Eastern Healthcare Ltd

Brundall Care Home

Inspection report

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Ratings

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

Overall summary

This inspection was unannounced and took place on 19 March 2015. The inspection was carried out by three inspectors.

The service provides care and accommodation for up to 40 older people who require nursing or dementia care. On the day of this inspection there were a total of 29 people using the service, 17 in Kingfisher (dementia unit) and 12 in Nightingale (nursing unit). Because the shaft lift was out of order, four people who normally lived in the Nightingale unit were temporarily living in the Kingfisher unit as they were unable to access their own rooms on the first floor.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager has been in post since 2013.

There were some gaps in the Medication Administration Records (MAR) and also some MAR charts had handwritten changes to the medicines prescribed without a record of who authorised the change. Some

Summary of findings

people were having their medicines crushed although the service had not consulted with the pharmacist to confirm it was safe to do so. You can see what action we have told the provider to take at the back of the full version of this report.

CQC monitors the operation of the Deprivation of Liberty Safeguards which applies to all care services. There was a lack of understanding about the Mental Capacity Act and the Deprivation of Liberty Safeguards and how they impacted on the way people were cared for. There were no mental capacity assessments in place to help staff identify people who lacked capacity to make decisions for themselves and how to act in the person's best interests. You can see what action we have told the provider to take at the back of the full version of this report.

Some people felt that there were enough staff on duty to meet their needs but others did not agree. Two staff in each unit were going on their breaks together, leaving each unit short of staff periodically. This meant that people were having to wait to receive the care and support they needed and were often left for long periods of time unsupervised. You can see what action we have told the provider to take at the back of the full version of this report.

People's dignity was compromised at times. The clothes for some people had been lost in the laundry and people were on occasion seen to be wearing other people's clothes. Some people who were being cared for in bed had their bedroom doors left wide open resulting in them being seen by other people and visitors in a state of undress. You can see what action we have told the provider to take at the back of the full version of this report.

People were not able to tell us about their own care plans and if they had been consulted about what was in it. Some relatives had signed to show they had been consulted. Care plans did not contain enough information about the social and emotional needs of people. The care plans were not person-centred. Most people and their relatives were happy with the care they received although they sometimes had to wait for staff to be available. You can see what action we have told the provider to take at the back of the full version of this report.

People told us that they felt safe. Staff were trained about recognising signs of abuse and what to do if they suspected abuse was happening. Staff also spoke about treating people as individuals with diverse needs.

People were supported by staff with the necessary skills and experience. Staff received training that was relevant to their role. Staff were kind, caring and compassionate.

People enjoyed a good lunchtime experience. They were supported to eat well and healthily, with choices and options available at mealtimes. They were also supported to be as independent as possible through the use of aids and adaptations of cutlery and plates.

The home sought the views of people living at the service and their relatives. Resident and relative meetings took place and quality surveys completed. Complaints were investigated and improvements made to the service based on the outcome of the investigations.

Quality monitoring of the care provided was completed. Audits of care records were in place but the medicines audit failed to identify the shortcomings in the recording on the MARs. Accident audits were in place and any incidents analysed so that improvements to practice could be made and risks to people reduced.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

We found that there were some gaps in the medicine administration records. Some medicines were being crushed without prior consultation with the pharmacist to ensure it was safe to do so.

People felt safe and staff understood about protecting people from the risk of abuse.

The staff on duty were not consistently deployed to ensure they were always available to support people and keep them safe.

Inadequate

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

There was a lack of understanding about the Mental Capacity Act and how it impacted on the way people were cared for. There were no mental capacity assessments in place.

Staff received training relevant to their role and had the necessary skills and experience to care for people effectively.

People enjoyed their meals and had choices and options available to them. Food and drink was available throughout the day and night.

Requires Improvement

Is the service caring?
The service was not consistently caring.

People's dignity was compromised at times because they were on occasions wearing other people's clothes. People were sometimes rushed when receiving personal care.

Staff were kind and caring towards people and treated them with respect for the majority of the time.

Requires Improvement

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

People's care plans were not person-centred. They did not include information about the person's social needs or their likes and dislikes.

Staff understood the physical needs of people and how they should be met.

People and their relatives knew how to make a complaint.

Requires Improvement

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

Requires Improvement

Summary of findings

Quality monitoring was taking place but did not identify shortfalls in medicines recording, staffing concerns and the lack of person centred care planning.

People and their relatives were consulted about the quality of the service.

Audits of accidents and other incidents took place with improvements to practice occurring where necessary.

Brundall 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 19 March 2015 and was unannounced. This inspection was completed by three inspectors.

Before the inspection we reviewed notifications that had been sent to us by the service. These are reports required by law, such as the death of people, safeguarding concerns, accidents or injuries. We also contacted the local authority quality monitoring team to seek their views about the quality of the service provided to people.

During our inspection we gathered information from a variety of sources. For example, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We completed a SOFI in both the Kingfisher and Nightingale units.

The records we looked at included staff rotas, medication records, Mental Capacity Act and Deprivation of Liberty Safeguard assessments and applications and the care records for eight people.

We spoke with approximately 10 people using the service and three relatives. We also spoke with seven staff including two registered nurses, four care staff and the registered manager.

Inadequate

Is the service safe?

Our findings

People told us that there were not always enough staff on duty to give them help and support when they needed it. One person who was waiting for staff to assist them with their personal care said, "I am still waiting for the staff. I have to wait a long time. I am not comfortable." Another person told us, I have been sat here all day and want to lay down. I am not comfortable…I need to lay down but am having to wait." A third person said, "Some days things are fine. Some days they are not so fine and I feel I am kept waiting too long."

We spoke with people's visitors and they raised their concerns about how long their relatives sometimes had to wait for assistance. One visitor told us that their relative often had to wait for an hour before staff came to assist them. Other relatives spoke more positively with one stating that they felt there were enough staff and their relative did not have to wait too long to be supported.

Our observations showed that people were needing to wait at times for the support they needed. One person asked for assistance to go to bed and it took 40 minutes for staff to become available to respond. We also spent a period of 90 minutes in a small lounge that was upstairs out of the way, with three vulnerable and highly dependent people sitting in it. We saw a member of staff enter the room briefly to check people were safe on only two occasions.

We were told that the staff on duty on the day of our inspection were one registered nurse and four care staff on the Nightingale unit and one registered nurse and three care staff on the Kingfisher unit.

We noted that care staff were taking their breaks two together, leaving the home understaffed and people at risk. For example, we noted that on the Kingfisher unit, there were no staff supervising the vulnerable people in the communal lounge when we arrived on the unit. This was because two staff had gone on their break together and the other two staff were providing personal care in someone's room. This remained the situation for a period of 15 minutes, at which time we became so concerned that we brought our concerns to the notice of the registered manager. We established that two staff had also taken their break at the same time on Nightingale and this appeared to be normal practice.

On both units, there were long periods of time when there were no staff in communal areas supporting people and this was consistent with the feedback we received from some relatives.

This was in 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) Regulations 2014.

We looked at the arrangements for the storing and administration of medicines in the service. We looked at the Medicines Administration Records (MAR) and compared them to the person's medicines profile kept in their care plan. We noted that not all of the medicine profiles accurately reflected the medicines that people were taking and this could cause confusion to staff as to what medicines people should be given. We saw occasional gaps in the MAR charts where staff had not signed to say the medicines had been given and we could not therefore be confident that people were receiving their medicines as prescribed, although staff confirmed that they had been given. Some MAR charts had handwritten instructions about changes to medicines but staff had not recorded who had authorised the changes.

We saw that people's medicines records did not give guidance to staff when administering medicines that could be given in variable doses so that they knew how much to administer. We noted that the majority of time staff administered the higher dose. Staff did not record why they had given the higher dose and the registered nurses were unable to explain to us why they had given people the higher dose. These medicines were mainly of the type that had a sedative effect and there was a risk that people were being given a higher dose than was necessary which made them drowsy.

We also noted that ointment, lotions and creams were not always being signed for to show they had been applied. We looked at people's daily records and saw that care staff had documented on approximately half of them that they had applied the creams and ointments. Therefore we could not be sure that people were receiving treatment as prescribed.

We were advised that some people had their medicines crushed and disguised in food such as yoghurt. The registered manager told us that in most cases it was the choice of the person receiving the medicines that they

Inadequate

Is the service safe?

should be given in this way. However, we saw records that showed this decision had been made in consultation with the GP and occasionally with the person's relative. Crushing medicines changes the rate at which medicines are absorbed and can result in unpleasant side effects or a reduction in their effectiveness. The pharmacist had not been consulted to ensure it was safe to crush each of these medicines.

This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were ordered, stored and disposed of safely. We observed one of the nurses undertake a medicines round and saw that this was done in a safe manner. We confirmed through looking at records and speaking with staff that only suitably qualified staff administered medicines to people.

People told us they felt safe at this home. One person said, "Yes, I feel safe here. There is nothing to worry about. All the staff are trustworthy and I don't have any concerns about them." Those who could speak with us said they felt able to raise any concerns they might have about feeling safe.

We spoke with staff and they could tell us about the different types of abuse. They were able to describe the signs they would look out for and what action they would take if they suspected abuse was happening. All staff had undertaken training about safeguarding people from abuse. Staff had also completed training about equality and diversity and understood about treating people as individuals with diverse needs.

The service operated recruitment practices that included a minimum of two written references. All checks were carried out to ensure that staff were of good character and appropriate to work with vulnerable people.

People's risks in relation to their care needs had been assessed. These risks were in respect of pressure area care, mobility and falls, moving and handling and nutrition. Nationally recognised screening tools had been used to identify risks to people. These included the Malnutrition Universal Screening Tool (MUST) to help identify people at risk of malnutrition or obesity.

Requires Improvement

Is the service effective?

Our findings

Where people did not have the capacity to make their own decisions the appropriate assessments had not been carried out. There was no evidence that the home had followed the principles of the Mental Capacity Act (MCA) when supporting the people to make decisions about how they would want their care and treatment to be delivered. In addition, there was no evidence of any best interests decision making process. There was no care plan in place in relation to how best to support the person to make their own decisions, or to act in the person's best interests.

We noted that where people were having their medicines crushed and placed in food or yoghurt there was nothing documented to state that this decision had been made with the person and in their best interests. This practice is known as covert medication. We discussed this with the registered manager who told us that they would take the appropriate action to ensure that covert medicines were administered in line with the law.

The staff we spoke with had varying understanding about mental capacity and Deprivation of Liberty Safeguards (DoLS). Most had some basic understanding of the principles of the MCA and DoLS. Some of the staff could tell us about capacity and how this related to people making decisions. However, other staff members did not understand mental capacity or how they might deprive a person of their liberty and the impact this had on caring for and supporting people.

We were told that no applications under DoLS had been made to the authorising body for authority to deprive a person of their liberty. We reviewed people's care plans and saw that consent to care and treatment had not been recorded consistently.

This included the use of bed rails, which in some circumstances can be used as a form of restraint. In one care plan a relative had signed consent for bed rails to be used but we could not see any evidence that they had legal authority to do so.

This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed staff asking people for verbal consent before delivering care and support. This included placing protective wear on people at lunchtime and assisting people to move from the dining table to their chair after lunch.

People told us that they enjoyed their food. One person said, "The food is always alright. There is enough to eat and you get a choice." Another person told us, "I like the food here. It is nice and tasty and you don't go hungry."

We observed the lunchtime experience in both dining rooms and saw that there were sufficient staff available to support people to eat their meal in a timely way. This included assisting people to cut up their food and help to eat it if necessary. People were given adapted plates and cutlery where necessary so that they could maintain their independence as much as possible.

At the time of our inspection, the permanent cook was not working and it had been necessary for the service to arrange for an agency cook to cover the duties. We noted that all people's dietary needs were met as required and that there were good communication systems in place between staff to ensure that this happened.

Three of the care plans we looked at showed that people's nutritional and hydration needs had been assessed. There were plans of care in place to meet people's needs. This included people requiring fortified meals, soft diets and additional milky drinks to help them to eat and drink well. People had target amounts of fluid that they should drink each day and we saw that both food and fluid intake was recorded. However, we noted that some staff were recording that a full drink had been given to a person when it had not actually all been drunk. This meant that the records were not accurate and the staff team could not be sure that people received the amount of fluids they needed.

We saw that people were weighed each month to ensure that staff were alerted to any significant change in their weight. We noted that for one person their weight loss did not trigger any action or risk reduction plan by staff to ensure that they were not at risk of malnutrition, particularly as the person's records showed that they were not eating.

People were supported by staff with the necessary skills and experience to meet their physical needs. Staff described the training they had completed and they

Requires Improvement

Is the service effective?

confirmed that refresher training was arranged as necessary. They told us that much of the training was presented by the registered manager. The staff we spoke with told us they had access to specialist education to help them meet the needs of the people they cared for. This included courses in palliative care, dementia and the care of people living with Parkinson's disease.

During our review of people's care plans we saw that people were supported to maintain good health, have access to healthcare services and receive on-going healthcare support. This included records in relation to people being seen by their optician, audiologist, nutritionist and speech and language therapist. However, we saw that staff did not always follow the advice given by health professionals. For example, one person required staff to ensure that their hearing aid was in place but this did not always happen. This had a negative impact on the person when staff failed to support them as required and as a result they often became distressed.

Requires Improvement

Is the service caring?

Our findings

We spoke to visitors to the home and two of them told us that they were dissatisfied with the way their relatives were cared for. Both spoke about their relatives having several of their clothes lost in the laundry despite being labelled. Both relatives also described how they had on occasion visited to find their loved ones wearing other people's clothes. This had particularly distressed one person who was given another person's nightdress to wear.

At times we saw people's dignity being compromised, for example when they were uncovered in bed and their bedroom doors were wide open. We also saw that people were left with their clothes protectors on for up to an hour after the meal, with food down them and their clothes.

We saw staff rushing people with their care and support at times. This was particularly evident when assisting people to the toilet. Staff did not adequately explain the use of the hoist each time. Staff did not always allow people sitting in the lounges enough time to drink, giving people a few sips without speaking to them before moving on to the next person.

This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service told us they were satisfied, on the whole, with the care and support they received. One person said, "The staff are all very kind and do what they can for you. They are extremely busy and you sometimes have to wait a while but they do their best." Another person told us, "The staff are wonderful, they really look after us. They are kind." A further person commented, "Most of them [staff] are wonderful. They really care for you. They chat and have a laugh with you when they can. They are busy though and sometimes this can lead to one or two of them being a bit grumpy."

At times people's privacy and dignity were respected and promoted. We saw good practice during the lunchtime period when people were assisted to eat their meals. This was done in a positive, discreet and encouraging manner.

We observed the interaction between the staff and people using the service and saw that staff were generally kind and caring towards people.

Visitors to the home had mixed opinions about how caring the service was. Two visitors felt the care was poor and described how their relatives had to wait a long time to get support from staff. Another visitor was very satisfied and happy with the care their relative received, describing staff as, "…kind and good."

The people who were able to speak with us were not sure whether they had been involved in their care planning. People could not recall seeing their care plans and told us they did not know what they contained. However, people told us that they felt that their needs were mostly met. We saw staff involving people in decision making about daily living. People had options explained to them, such as what they could choose to eat.

Requires Improvement

Is the service responsive?

Our findings

The amount of information contained in people's care plans varied. For example one care plan we looked at contained detailed information about how staff could effectively communicate with the person. However, in the main we found that people's care plans were generic in nature and not person-centred. There was no information about the person's previous history, what they enjoyed doing and their likes and dislikes. People and their families had not been fully involved in developing their plans about all aspects of their physical and social care needs.

People's social care needs were not adequately met. There were no clear care plans for people that supported them to engage with their hobbies or interests. We saw a member of staff on the Kingfisher unit paint some people's nails and hand out magazines for people to look at. On the Nightingale unit, people were either in their rooms or were in one of the lounges. People were either watching the television or sleeping. In the one of the lounges three people sat either watching the television or listening to the radio. We saw no other social stimulation taking place.

We were told that one care staff was allocated each day to provide one to one and group activities in each of the units during the afternoon. Whilst we saw some nail painting taking place in the Kingfisher unit during the morning, we saw no orgainsed activity or meaningful occupation happening in the Nightingale unit.

Separate daily records were kept for each person. They provided evidence that people in bed were repositioned regularly. However, we observed that people who were immobile and spent their day in a chair were not adequately repositioned. This meant that these people were at increased risk of developing a pressure ulcer because they stayed in the same position for many hours.

One of the care plans we looked at stated that the person enjoyed other people's company and that interaction with others helped to reduce their anxiety. We were aware that this person was calling out for much of the day and staff told us this was due to the person being either anxious or feeling unwell. We saw staff periodically spending only a few minutes with this person during the day to try and reduce their anxiety but this was inadequate and did not meet the person's social and emotional needs.

This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people were not able to be involved in planning their care due to ill health or because they were living with dementia. One person said, "I am happy here and get well looked after." Another person said, "My needs are attended to just fine. The girls [staff] know what I need each day and I don't have any complaints."

We also spoke with some visitors to the home. One visitor told us they were very happy with their relative's care. They said, "Staff are very kind and good with [person]. They keep me informed." One visitor described how their relative needed a hearing aid so that they could communicate with other people but staff often forgot to put the aid in their ear. They said, "…this causes [person] to become frustrated resulting in [person] becoming irritable and shouting at people."

Staff were able to explain each person's needs and how they should be met. Staff told us that they knew what was in each person's care plan although they did not normally have time to read them during their shift and relied on information shared at handover meetings at the start of their duty. However, we found that people's needs were not always being met.

The service had a complaints procedure displayed in the entrance hall. The complaints procedure contained the contact details for the provider so that anyone dissatisfied with the response to their concerns could escalate them. People we spoke with knew how to make a complaint. One person told us, "I would speak to the staff." Another person said they would ask to speak with the registered manager or deputy manager. Visitors also knew how to complain and said they felt able to raise any concerns they might have with staff.

Requires Improvement

Is the service well-led?

Our findings

The staff we spoke with told us that they felt well supported by the registered manager and listened to 'most of the time.' They felt they could approach the registered manager and deputy manager and they would be listened to even though there was not necessarily any action taken as a result. However, if staff were to report that someone was at risk of abuse then staff were confident that senior management would take the appropriate action.

Staff confirmed that staff meetings took place and that they were encouraged to attend. They said that the registered manager spoke to them about the service and any improvements that were required during staff meetings. However, they said that they felt more 'talked to' rather than encouraged to raise suggestions. Our observation during the inspection identified that there was a lack of meaningful activity for people. One member of staff said they had suggested having an activities person with protected time to provide activities for people rather than relying on care staff, who may not have the time for activities during the afternoon. There were mixed feelings amongst staff as to whether they thought the registered manager took on board their ideas and suggestions.

We spoke with the registered manager about our concerns over staffing arrangements and they stated that staff were not meant to go on their breaks at the same time. We noted in the minutes of the last staff meeting that staff had been told they had to go on their breaks one at a time but we observed that this was not being adhered to. This meant that staff cover was not being monitored to ensure that people were kept safe.

Staff confirmed that they received regular supervision and annual appraisal. They said they could discuss their role and any issues they may have. During the supervision, they discussed training needs and used the opportunity to identify any actions they needed to take to develop professionally.

The registered manager kept us advised of events that took place in the service. For example, we are advised of any safeguarding concerns and were notified that the service had been interrupted due to the breakdown of the passenger lift.

Quality monitoring was taking place in respect of the care that people received. Care plans were audited monthly to ensure they were kept up to date. An audit of medicines was also completed monthly so that any errors or discrepencies could be identified and investigated. However, the audits did not identify the gaps in the Medication Administration Records (MAR) or the handwritten amendments without apparent authorisation on the MAR charts. Also, the audits did not highlight the generic nature of the care plans and the lack of information about people's social and emotional needs and how they should be met.

The registered manager told us that they completed a monthly audit of any accidents occurring to people living at the home and staff. They said that this was to help identify any patterns so that remedial action could be taken immediately.

Audits of the environment were also taking place. For example, fire safety audits were being completed, with weekly fire alarm checks taking place. The emergency lighting was on a service contract and we saw that this was up to date. The gas safety certificate was also seen and we were advised that this was also on a service contract.

We had been advised by the service that the passenger lift had broken down some weeks before our visit and it had been necessary to replace the lift. The new lift was commissioned on the day of our inspection and this meant that all displaced people were able to return to their own rooms. The service also uses a number of hoists and we saw that they were due for servicing in May 2015 and that this had been booked.

People's views were sought and resident meetings took place although we were told that very few people joined in. The registered manager said that they went round and spoke with people most days to make sure they were happy with the care they were receiving. Despite this the registered manager had not identified the concerns about staffing. The registered manager said they had an open door policy and people could speak with them at any time. We were also provided with a copy of the most recent relatives meeting, which took place in March 2015. This had been well attended and had given relatives an update of events at the home.

We were provided with a summary of the most recent relative survey that was completed in February 2015. The summary overall was positive, with high satisfaction being expressed with the staff team. The summary did not

Requires Improvement

Is the service well-led?

include the response rate nor the scores to each of the questions asked. Relatives were asked for their views about the welcome they received from staff, if the manager was approachable, if they received enough information and were kept informed and if staff were knowledgeable. No learning points were recorded in this document so that improvements could be measured against it.

We looked at how people's complaints were handled. The registered manager said that most complaints came from relatives and many of them were received via email. All were reviewed by the registered manager and any concerns were fully investigated with a written response being sent to the complainant. Analysis of complaints received was completed and any actions to resolve the situations and improve the service were taken.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with unsafe medicines practice because medicines were crushed and records not always maintained. Regulation 12 (2) (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People who use services and others were not protected against the risks associated with consent to care and treatment because staff did not understand about the Mental Capacity Act and mental capacity assessments had not been completed. Regulation 9(5).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing People who use services and others were not protected against the risks associated with staffing because people were left unsupervised and people had to wait to long periods to receive the care they needed. Regulation 18(1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People who use services and others were not protected against the risk associated with privacy and dignity because these were compromised at times. Regulation 10.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People who use services and others were not protected against the risk associated with person centred care because care records did not accurately reflect people's needs. Regulation 9(3).