New Excel Homes Ltd

Aarondale Care Home

Inspection report

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Tel: 01257471571

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Aarondale Care Home is a care home providing personal care for up to 48 older people, including those living with dementia. The service is purpose built and accommodation is over three floors. At the time of the inspection there were 44 people living at the service.

People's experience of using this service and what we found
The safety of the service was inadequate. Practices at the service placed people at risk of harm. People did not always receive their medicines safely. Risks to people had not been appropriately identified, assessed and mitigated.

Systems in place to monitor, assess and improve the safety and quality of the service being provided were not robust. Some of areas of the service appeared worn and tired and required repainting. We saw fire exits which were partially blocked, meaning people were at risk of safely evacuating the building in the event of an emergency. Equipment which was in place to ensure people were moved and transferred in a safe way, was not always being used by staff.

The oversight of the service was inadequate. There were failures in the provider's quality and assurance systems. Records relating to care and the management of the service were either incomplete or inaccurate and not kept up to date. Although some concerns found during the inspection had been identified by the providers monitoring systems, actions had not been put in place to address them.

The service was not effective. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Not all staff had received the necessary training to help them carry out their role in a safe and competent manner. People were not adequately supported with their nutrition and hydration needs. People were not always being supported in a way which led to good outcomes for their care and support.

We have made a recommendation about reviewing people's care plans for care and support.

The service was not always caring. People's dignity was compromised by the lack of consideration given to the general environment and the quality of food.

The service was not always responsive. Care records were inconsistent and did not contain the most up to date information about people's health care needs and requirements. Staff did not always communicate with people in a way they understood.

We have made a recommendation about staff developing more effective communication skills.

We observed some positive interactions between staff and people living at the service.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk.

Rating at last inspection
This service was registered with us on 1 October 2020 and this is the first inspection. The last rating for the service under the previous provider was Good, published on 13 August 2019.

Why we inspected
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively. This included checking the provider was meeting COVID-19 vaccination requirements.

The inspection was prompted in part due to concerns received about infection control and staffing. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective, Caring, Responsive and Well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, need for consent, staff training, meeting nutritional and hydration needs and good governance at this inspection.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures.' This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvement.

If the provider has not made enough improvement within this timeframe, and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Aarondale Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by three inspectors. An Expert by Experience made telephone calls to people's relatives the day after the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Aarondale Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Aarondale Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

At the time of the inspection, the service had a manager who had applied to be registered with the Care Quality Commission. This means that they (once registered) and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. Following the inspection, the manager resigned from the service and the registered provider was actively recruiting for a new manager.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We carried out a site visit. We spoke with five people living at the service, and five care staff. We also spoke with the registered provider, the manager, the chef, the kitchen assistant and a senior carer. We looked at records in relation to people who used the service including six care plans and multiple medication records. We also observed the delivery of care and support throughout the day. We looked at records relating to recruitment, staff rotas and systems for monitoring the quality of the service provided.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with four relatives to help us understand their experience of the care and support their loved one received.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection of this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely
• People were at risk of not receiving their medicines as prescribed, and in line with best practice guidance. Staff were not always trained and competent to administer medications safely.
• Medication administration records (MARs) did not record enough information to keep people safe. Handwritten records were not always signed by two staff to ensure the accuracy of the information recorded.
• There was a lack of guidance for staff on how to safely administer medicines to be given 'as required' (PRN medicines). This meant people were at risk of being given medication when they did not always require it.
• People's prescribed thickener (thickener is used for people with a swallowing disorder and helps minimise the risk of choking) was not managed safely. Staff did not always record the amount used when added to drinks, so there was no evidence thickener was given correctly.
• Topical medicines (medicines applied to the skin) were not always administered safely. For one person who was prescribed a pain-relieving patch, there was no record of where this was being applied, meaning there was a risk of skin irritation and potential overdose.

We found no evidence that people had been harmed however, there was a failure to manage medicines safely. This placed people at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
• Risks to people were not always identified and assessed effectively. Where risk had been identified there was no guidance for staff on how to manage and mitigate the risk.
• People were not involved in managing risks that may affect their safety. For one person who smoked cigarettes in their bedroom, there was no evidence this risk had been assessed.
• The premises were not safe. We found a can of vinyl adhesive which was labelled as highly flammable left in a communal toilet. The door to the maintenance room was left propped open for a prolonged period of time, which placed people at risk of harm from sharp tools and toxic chemicals.
• We observed a fire exit and fire evacuation chair on a stairwell obstructed by items such as vacuum cleaners, walking aids and cardboard boxes. This placed people at risk of exiting the building in the event of an emergency. We highlighted our concerns to the fire service.
• People were at risk of general environmental risks. The radiator in one person's bedroom was excessively hot to the touch meaning there was a risk of a burning injury. Another person assessed as being at risk of falls required a sensor mat to help minimise this risk. However, when we visited this person in their room, the sensor mat was out of reach and unplugged.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety and risk was effectively managed. This placed people at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
• The service did not appropriately identify and learn from when things had gone wrong. There was little evidence of learning from events and little action taken to improve safety. The manager used memos to highlight such issues, with a requirement for staff to read and sign, however staff had not signed to confirm their understanding.
• People were not always protected from avoidable harm. Accidents and incidents were not recorded in enough detail. There was no oversight of accident and incidents, meaning patterns and trends were not identified and not enough action was not taken to help minimise the risk of recurrence.

Preventing and controlling infection
• The service was not always taking enough action to help minimise the risk of infection. At the time of inspection, the provider had a legal duty to confirm the COVID-19 vaccination status of all visitors to the home. We were not asked for this information on the day of our visit.
• Although the manager informed us that people had received both vaccinations, peoples care plans did not record and reflect this.
• We could not be assured that cleaning records were an accurate reflection of practices. For example, a toilet cleaning record was ticked to say it had been cleaned on the afternoon of our visit, despite us viewing this record in the morning.
• There were adequate supplies of PPE and staff used this appropriately.

Systems and processes to safeguard people from the risk of abuse
• The service did not always ensure systems were up to date to protect people from the risk of harm and abuse. Not all staff had received safeguarding training. However, staff we spoke with understood how to safeguard people from abuse and how to report any safeguarding concerns.
• People felt the care provided by staff was safe. One person told us, "Yes, I do feel safe. The girls [Staff] look after me."

Staffing and recruitment
• There were enough staff on duty to meet people's needs. Recruitment of new staff was safe. Pre-employment checks were completed to help ensure staff members were safe to work with vulnerable people.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection of this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience
• The provider failed to ensure staff were adequately trained and had the skills, knowledge and competence required for their role. Not all staff had received support through supervision and appraisal. Some staff were administering medication without having undergone a competency assessment to ensure they were safe to do so. One member of staff told us, "I've had no fire safety training, no mock drills and no shadowing. I've seen seniors recruited into the role with no experience."
• Some staff did not always recognise poor practice. Some staff whose first language was not English, spoke in their native language in the presence of people. This meant people were not always cared for by staff with whom they could effectively communicate their care needs.
• Whilst the registered provider had demonstrated innovation in overseas recruitment of staff during a time of national care staff shortages, staff were not always provided with a sufficient induction programme to ensure they were equipped with the skills required for their new roles.

The provider's failure to fully support staff, placed people at risk of potential harm. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Following our inspection, the provider provided us with written assurance that the training and development needs of staff would be addressed imminently.

Ensuring consent to care and treatment in line with law and guidance.

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

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

• The provider was not always complying with the principles of the MCA. We found peoples' assessments did

not take account of individual and specific decisions. Where people had been assessed as lacking mental capacity, there was no evidence that decisions had been taken in accordance with the person's best interests, and that proper consultation with relevant others such as family members, had taken place.
• There was a lack of up to date MCA training which impacted on staff knowledge and understanding of the principles. Some people's care records contained inconsistent information and recorded that they had capacity to make decisions in one part of the record but lacked capacity in other parts. This meant that we could not be assured that people had genuinely consented or been properly consulted about decisions regarding their care and support.
• Although the service kept a log of DoLS applications, there was no evidence that new applications for those that had expired had been made.

The provider failed to act in accordance with legislation regarding the Mental Capacity Act 2005. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
• There was a lack of guidance for staff on how to support people with their specific dietary requirements. Information regarding people's nutrition and hydration needs was not always recorded in their care records.

• People were at risk of eating potentially contaminated food. Our inspection of the kitchen found some foods, including soft cheeses, were out of date. Foods that had been opened were not dated, meaning they were potentially unsafe to consume. We highlighted our concerns to the Food Hygiene department of the Local Authority.
• We observed people having lunch and found people being served with food which was different to that stated on the menu and food which was badly burnt. We had to intervene and ask the chef to serve people with an alternative. One person told us, "Food is poor, I tend to just have a sandwich. We never get told what we are having."
• The chef lacked training and skills in how to meet people's nutritional needs. People with specialised dietary requirements such as a liquidised diet, were served with food that had simply been blended. It was not possible to identify what this food was, and it appeared unappetising.
• Drinks were not readily available to people. We looked in people's bedrooms and found people did not have a jug of water or juice to help maintain their hydration levels throughout the day.

The provider failed to ensure people had access to a variety of nutritious and appetising food and sources of hydration to ensure their hydration and nutrition needs were being met. This was a breach of Regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
• The provider had not always adapted the premises to improve people's quality of life. Parts of the service appeared worn and in need of re-decoration. Paintwork in the communal areas, including handrails in corridors, was badly chipped which could impede effective cleaning.
• The provider did not assess or properly manage environmental and equipment related risks. We were not assured bath chairs were safe to use. The servicing of bath chairs in two communal bathrooms was out of date. The manager told us one of the baths were not being used. However, there was no appropriate signage to confirm this was out of use, and staff told us they were still using one of the baths.
• Equipment to support people with their mobility was not safely stored and maintained. Wheelchairs were stored in bathrooms, creating an infection control risk. One person's wheelchair did not have footplates. We followed this up and found that maintenance checks on wheelchairs were not up to date.

• Hoists were stored in bathrooms and were not being charged. Staff told us they were not always being used. Daily care notes did not always record how people were being moved. This meant we could not be assured people were being transferred in accordance with their moving and handling assessments. A member of staff told us, "Some staff do not follow the correct procedure."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support
• It wasn't always evident that people's needs were assessed before admission to the service. Care plans lacked detail about people's choices and preferences regarding their care and support. There was no evidence that people's relatives had any involvement in the care plan process. A relative confirmed, "I don't know anything about a care plan."
• People were not always being supported in a way which led to good outcomes for their care and support. Care plans lacked person-centred details such as information about the person's background, interests and future wishes. For example, one person's care plan referred to them by a different name and the incorrect gender.

We recommend the provider reviews all care plans to ensure they contain relevant, current and person-centred information.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection of this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
• People's dignity was not always respected. People did not always receive their own clothes to wear. Relatives told us, "I saw [Name] had someone else's clothes on. I brought it up with a senior carer" and "They put [Name's] clothes into the drawers all screwed up, no time to fold them. In the wardrobe things are on the floor and not on hangers. It's disrespectful. I have seen [Name] in clothes that are not theirs. I once saw someone in their dress."
• People's dignity was also undermined by the lack of consideration given to the safety of the environment, and the quality and presentation of the food, this meant people's enjoyment of their surroundings and mealtimes was compromised. This did not demonstrate a caring attitude.
• Staff were able to describe how they protected people's dignity and privacy, including closing doors and curtains when providing personal support.
• Records regarding people's care and treatment were stored securely.

Supporting people to express their views and be involved in making decisions about their care
• We were not assured people were encouraged to express their views and make genuine decisions about their care and support. We requested the provider to send us evidence that people's feedback was sought, for example, in the form of residents' meetings and questionnaires. However, this was not received.

Ensuring people are well treated and supported
• We observed some positive interactions between people and staff throughout the day. Staff were kind and tactile. They addressed people by name and explained before any support was carried out.
• People and relatives told us the staff knew people's needs and treated them well. One person told us, "Yes, the staff are kind." Comments from relatives included, "They [Staff] seem kind and gentle with [Name]. They are very nice when they speak to me," "Can't fault the staff. Nice when you go in, very polite and pleasant" and "Staff are caring and helpful, lovely."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection of this newly registered service. This key question has been rated requires improvement. This meant that people's needs were not always met.

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
• Some staff understood how people communicated and used appropriate methods when communicating. However, for staff whose first language was not English, conversations were held in the presence of people in the staff member's own language. As many people at the service lived with dementia, this could act as a barrier to effective communication and lead to feelings of isolation.

We recommend the provider organises staff training to enable staff to better communicate with people in a way they can fully participate and understand.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
• People's care and treatment was not always designed to ensure it met their needs. For one person who was deemed to express behaviours that may challenge staff, their needs had not been appropriately assessed or recorded, meaning there was no guidance for staff on how to manage and potentially reduce the person's anxiety.
• People were not always involved in developing their care plan. People's care plans did not provide enough detail to enable staff to deliver effective care to people.
• Care records did not always contain plans for people with specific physical health conditions, such as diabetes.
• Care provided by staff was not documented appropriately, and meant people were at risk of not receiving appropriate care and treatment.
• Peoples' care plans were standardised and often contained irrelevant and inaccurate information with little evidence of person-centredness.
• Although care plan reviews were recorded, care plans were not always up to date meaning they did not guide staff on their current treatment and support needs.

Supporting people to develop and maintain relationships to avoid social isolation
• The provider was in the process of recruiting a full time activity co-ordinator to help facilitate activities for people. On the day of our inspection, we did not see people engaged in activities and observed some people repeatedly walking up and down corridors.
• The service facilitated visits from people's friends and relatives, which helped people maintain social relations which were important to them.

End of life care and support

• The service did not engage people in planning their end of life care. There was no evidence that peoples' needs for end of life care had been considered. There was a risk that people may not receive the support they required to experience a comfortable and dignified death.

• Staff training was not fully complete for end of life care.

Improving care quality in response to complaints or concerns

• There was a complaints management system in place. However, there was no evidence of any oversight of complaints to determine possible themes.

• Although complaints were responded to, as there was insufficient overview, it was not possible to determine if any action taken had improved matters.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection of this newly registered service. This key question has been rated as inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Planning and promoting person centred, high-quality care and support

- The service was not well-led, there were significant shortfalls in oversight and governance. The delivery of high quality care was not assured. Systems to assess, monitor and improve the service had not been implemented and operated effectively. Risks to people's health, safety and well-being were not identified and mitigated.
- The manager and registered provider significantly needed to improve their understanding of quality performance, risk and regulatory requirements. Although some systems were in place to assess and monitor the quality and safety of the service, the provider did not use them effectively to identify and address concerns found at this inspection.
- The provider failed to maintain an accurate and current record of the care and support provided to people. Where people had been assessed as being at risk of dehydration or weight loss, nutritional and hydration intake had not been monitored and recorded. Similarly, where people were assessed as requiring weekly weighing, there was no record of this having been done.
- People were also at risk of harm due to insufficient pressure area care. Where people had been assessed as requiring regular position changes to help maintain their skin integrity, records were either incomplete or had not been recorded.
- The provider did not plan, promote and ensure people received person centred and high-quality care. Outcomes for people were not always person centred.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate the safety and quality of the service was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care;

- Reporting of incidents, risks and issues was unreliable and inconsistent. Systems for identifying, capturing and managing risk was ineffective. We were not assured that legal requirements were understood by the provider.
- Monthly medicines audits were undertaken but failed to identify the issues found during our inspection.
- Accidents and incidents had not been reported in enough detail and had not been fully analysed to provide effective learning and so help drive forward the quality and safety of care.
- There was little evidence of learning, reflective practice and service improvement.

• Where audits had highlighted issues, there were no adequate action plans in place, and it was not evident if actions had been carried out.
• Although manager's meetings took place, minutes were poorly completed and there was not a clear follow up of actions set in one meeting to the next.

We found no evidence that people had been harmed however, the provider failed to monitor or take action to address issues and make improvements. This placed people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
• People were not routinely involved in the development or management of the service. The provider was not promoting or championing people's rights in this way. Feedback was not regularly sought from people, their relatives and staff.
• The registered provider did not always demonstrate they were committed to actively seeking the views of people and staff. Some staff told us they were reluctant to speak up and make suggestions for improvement as they were not listened to. One staff member told us, "I don't feel I can speak up, I am shot down."
• The service did not always work in partnership with others such as commissioners, safeguarding teams and social care professionals. Feedback from external agencies confirmed requests for information was often delayed. This did not ensure positive outcomes for people.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• The manager was aware of their responsibilities in line with regulatory requirements. They knew to notify CQC of incidents and events that occurred at the service.
• The provider did not always demonstrate an understanding of their duty of candour. For example, accident and incident records did not always record as to whether people's next of kin had been informed.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to act in accordance with legislation regarding the Mental Capacity Act 2005. This was a breach of regulation 11 (1) (2) (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was a failure to manage medicines safely. This placed people at risk of harm. This was a breach of regulation 12 (1) (2) (g). The provider failed to ensure systems were in place to demonstrate that safety and risk was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (1) (2) (a) (b) (c) (d) and (e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider failed to ensure people had access to a variety of nutritious and appetising food and sources of hydration to ensure their hydration and nutrition needs were being met. This was a breach of regulation 14 (1) (2) (4) (a) (c) and (d).

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care	governance The provider failed to ensure systems were in place to demonstrate the safety and quality of the service was effectively managed. The provider failed to monitor or take action to address issues and make improvements. This placed people at risk of harm. This was a breach of regulation 17 (1) (2) (a) (b) (c) (e) and (f).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to support staff to carry out their roles by failing to provide adequate training and supervision. Not all staff had the knowledge and skills required to support people safely. This placed people at risk of harm. This was a breach of regulation 18 (1) (2) (a) and (b).