

There was a falls and incidents monitoring record. This recorded a number of incidents where people had been found with minor injuries such as bruising. However there was no record of what actions, if any, had been taken following these incidents. This meant there was no information about the actions needed and no system that enabled the registered manager or the provider to check if appropriate action had been taken to manage the risk to people.

This lack of quality assurance systems and information to manage risks is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social care Act 2008 (regulated Activities) Regulation 2014.

We discussed with the registered manager their view about the service and what they wanted to achieve. They told us they wanted an "open, transparent service….everyone feels able to speak out, air their views and involve residents as much as possible". They said they wanted to "deliver good standard person centred care, top priority residents are safe, quality of life was maintained and know they feel cared for".

Staff had mixed views about the management of the home. There was a view that the registered manager was supportive and approachable: "Very helpful, a good manager" "cared about the residents". There was also a view there was not an open approach and listening to staff views. Some staff told us how at staff meetings they did not feel listened to or "believed". We were told how the registered manager had told staff off in front of other staff. One person told us how the registered manager "sometimes speaks to staff not very nicely".

However people told us the registered manager was "always around" and "approachable". One person said "I can talk to her because I say what I think". We asked people if there were residents meetings and were told no. One person said "No I would like it, think it would excellent idea". We were told by a staff member there had been residents meeting in the past.

We discussed with the registered manager, as part of our feedback, concerns around staffing of the home particularly the retention of staff and impact on consistency of care, experience and knowledge of staff. The registered manager acknowledged this had been an area of concern. They told us they were attempting to review salaries to help recruitment. We also discussed the shift arrangements of the home namely 14 hour shift. They told us this was a choice of individuals and not compulsory.

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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The registered person was not operating effective and safe recruitment procedures.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered person failed to protect people against the risks of inappropriate or unsafe care by regularly assessing and monitoring the quality of the service provided.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person was not protecting people against the risks associated with the failure to have appropriate arrangements for the management of medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered person failed to take appropriate steps to ensure that, at all times, there are sufficient staff to meet people's health and social care needs.**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered person failed to have procedures in place for dealing with emergencies.