Lister House Limited

Lister House Nursing Home

Inspection report

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Bradford
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Ratings

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

Overall summary

ister House Nursing Home provides accommodation and nursing care to up to 32 people at any one time. The home is located in Heaton, Bradford with accommodation spread over two floors. The client group includes a mixture of older people living with dementia, and people of a range of ages with physical disabilities. On the date of the inspection there were 28 people living in the home.

A registered manager was not in place with the previous manager deregistering in November 2014. 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. A new manager had been recruited and told us it was their intention to apply for the registered managers position.

Medicines were not always safely managed. Systems were in place to ensure medicines including controlled drugs were stored safely and appropriately. However we

Summary of findings

found examples of people not receiving their medicines as prescribed which put them at risk of harm. The administration of medicines was not always robustly documented.

People told us they felt safe in the home and we found staff had a good understanding of how to identify and report risks to people's safety. Risk assessments were in place for each person which detailed how to protect people from harm.

Staffing levels were not sufficient to protect people from harm. We found communal areas were not adequately supervised and people experienced delays in getting up in the mornings. The lunchtime experience was also delayed and some people had to wait unacceptable amounts of time for their meal as a result of low staffing levels.

People reported the food in the home was good and said there was sufficient choice. They told us that the chef was adaptable in that if they didn't like the choices on offer they would be offered something else.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We did not see any restrictions on people's liberty which could constitute a deprivation of their liberty. Discussions with the manager and staff demonstrated a good understanding of the legal framework in which the home had to operate. This gave us assurances that the manager and staff knew how to act within the Mental Capacity Act 2005 (MCA) to ensure people's rights were protected.

People's needs were regularly assessed but people did not always receive care in line with their assessed needs. Nutritional supplements and fluid thickeners were not always added to food and drink putting people at risk of harm. Another person's mattress was not on the correct setting which meant they were not receiving appropriate pressure relief.

People and their relatives told us staff were kind and caring and treated them well. We observed care and support and saw staff knew the people they cared for, spoke politely to them and showed a high level of respect. We saw examples of individualised care and support provided to people's preferences.

A complaints system was in place and the people we spoke with had confidence any concerns and complaints would be appropriately dealt with. People spoke positively about the service, demonstrating a high level of satisfaction with the service.

The new manager had plans in place to ensure a robust programme of quality assurance was put in place, however this had not yet been fully implemented on the date of our inspection. We found

a number of concerns with the medication management system, care quality, and staffing which should have been identified and rectified through an effective system of quality assurance.

We identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we asked the provider to take at the back of the 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?

Requires Improvement

The service was not always safe. The administration of medicines was not always robustly documented which meant we could not confirm people received their medicines at the right times. We also found two people were not receiving their medicines as prescribed. This put them at risk of harm.

We found staffing levels during the daytime were not reflective of safe care. Staff struggled to supervise communal areas and some people experienced delays in getting up in the morning and in receiving their lunchtime meals due to staffing levels.

People told us they felt safe in the home. Staff understood safeguarding procedures in order to keep people safe. Risk assessments were in place for each resident which detailed the key risks to them and how to protect them from harm.

Is the service effective?

Requires Improvement

The service was not always effective. We found staff were knowledgable about the people they were caring for and had access to a range of mandatory training. However there were no current first aid trained staff, this meant there was a risk staff would not respond appropriately in an emergency situation.

Staff demonstrated a good understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards. This gave us assurances that the manager and staff knew how to act within the MCA to ensure people's rights were protected.

People told us they had plenty to eat and drink in the home. However we found effective care was not always provided as two people were given normal fluids when they required them thickening and another person was not always given their food supplement .

Is the service caring?

Good

The service was caring. People told us that staff were kind and caring and treated them well. This was confirmed by the interactions we saw between staff and residents. People were treated as individuals and staff provided personalised care and support.

People told us staff listened to them and involved them in decisions in relation to their care and support.

Is the service responsive?

Requires Improvement

The service was not always responsive. People's needs were regularly assessed and plans of care were in place for staff to follow. However the care and

Summary of findings

support people received was not always appropriate, for example one person had not been weighed in line with the requirements of their care plan and another person was not receiving the correct level of pressure relief as their mattress was on the wrong setting.

A complaints policy was in place and this included arrangements to respond to written and verbal complaints. People reported a high level of satisfaction with the service and said they would be confident any complaints would be resolved by management.

Is the service well-led?

Requires Improvement

The service was not always well led.

We identified a number of breaches of regulation which should have been identified and rectified through a robust system of quality assurance. Although the new manager had plans to introduce a range of audits and checks, these were not yet fully embedded in order to identify and rectify issues.

People and staff spoke positively about the manager at the home and said they were supportive and deal with any issues or problems. People were involved in the running of the home through periodic resident meetings and were also asked for their feedback through annual surveys.

Lister House Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

At the last inspection in June 2013, the home was complaint with all the national standards that we looked at.

The inspection took place on 20 January 2015. This was an unannounced inspection.

The inspection team consisted of three 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 spoke with 11 people who used the service, two relatives, the registered nurse, four care workers, the chef, the domiciliary assistant, and the newly appointed home manager. We spent time observing care and support being delivered. We looked at seven people's care records and other records which related to the management of the service such as training records and policies and procedures.

We did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before the inspection, we reviewed all the information held about the provider.

Requires Improvement

Is the service safe?

Our findings

We looked at the medicine management system. Medicines were administered to people by trained nursing staff. A medication policy was in place. The policy demonstrated the provider had taken steps to ensure that they complied with current legislation and best practice in the administration of medicines. However our inspection revealed there to be shortfalls in the management of medicines.

We looked at the medicine administration records (MAR) and found that in the preceding 14 days, signatures to record the administration of medicines were missing on 20 occasions. This meant it could not be confirmed whether these people received their medicines correctly.

We saw that one person had been prescribed one medicine to be given on alternate days. Signatures on the MAR sheet and the remaining stock levels indicated that in the previous 16 days the medicine had once been given on four consecutive days and once on two consecutive days. This showed they were not receiving their medicines as prescribed. On another occasion we saw that a person had been prescribed a patch to be administered every three days. We saw that in the previous 16 days the medicine had, on two occasions, been administered on consecutive days and only twice had been administered as prescribed, demonstrating inappropriate management of this person's medication. These two examples of the maladministration of medicines showed the provider was not ensuring that people were protected from the risks involved in the administration of medicines.

Inspection of the medicines fridge demonstrated that eye drops were not dated upon opening. These medicines were required to be discarded after 28 days but we could not be assured this was happening. The registered nurse took the current eye drops out of use to ensure people were protected against further risks of being administered out-of-date medicines.

We found in the fridge two unopened bottles of antibiotic medicine. Upon checking this against the MAR sheet we found written 'Error - ordered for wrong client'. We discussed this with the manager who could not give any explanation as to why this had occurred, nor could it be demonstrated who, if anyone, should have been prescribed the medicine.

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

We looked at information available for staff when people were prescribed medicines for administration of "as required" (PRN) medication. We found that when people were prescribed medicines for such matters as pain relief that a record was held of the times when a person declined or took the medication. Clear protocols existed to guide staff as to when PRN medicines should be given.

Appropriate arrangements were in place for the storage of medicines and we found medicines were stored appropriately. Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled medicines. We saw that controlled drug records were accurately maintained. The giving of the medicine and the balance remaining was checked by two appropriately trained staff.

We found staffing levels were not sufficient to meet people's needs. The manager told us that during the day, staffing consisted of one registered nurse and four care workers at all times. However, we found that this was not appropriate as there was significantly more pressure on care workers during the daytime period.

Through observation of care delivery we concluded there were not enough staff during the daytime period. For example, we observed care in the lounge for a period of over 15 minutes and during that time no care staff were in attendance or carrying out checks, even though there were five people in the lounge. One person in the lounge was showing signs of distress and kept getting up to leave the room; however, there were no staff around to comfort them or ensure their needs were met. During lunchtime we also found there were not enough staff. We saw that lunch was planned for 12.30 and people were seated at the table at this time, but lunch did not arrive until 13.00 and one person fell asleep waiting at the table. We also saw two people did not get their lunch until 13.45. Care staff were very busy all morning and we saw some people had to wait until almost 12.00 before they were assisted out of bed. Staff told us that 14 people in the home required two staff to assist them with their personal care and 11 people needed assistance at mealtimes. This put pressure on the four care workers on shift and meant lengthy delays assisting people to wash/dress or mobilise and at mealtimes.

Requires Improvement

Is the service safe?

We saw staff were busy and had little time to engage in meaningful conversation with people, this was confirmed by some comments we received such as one person who told us, "The staff are too busy to chat." Another person said, "Have to wait for staff but they can't help it they are busy."

We spoke with the manager who told us they had identified that staffing was not always sufficient during the day and were planning on making some adjustments to ensure daytimes were better staffed.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

We saw that there was a whistleblowing policy in place and staff were able to describe the policy and its purpose. Staff had received safeguarding of vulnerable adults training. Staff we spoke with confirmed they had attended adult safeguarding training. They were able to describe different types of abuse that could affect people who used the service, demonstrating a level of awareness and understanding that provided assurance that the training was effective. This helped to keep people safe. Everyone we spoke with told us they felt safe and secure in the home. For example one person told us, "I would rather be here than alone in my bungalow."

We saw there were risk assessments in place for wheelchair use, bed-rails and assessments to prevent falls. Where someone was assessed as being at high risk, such as difficulty with swallowing and at risk of choking, then control measures had been recorded to state how the risk would be minimised. For instance we saw that a person with a high risk of choking had been assessed by a speech and language therapist (SALT). Advice given was recorded in the care plan to help staff keep them safe. We found that people who were thought as being at risk of rolling out of bed were assessed to ensure that the provision of bed-rails was appropriate and did not infringe people's liberties by using undue restraint. These assessments helped to keep people safe.

We undertook a tour of the premises. We encountered a strong smell of urine on entry to the building and some stains on the carpet. We raised this with domestic staff who made arrangements to ensure the area was deep cleaned. We found the building to be warm with adequate communal areas for people to spend time, although the dining room was rather small and could only accommodate a small proportion of the people who lived in the home at any one time. The home was on the whole adequately maintained although we saw some areas which required attention in the near future. For example, the corridor floor was carpeted with tiles and we observed that some of them had begun to turn up at the corners increasing the risk of trips/falls. Maintenance staff were employed and systems were in place to communicate and rectify building defects. We saw regular maintenance was carried out on the gas, electrical, water and fire systems to help keep people safe. Upon our arrival we noted that the entrance door was locked with entry into the home only being accessible with the staff's knowledge. We saw that all other points of potential entry were secure as were downstairs windows. This demonstrated the provider was mindful of the need to provide a secure and safe environment in which to care for vulnerable people.

Requires Improvement

Is the service effective?

Our findings

People told us they were well looked after and satisfied with the care provided by the home. For example one person said, "[I] Like it here, food is good." Another person told us, "I am well looked after, I only came for respite care but have asked to stay. Everything I need they give me. They made me feel welcome and it's great."

We found a range of mandatory training was provided to staff which included fire, food hygiene, dementia, infection control and manual handling with most staff up-to-date in these subjects. Detailed induction training was provided to new staff. Feedback from people and their relatives indicated staff had the correct skills to care for them. Conversations with staff revealed they had good knowledge of people's individual needs and the subjects such as safeguarding which we asked them about indicating training was effective.

However, during the inspection we found that no care workers were currently first aid trained and management were unable to confirm that nurses were up-to-date with basic life support. This meant there was a risk that staff would not be able to provide appropriate care in an emergency situations. We saw the provider had recently identified this shortfall and had booked staff on training in March 2015. However this shortfall meant that at the time of our inspection, there was a lack of arrangements in place to provide first aid.

This was a breach Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. No people at the home were subject to DoLS. Discussion with the manager demonstrated a good understanding of the legal framework in which the home had to operate. Staff with whom we spoke said they had received training in the Mental Capacity Act 2005 (MCA) and specifically on the Deprivation of Liberty Safeguards contained within dementia awareness training. Staff demonstrated a good understanding of the MCA and DoLS. This gave us assurances that the manager and staff knew how to act within the MCA to ensure people's rights were protected.

We saw that care plans clearly recorded whether someone had made an advanced decision on receiving care and treatment. The care files held 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions. The correct form had been used and fully completed recording the person's name, an assessment of capacity for this element of care, communication with relatives and the names and positions held of the healthcare professional completing the form. We spoke with two care staff both of whom knew of the DNACPR decisions and were aware that these documents must accompany people if they were to be admitted to hospital.

We spoke with staff about the use of restraint. Staff we spoke with were able to distinguish between lawful and unlawful restraint. They were able to define what may constitute restraint, in particular the use of bedrails. This showed us staff were aware of restrictions and restraints which may impact on people's rights.

We saw a varied range of food was available for people. Information was present on people's food preferences contained within a diet sheet available to kitchen staff to ensure that people's individual nutritional needs were met. This included information on any special diets such as diabetic or those with cultural requirements. We spoke with had a good understanding of people's individual needs . We saw a choice of meals was provided at each meal and this varied on a four week cycle. Food looked hot and appetising and feedback from residents was positive. One person said, "If you don't like the food you can tell the chef and he will do something about it." Another person said, "I love the food – its lovely. You get a choice."

Through observations of care, we concluded the mealtime experience could have been improved. The service was disorganised, some people had finished eating when others were beginning to be served. Tables were not set fully and equipment was missing; for example, plate guards were only provided half way through the meal. Care staff offered assistance with eating to some people in the dining area whilst also trying to help those in the lounge. This meant they broke away from people during assistance. In the morning people were offered a drink of orange juice but no choice given; for example, people were not offered tea or coffee. There were no condiments or sauces on the table at breakfast time.

Nutritional risk assessments had been completed which identified if the person was at risk of fluid imbalance or malnutrition and reflected the level of support they required for eating and drinking. However, we found that

Requires Improvement

Is the service effective?

advice given by health care professionals was not always followed. We saw that one person had been visited by a dietician. The dietician had prescribed a high protein supplement drink to be taken twice a day and a further nutritional supplement to be added to porridge. Whilst the high protein drink was administered as prescribed the nutritional supplement was not always added to porridge. Records showed it was not given on three occasions in January 2015. The nurse told us that sometimes the care staff gave the porridge without ensuring the supplement was added. The nurse said they would reinforce the need for instructions to be followed. In two people's care plans we saw there was the need to thicken their fluids because of the risks associated with dysphagia (swallowing difficulties), however we observed they were given normal fluids. We raised this with the nurse on duty who told us these fluids should have been thickened.

We found fluid intake was regularly monitored and added up but we also had concerns over the fluid intake of some people; for example, one person's fluid intake was recorded as 625ml in a day. There was no evidence of any action taken to ensure they were sufficiently hydrated.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

We saw evidence in written records that staff had worked with various agencies and made sure that people accessed other services in cases of emergency, or when people's needs had changed. This had included GP's, hospital consultants, community nurses, specialist nurses in the field of tissue viability, Parkinson's nurses and speech and language therapists. Care workers described nursing staff as responsive in dealing with medical concerns promptly. People reported they had access to healthcare professionals, for example one person told us they had a hernia recently and staff at the home had pushed for it to be repaired quickly.

Good

Is the service caring?

Our findings

People spoke positively about staff for example comments included, “I have no complaints the staff are very kind.” A relative told us staff always remembered preferences stating “My mum likes coffee rather than tea with meals.” Another person told us, “Very good, very nice ladies.”

This was confirmed by the interactions we observed. All staff, including the handyman and kitchen staff and cleaners, knew and identified people by name. We saw all people at the home appeared at ease and relaxed in their environment. We saw that people responded positively to staff with smiles when they spoke with them. Staff were observed to be kind and patient with people, for example, we saw some good interactions with staff reassuring one person whilst they were transferred using a hoist. We saw staff were sensitive to people’s individual needs and we saw examples of personalised care and support. For example, we saw one care staff speaking with a person in their native language; the person told us they appreciated this telling us, “It makes me feel more at home.”

We witnessed staff caring for a person living with dementia who was exhibiting distressed behaviour in a communal part of the home. We saw staff caring for the person with kindness and empathy. Screens were provided to afford the person as much privacy and dignity as possible and to protect other people from becoming involved. Our observations indicated staff had a good understanding of the individual person’s needs and had the skills to attend to people with behaviours that challenged due to dementia.

People were clean and tidy, the men were clean shaven and staff assisted people with looking neat, for example providing support with combing and straightening hair.

Care planning had the facility for the person receiving care or the relative to sign. We saw that signatures were commonly in evidence or an acknowledgement that the person did not or could not sign which showed that valid consent had been sought. Whilst near relatives had been engaged in care planning one person did not have regular access to family. The person had a learning disability and had developed dementia in later life. We saw that an assessment of mental capacity had been carried out. No-one other than paid care staff were providing support to the person. The provider had not made arrangements for the person to be supported by an advocate which meant there was a risk their rights would not be protected.

People indicated they were listened to and as a result felt respected by staff. This was confirmed by the interactions we saw. For example, we saw one staff member patiently ask a person what clothes they wanted to wear and helped them to choose an outfit which they were happy with. We saw the handyman checking with one person’s daughter about the layout of their new room and offering to adapt as necessary.

People reported no problems seeing their families. We saw visiting times were between 8am – 8pm but arrangements could be made to visit outside these hours with prior permission of the home. Protected mealtimes were in place to ensure visitors did not disturb people in communal areas during mealtimes.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives reported staff were responsive to their needs; for example, one person told us that the manager had pushed for them to get a new wheelchair more suited to their needs. A relative told us, "It's a lovely home and they keep me informed." They told us the home had helped obtain a special bed for her mother and then moved her room to accommodate the larger bed.

Care plan documentation was in place for most people and there was evidence of regular care plan reviews. People's needs were assessed prior to arriving at Lister House and this was then used to populate more detailed care plan documentation. Each person's care records contained a range of care plans in place to ensure staff cared for people appropriately. These included health, dementia, continence, eating and drinking, personal safety and night care. These contained instructions for staff to follow.

Although we found some good examples of care and support, we found several examples where people did not always receive care in line with their assessed needs; this put them at risk. We observed one person had their pressure reliving mattress on the wrong setting for their weight which meant there was a risk that they were not receiving the correct level of pressure relief and/or comfort. We raised this with the nurse on duty who agreed and took action to ensure the setting was adjusted. There was nothing recorded in the person's care plan which stated what setting it should be on to guide staff or inform any checks. Similarly another person's care plan also did not contain details of the setting their mattress was required to be on which meant there was a risk it was also incorrect.

Care records showed one person had not been weighed since November 2014, despite their care plan indicating they were at risk of malnutrition. This meant there was a risk that any weight loss would not be promptly identified as information regarding recent months weights was not present. We observed another person was being cared for in bed. They did not have their call buzzer within easy reach during the morning period. This meant they could not promptly summon assistance should they needed it.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw activities people were involved in were recorded within a dedicated file, which demonstrated to us that people had access to a range of activities. These included contracted entertainers who visited the home to undertake activities such as quizzes. We also saw people had access to religious clergy to meet any spiritual needs. People spoke positively about the activities on offer. One person told us, "There's lots of entertainment in the lounge, we have bingo and quizzes. We had a pantomime at Christmas and there's a motivational person who does exercises and singing but she's not here today." However, we observed one staff member assisting two people to complete children's colouring in sheets; we judged staff could have been more creative in providing a more age appropriate activity for these people.

A complaints policy was in place and we saw forms were present to report and investigate both formal written complaints and more minor "niggles". A suggestions box was also in place to allow people to raise issues confidentially. People we spoke with told us that they didn't have a need to complain but thought that they would be taken seriously and dealt with appropriately by management.

Requires Improvement

Is the service well-led?

Our findings

The home did not have a registered manager in place, the last manager left in September 2014. The provider had recently recruited a new manager who told us it was their intention to apply for the registered manager's post.

Staff we spoke with seemed happy and settled although it was clear that they were very busy. For example one staff member said, "I love my job and working here." Staff told us the new manager was a positive addition to the team. We observed there was good rapport from staff with residents and each other.

The manager demonstrated to us their vision for the service for further improvement and the implementation of a range of quality checks, this would include 45 minutes to an hour a day spent carrying out audits. However, these had not yet been implemented to ensure the identification and rectification of emerging risks. For example, we found risks to the way medicines were managed. Although a recent medication audit had been completed in December 2014, it was basic and did not contain an action plan for improvement. We found some people were not given their medication as prescribed and the administration of medications was not always robustly recorded. These issues should have been identified and rectified prior to our visit through a robust system of quality assurance.

We found there was no system in place to monitor client dependency to ensure that staffing numbers were suitable, for example looking at number of staff per floor compared with people's medication needs, mobility and assistance required with continence and eating. There were no audits of staffing levels to ensure they were suitable at particular times of day. We found there were insufficient staff to ensure people's safety during the daytime. These issues should have been identified and rectified through a robust system of quality assurance.

We found no care quality audits were undertaken and we found care and welfare issues which should have been identified and rectified before they were a risk to people. For example, one person did not have their nutritional supplement and two other people did not have their fluids thickened as per their care plans. One person had not been weighed in line with their care plan and another person's mattress was on the wrong setting. A robust system of audit of care quality, nutrition and mealtime experience should have identified and rectified these issues.

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

Systems were in place to seek the views and feedback of people who used the service. People and their relatives reported that residents/relatives meetings took place and people told us they were well informed by the home. We looked at minutes from a recent 'residents'' meeting which showed people were asked for their views on activities, food and mealtimes. Nobody we spoke with could suggest anything that might be improved or changed indicating a high level of satisfaction with the service. Annual surveys had recently been sent out to people who lived at the home and these were in the process of being returned. The feedback from the sample we looked at was positive. The manager told us these would be collated and analysed.

We saw performance issues were identified with staff through staff meeting, appraisal and supervision process, although supervisions and appraisals were not yet completely up-to-date. Where concerns had been identified about staff practice, their supervisions had been prioritised and we saw evidence issues had been identified and flagged up with staff through this system such as the need to improve communication with families.

A system was in place to record accidents and incidents with documentation showing that clear actions were put in place following incidents.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **The registered person had not taken steps to safeguard the health, safety and welfare of service users at all times ensuring there were sufficient numbers of suitably qualified, skilled and experience staff on duty.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **People were not protected against the risks of unsafe care as the delivery of care did not always meet people's individual needs.**

Regulated activity	Regulation
	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The registered person did not have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity had received appropriate training (first aid/basic life support).**

Regulated activity	Regulation
	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The registered person had not protected people against the risks associated with the unsafe use and management of medicines because the provider did not have appropriate arrangements for the recording and administering of medicines.**