Four Seasons Homes No.4 Limited

Marquis Court (Tudor House) Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 20 September 2016 and was unannounced.

Marquis Court (Tudor House) provides accommodation for up to 52 people who require nursing or personal care, divided into a nursing and a residential unit over two floors. Some people have more complex medical conditions and some people are living with dementia. On the day of our inspection visit, 36 people were living at the home.

We inspected the home in November 2015 and rated the home as Requires Improvement overall with specific concerns about the sufficiency of staff to meet people's needs and the effectiveness of the systems used to assess, monitor and improve the quality of the service. We received an action plan from the provider which said the improvements would be made by July 2016. At this inspection, we found some improvements had been made but further action was still needed. We also found improvements were needed in the administration and management of people's medicines and the risks associated with people's care.

There was a registered manager but they had recently left their employment with the provider and were no longer working at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The management of the service was being overseen by the regional manager and a nurse consultant, who had been brought in to deliver improvements at the service. The regional manager told us the provider was arranging for an interim manager whilst a permanent manager was recruited.

At the last inspection we asked the provider to ensure there were sufficient staff to meet people's needs at all times. At this inspection we found there were sufficient staff to meet people's needs but further action was needed to ensure staff were effectively deployed to provide timely support to people in communal areas and during mealtimes.

At the last inspection we asked the provider to make improvements to their quality assurance systems to ensure the quality and safety of the service was maintained. In the absence of the registered manager, some of the systems being used to monitor the quality and safety of service provided were not up to date and we found shortfalls in the management of people's medicines and the systems used to monitor the accuracy of care records. We found there was a lack of management oversight which meant that some people did not receive their medicines as prescribed and staff did not always take action when people's needs changed. Risks associated with people's care were not always well managed and some people did not receive care and treatment that met their individual needs and ensured their safety and wellbeing.

Whilst some staff were observed to treat people in a kind and compassionate manner this was not always demonstrated by other staff, who did not always treat people with dignity and respect. Staff did not always interact with people when they were supporting them. Staff and they encouraged people to make choices about their daily routine to promote their independence.

People told us they had enough to eat and drink but some people weren't happy about the quality and variety and meals and this was being addressed by the provider. People told us they received the support of other health professionals when needed.

Staff told us they received an induction and training to fulfil their role and the provider was taking action to ensure staff received all the training they needed to provide effective care. Staff felt supported by the management team overseeing the service but were concerned that the improvements that had been made would not be sustained.

Staff gained people's consent before providing care and support and understood their responsibilities to support people to make their own decisions. Where people were restricted of their liberty in their best interests, for example to keep them safe, the required legal authorisations had been applied for.

People were provided with opportunities to join in social activities and were encouraged to follow their hobbies and interests. People were encouraged to maintain important relationships and visitors were made welcome.

People felt able to raise concerns and complaints but did not ways feel action was taken. People told us they had given their feedback on the service but were not aware of any changes that had been made to improve the service.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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?

Requires Improvement

The service was not consistently safe.

Improvements were needed to the way staff were deployed during mealtimes and in communal areas to ensure people received support in a timely manner. Risks associated with people's care were not always well managed and some people did not receive care and treatment that met their individual needs and ensured their safety and wellbeing. People did not always receive their medicines as prescribed. Staff understood their responsibilities and knew what action to take if they had any concerns people were at risk of abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Improvements were needed to ensure people had a pleasurable mealtime experience and the provider was addressing this. Staff were provided with an induction and ongoing training to deliver effective care. Procedures were in place to act in accordance with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. People told us they received the support of other health professionals when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

We saw that some staff were kind and caring but other staff did not always treat people with dignity and respect. At times, there was limited interaction between people and staff. Staff encouraged people to make choices about their daily routine and be as independent as possible. Visitors were made welcome.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People felt able to raise concerns and complaints but did not ways feel action was taken. People were offered opportunities to join in group social activities and encouraged to follow their

hobbies and interests.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There was a lack of management and oversight at the service which had impacted on the quality and safety of some people's care. In the absence of the registered manager, some of the systems being used to monitor the quality and safety of service provided were not up to date and were not effective in identifying shortfalls and driving improvements. Staff felt supported by the temporary management team but were concerned that the improvements being made would not be sustained. People were asked for the views on how the service could be improved but they were not aware of any changes that had been made.

Marquis Court (Tudor House) Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 20 September 2016 and was unannounced. The inspection was carried out by two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information we held about the service which included statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. The provider had stopped admitting people into the home. They told us they had had identified concerns with the management of medicines, a lack of personalised care and poor documentation and had contracted a nurse consultant to deliver the required improvements. The local authority commissioning team who fund the care for some people at the home, carried out monitoring visits and told us they had concerns about the quality of care being provided and were working with the provider in relation to these to bring about improvements. We used this information to help us plan the inspection visit.

On this occasion, we had not asked the provider to send us a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However, we offered the provider the opportunity to share information they felt relevant with us

We spoke with eight people who lived at the home, three relatives, four care staff, one nurse and an

administrator. We also spoke with the regional manager and the nurse consultant. Some of the people living at the home were unable to speak with us about the care and support they received. We used our short observational framework tool (SOFI) to help us understand, by specific observation, their experience of care. We observed how staff interacted with people, and the support they provided in the lounges and dining areas.

We reviewed the care plans of six people and looked at other records relating to the management of the service, including quality checks.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we found a continued breach of Regulation 18 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were insufficient numbers of staff to meet people's care and treatment needs at all times. At this inspection we found that there were sufficient staff to meet people's needs but improvements were still needed because, at times, people had to wait for support because staff were not always deployed effectively.

People we spoke with told us there were times when there were insufficient staff available to meet their needs because staff were absent through sickness or holiday. One person said, "Sometimes there are enough staff but sometimes they get short staffed so I try not to use the buzzer, although they don't usually take too long to come if I do". Another person told us improvements had been made under the new temporary management arrangements and agency staff were brought in to cover absences. They said, "If you call them and they are short-handed they can't come immediately but it's better now that it has been. The provider is employing more staff now". Staff we spoke with told us that at times they felt stretched but they usually had enough staff and any absences were now covered by agency staff. One member of staff said, "We used to be short on shifts and having agency staff was a 'no no', but this has changed since the new managers have come in". Another said, "We are now allowed to use agency staff and staffing levels are better now we can use them".

We observed that most of the time there were enough staff to support people but at times there were no staff in the communal areas. There were no facilities for people to call for assistance in these areas and people told us they had to call out to staff when there were no staff members around. One person told us, "I don't have a call bell and there isn't one in here in the lounge. If there's a problem and anybody needs help I shout for the staff. I watch out for the other people here to make sure they are okay". On the residential unit, we observed one person called out for a drink three times and we had to go and find a member of staff to assist them. At lunchtime, there were delays in providing support to people who needed assistance to eat their meal. We saw that not all staff were deployed to support people with their meal, for example a member of the care staff was assisting the nurse to administer medicines.

We brought this to the attention of the regional manager who told us all staff should be available to support people with their meals. They told us staffing levels were based on people's dependency levels and a recent review had been carried out to ensure enough time was allocated to provide people with appropriate support at mealtimes. We saw that people's dependency levels were reviewed on a regular basis and whenever people's needs changed and rotas confirmed that the minimum levels set by the provider were being maintained and any shortages were covered by agency staff. The regional manager told us more staff were being recruited and they would look at how all staff were deployed to ensure people received timely support.

On the residential unit, people did not always receive their medicines to ensure their health and wellbeing. Whilst the provider had identified that improvements were needed to ensure people received their

medicines at the right time, we found that staff did not always ensure people's medicines were reviewed when needed. For example, checks of medicine administration records (MAR) showed that some people had refused their medicines and they had not been referred to the GP for a review in accordance with the provider's procedures. People's medicines were not always available when they needed them and action was not taken to obtain medicines that were needed on an urgent basis. Checks on MAR showed that four people had not received their medicines on some occasions because they were out of stock. For example, one person had not received medicine for chest pain for two days and another person had not received a medicine prescribed for pain relief for three days. This meant these people were at risk of experiencing pain or discomfort due to the delay. The provider was aware of this and told us there were problems with the supply of medicines via the pharmacy. They told us they planned to hold meetings with the GP's and the pharmacy to address the issues.

Staff did not always follow good practice when recording people's medicines. For example, where MAR charts were handwritten when people's medicines changed, another member of staff had not checked this for accuracy to ensure people received their medicines as prescribed. Topical medicine charts were in use for the application of external use creams and lotions. However, staff did not always sign when they administered these which meant we could not be certain that these were being administered as prescribed. Effective systems were not in place to ensure an accurate account was maintained of the medicines people received on an 'as required' or PRN basis, for example for pain relief. We counted the medicine held in stock for four people and found that this did not match the numbers recorded on the MAR chart which meant people's MAR charts were not accurately maintained and the provider could not be confident people had received their medicines as prescribed. The regional manager told us they would introduce a system to monitor the stocks on a daily basis. Medicines which were no longer needed were not stored in a tamper-proof cupboard in accordance with the Misuse of Drugs Act 197. This meant the provider had not addressed concerns raised at the last inspection. The regional manager told us they would ensure that this was actioned immediately.

The above issues demonstrate a breach of Regulation 12 (2) (f)(g) of the Health and Social Care Act (Regulated Activities) Regulations 2014, Safe care and treatment.

We saw that when people were supported to take their medicines, staff were patient, explained to people what the medicine was for and waited for people to take their medicine before moving on. We saw that people's preferences for taking their medicines were respected, for example one person liked to take their tablets one by one and we saw staff followed this

Risks associated with people's care were identified and management plans were in place to minimise the risks. However, staff did not always take action when people's needs changed. For example, one person had been assessed as needing to consume a set amount of fluid each day because they were at risk of dehydration. We saw the person's fluid intake was being monitored by staff but on three consecutive days, their total intake was well below the recommended level and action had not been taken to ensure their welfare. This meant the person was not being protected from the health risks associated with not having enough to drink.

Where people needed to be repositioned at regular intervals to minimise the risk of skin damage through pressure, we saw people did not always receive the care and support they needed. Staff we spoke with were not always clear about how often people should be supported to move and some of the care records we looked at were inconsistent or had conflicting information. For example, one person's records showed they should be repositioned at both two and four hourly intervals. Another person's records showed that gaps of more than the recommended four hours had occurred. There was no evidence available of any clinical

oversight to ensure people received their care as planned. This meant people may be at increased risk of developing skin damage.

There was no system in place for the safety monitoring of pressure relieving equipment and staff did not always have guidance in the correct use of equipment. One person told us their mattress was not comfortable and we asked staff to check the setting was correct. Staff had to obtain a manual for the mattress and it was found to be set slightly higher than recommended and was then reset. Staff confirmed that the information was not recorded in the person's care records. Whilst we saw that the regional manager had ensured that all defective pressure cushions had been replaced, there were no checks carried out to ensure all pressure mattresses in use were set correctly. This meant people were at risk of not receiving the required therapeutic support if the equipment was not set correctly.

Whilst these concerns did not result in people suffering actual harm, the provider had failed to recognise the risks and as a result was not taking action to people from avoidable harm. This is a breach of Regulation 12 (2)(a)(b) of the Health and Social Care Act (Regulated Activities) Regulations 2014, Safe care and treatment.

People told us they felt safe when staff supported them to mobilise. One person told us, "I've got equipment to help me move and I need two carers. They're not allowed to have one". We saw that risks to people had been assessed and safe moving and handling plans were in place to guide staff on how to minimise any identified risks. We observed staff moving people safely in line with their documented requirements.

People felt safe and liked living at the home. Relatives we spoke with told us they felt their relations were safe and well cared for by the staff. One relative told us, "The staff are very good". Staff we spoke with had received training in safeguarding and could tell us about the different types of abuse and what action they would take if they suspected someone was at risk of being abused. All the staff we spoke with knew how to escalate their concerns if necessary. Staff told us they felt confident any concerns they raised with the temporary management would be acted on. We were aware that the provider had made referrals to the local safeguarding authority and our records confirmed we had received the required notifications. This showed action was taken to keep people safe from harm.

Staff told us and records confirmed that the provider carried out recruitment checks for both permanent and agency staff which included requesting and checking references and carrying out checks with the Disclosure and Barring Service (DBS). The DBS is a national agency that keeps records of criminal convictions. The registered manager had checks in place to ensure that nurses were registered with the Nursing and Midwifery Council. This meant the provider followed procedures to ensure staff were suitable to work in a caring environment which minimised risks to people's safety.

Requires Improvement

Is the service effective?

Our findings

Staff received an induction to prepare them for their role which included training and shadowing more experienced staff. One person told us, "Sometimes you get a new member of staff but they're not allowed to help, they just watch and learn". One member of staff told us, "We work through an induction booklet with a senior, who's assigned to you as a mentor. You have theory and practical training for moving and handling and get observed by our in-house assessor before you are signed off as competent". Staff told us they received training in a range of topics to enable them to meet people's needs. Records showed that staff received training in areas that were relevant to the care of people in the home although we saw that some staff had not received training in areas deemed mandatory by the provider. We discussed this with the regional manager who told us that this had been identified and was being addressed. They told us that new competence checks were being introduced to identify gaps in staff knowledge, for example around the monitoring of people's nutrition and hydration and the effective use of creams to protect people from the risk of developing sore skin.

The provider had a performance and appraisal system and staff confirmed they received supervision on a three monthly basis and an annual appraisal. Staff told us they hadn't always found the process positive. One member of staff told us, "I didn't always feel listened to, for example if I raised concerns about staffing levels but I definitely think things are getting better with the new managers".

On the nursing unit, the lunchtime meal was not always a pleasurable experience. We observed that some people who needed support to eat their meals had to wait for staff to become available which meant that they were served their meal up to half an hour later than other people. Staff were not always attentive and did not engage with the person they were supporting. There was limited conversation and at times, the staff watched TV instead which showed that people's wellbeing was not being supported. Some people were not satisfied with the quality and variety of food. Comments included, "It's the same thing every week, every time. I'd rather have a bit of fresh stuff". Another said, "It says roast turkey on the menu but nothing is ever roasted, it's always boiled". The regional manager told us the provider had recognised the need to improve the meals and a review was underway.

People we spoke with told us they had enough to eat and drink to maintain their health. One person told us, "We can have biscuits in between meals and they come round regularly with a drink". We saw that staff sought advice from professionals including the dietician and speech and language therapist to ensure people's individual dietary needs were met. For example, some people had a soft diet to minimise the risk of choking.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We saw that people's mental capacity had been considered in all aspects of their care and

capacity assessments had been completed. Staff we spoke with told us they had received training in the MCA and Deprivation of Liberty Safeguards (DoLS) and demonstrated at good understanding of the legislation. One member of staff told us, "Some people have fluctuating capacity so we make sure we give them time to make decisions or that we are catching them in the right moment". Staff recognised their responsibilities to support people to make decisions where they were able. One member of staff told us, "[Name of person] had difficulty talking but we always hold up different clothes and sometimes they acknowledge this and we take that as them choosing". People told us and we observed staff asking people for their consent before they provided care. Comments included, "They say would you like me to give you a hand?", and "They say [Name of person] can I do this for you?". This showed staff understood the importance of gaining consent.

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 under the DoLS. Applications for people who were being restricted of their liberty in their best interests had been applied for where required and approvals were notified to us accordingly. This showed the provider was acting in accordance with the legislation.

People were referred to other health professionals when needed. One person told us, "If I want to see the doctor, I mention it and I get to see him the next day normally". We saw that visits from professionals were recorded which showed that people saw the GP, optician and chiropodist on a regular basis.

Requires Improvement

Is the service caring?

Our findings

People and their relatives were positive about the staff and told us they treated them well. Comments included, "They are all nice and they do their best for you" and "I'm very happy". However, although we saw some areas of good practice, staff did not always treat people in ways that were respectful or supportive of their dignity. We saw some staff treated people in a kind and compassionate manner but this was not always demonstrated by other staff. Staff did not always respond to people's distress or treat them in a caring and compassionate way. For example, a person became upset and started shouting out when there were no staff in the communal lounge. A member of staff came into the lounge, walked past them to the kitchen and did not stop to comfort or reassure them. After about 10 minutes, another member of staff came into the lounge and responded to them. They sat and talked with them until they became calmer. We saw that staff did not always explain things clearly to people. For example a person was told that they couldn't have a particular drink but the member of staff did not explain why.

Staff did not always show concern for people and respect their dignity when they supported them with meals and drinks. At breakfast, we saw some people's food was left in front of them for some time and staff did not check that it was still hot. For example, we saw one person's bowl of porridge had formed a 'skin' on top. A member of staff started to help the person eat it but no attention was paid to the temperature of the food. Another person was supported with a drink which had been on their table a long period of time whilst they had been asleep. Staff did not always interact with people and conversation was limited. For example, we saw a person tried to initiate conversation with a member of staff three times without them responding. Staff did not always clear people's plates promptly when they had finished eating and some people were left with food debris on their aprons for some time before staff removed them.

Staff did not always support people to maintain their appearance to promote their dignity. One person needed support to wipe their nose and no staff came to their assistance. Another person who used the service kept prompting the person to wipe their nose but this went unnoticed by the member of staff in the room. The person later fell asleep learning forward with their head on the table in front of them and although another person kept telling them to sit up, no member of staff came to assist them. We saw that one person's glasses had fallen off and were hanging on their top lip but no staff supported them to remove or replace their glasses.

The above issues demonstrate a breach of Regulation 10(1) of the Health and Social Care Act (Regulated Activities) Regulations 2014, Dignity and respect.

We saw that people were encouraged to be as independent as possible and could make choices about how they spent their time. We saw some people chose to spend time in their room and some people moved around the home freely, for example they went out to have a cigarette when they wished. One person told us, "I'm not a good mixer, I prefer to spend time in my room". Staff encouraged people to do things for themselves where possible. One person said, "I wash myself even now but the staff come and wash my back. They're very good really".

People were encouraged to maintain relationships important to them and visitors were welcomed at the home. Relatives we spoke with told us they were able to visit their family members whenever they wanted.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives were happy to raise any concerns or complaints. However, some relatives felt their concerns were not always responded to when they spoke with staff informally. One told us, "If you've got a query, you get told leave it with me and I'll come back to you and that's the end of the story". Another relative told us they had spoken with staff about a lost item which had not been resolved. They told us they had to keep reminding staff about it and things had not yet been resolved. There was a complaints procedure in place. We saw that formal complaints were recorded and responded to but there was no evidence that verbal complaints were recorded and investigated to ensure people's concerns were always listened to and acted on.

At the last inspection, there were mixed views about the activities on offer at the home. At this inspection, people told us they had opportunities to take part in social activities and follow their hobbies and interests. People told us they were able to choose if they joined in. One person said, "I don't go very often, but that's my choice". Another said, I just go and listen, there's singing and karaoke". People's relatives told us their relations enjoyed the activities. One told us, "There are little shows and bingo, and people do painting and drawing". On the day of our inspection visit, a local church group hosted a service on each floor in the morning and in the afternoon, the activities co-ordinators supported people to enjoy a game of animal bingo, which prompted conversation about the different sounds. A member of staff told us, "The activities have improved. People enjoy the church services and the singers".

We saw people were encouraged to follow their individual hobbies and interests. We saw people singing along to music on the radio whilst colouring and filling in puzzles and crosswords. One person told us, "I've always loved colouring. I think I used to do this more than the kids". People had opportunity to look after their own plants and one person had an allotment at the home. A member of staff told us, "[Name of person] loves gardening and has an allotment here. They grow lettuce and tomatoes and people like the flowers". Another person told us they had their own hosepipe so they could water the plants on the veranda outside their room.

People's needs were assessed prior to moving into the home and their care was reviewed to ensure it remained relevant. Relatives told us they were kept informed about any changes in their relation and were invited to be involved in reviews to support them.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we found a continued breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because improvements were still needed to ensure the provider's quality assurance systems were consistently effective in bring about improvements. At this inspection the registered manager had left and some of the quality audits and checks were not up to date and as a result we could not be assured that they were being carried out effectively. We found there was a lack of management and oversight at the service which had an impact on the quality and safety of some people's care. Staff did not always take action when people's needs changed and people did not always receive their medicines as prescribed. The monitoring of care records had not identified the inconsistencies we found which meant the provider could not be sure staff had the information they needed to provide safe and effective care. Staffing levels had improved but there were still concerns with the way that staff were deployed. People did not always receive timely support with meals and there were no call bells to alert staff when people required assistance in communal areas.

Staff told us morale was low because they had been without a manager but felt things had improved since the nurse consultant had been working at the service. One member of staff said, "They're fab; you can go to them with any worries". Another said, "They know what they are doing and they give us confidence". However, staff were concerned that the improvements would not be sustained when the nurse consultant left. One said, "I can see changes but the worry is when the nurse consultant goes, things will go back to the way they were before".

The regional manager advised us of the provider's plans for the management of the home following the registered manager leaving. They told us the provider was arranging for a temporary manager until a permanent appointment was made. In the interim, the nurse consultant would continue with their review of the service and provide support to staff. They added, "The nurse consultant has already done a lot of work with staff to ensure they have the right skills for their role and supervision and staff meetings are ongoing". After the inspection, the provider submitted a copy of their quality improvement plan which showed they were taking action to make the improvements needed.

The provider sought people's views on the service through resident's meetings and satisfaction surveys and two people had been on the interview panel for the recruitment of care staff, which meant they had some choice and control over who provided their care and support. In addition, people were asked for their views on a monthly basis using an IPad which was monitored by the provider. Whilst the provider published the results of the annual satisfaction survey through a "You said, We did" poster which was on display in the reception, people we spoke with were not aware of any changes that had been made. A relative told us, "I must have filled in a dozen questionnaires, pages and pages; I never hear anything about them". The regional manager told us they would ensure feedback from surveys was included as a regular agenda item at resident's meetings.

We saw that the regional manager was working through the records to ensure that audits and checks were brought up to date, for example accident and incident monitoring was up to date and appropriate action

had been taken to prevent reoccurrence. We had received notifications of important events that had occurred in the service and the provider had published and displayed their rating in accordance with the requirements of registration with us.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. Regulation 10(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from the risks associated with medicines. Effective and safe systems were not in place for the administration, recording, storage and disposal of medicines. Regulation 12(2)(f)(g) People were not protected from the risks associated with their care and treatment. Effective and safe systems were not in place to assess, manage and mitigate risks. Regulation 12(2)(a)(b)