Imperial Care Homes Limited

Field View

Inspection report

Hayes Lane
Fakenham
Norfolk
NR21 9EP

Tel: 01328856037

Date of inspection visit:
09 February 2016

Date of publication:
10 May 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection visit took place on 9 February 2016 and was unannounced.

The home is registered to provide accommodation with personal care for up to 17 older people. There are 13 single bedrooms and two shared bedrooms. On the day of our visit there were 16 people living at the home.

The provider was also the registered manager. However, they were not permanently based at the home and visited only once a week. They had delegated management responsibilities to the care manager who was on site all week. 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.

People felt safe at the home and staff were knowledgeable about safeguarding adults and the different types of abuse to look out for. They knew what action to take if concerned about possible abuse.

The safety of people living at the home was compromised on a number of occasions in terms of day to day care. There were not enough staff on duty to always meet people's needs. People were not always able to get up or go to bed when they wanted too, and there were not always enough staff to spend time with people.
Care records and risk assessments were not up to date and did not reflect changes in need for people living at the home. Risk was not always assessed and appropriate steps were not always put in place to keep the person safe.

Medicines were managed safely and people received their medicines on time.

People were supported to eat and drink, however nutritional assessments and other records were not adequately maintained or kept up to date to ensure people had enough to eat. Food was cooked freshly every day and people were offered alternatives were available.

Staff and the registered manager's knowledge around the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguarding (DoLS) was poor and the process was not clearly followed to a level appropriate to people needs.

People's rooms were decorated with their personal belongings so that they were comfortable and the area was made into their own space as much as possible. People thought staff were very nice and they felt cared for. However on occasions staff did not stop to consider people's feelings.

The care records kept by the home were not always responsive to the needs of the people living in the

home.

People knew how to raise concerns and previous complaints had been dealt with.

The registered manager had failed to keep up with changes to legislation and their responsibilities as a registered person. Policies and procedures to support staff were out of date and some were incorrect. Audits for quality had been recorded as carried out however they had failed to identify issues or actions to resolve these.
You can see what action we told the registered manager to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were not always enough staff to meet the needs of the people living at the home.

People were not protected from risk in a consistent manner and this was not always appropriately recorded.

Medicines were given to people in a safe way and records were kept to show the receipt, administration or return of these medicines.

Is the service effective?

Requires Improvement

The service was not always effective.

People at risk of not eating or drinking enough did not have their needs fully assessed and monitored to reduce this risk. People enjoyed their meals.

Staff and registered manager knowledge around the Mental Capacity Act and Deprivation of Liberty Safeguards was poor and the process was not followed to ensure people were supported to make decisions or have their best interest decisions made known.

Staff training was in place and staff received regular supervision.

Is the service caring?

Requires Improvement

The service was not always caring.□□□□□□

People were happy with the care they received. However, staff did not always consider the feelings of those that lived at the service.

People's privacy and dignity were sometimes compromised.□

Is the service responsive?

Requires Improvement

The service was not always responsive.

People living at the home did not know what was in their care plans and care records were not updated with their personal needs.

People did not always have access to regular activities.

People knew how to raise complaints and concerns and were given opportunities to be heard.

Is the service well-led?

Requires Improvement

The service was not always well led.

Staff did not know the values of the service or what they meant. At times the registered manager had failed to keep up with changes to legislation and their responsibilities as a registered person.
Quality assurance processes were not effective in assessing and monitoring care being provided or the systems running the home.

Field View

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 visit took place on 09 February 2016 and was unannounced. The inspection team consisted of two inspectors.

Before the inspection, the provider completed 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. We reviewed this alongside the notifications that had been sent to us, as is required by law. We also contacted social care professionals at Norfolk County Council, and at Norfolk West Clinical Commissioning Group. After the visit we also obtained information about the last fire safety audit undertaken by Norfolk Fire and Rescue service, and information from the District Nursing Team.

We spoke with five people living at the home, a visitor of a person living at the home and a visiting health professional. We also spoke with the registered manager, care manager, senior care worker, two care workers and the cook. We spent time observing the care provided to people during the day.

We reviewed the care plans of six people; training records and staff files as well as a range of records relating to the way the quality of the service was audited.

Requires Improvement

Is the service safe?

Our findings

People living at the home did not always have relevant risk assessments in place. This meant that staff did not always have the correct information to reduce risk and respond in a safe manner should the need arise. For example, we saw in falls records that one person had fallen seven times in eight months. The registered manager was not able to tell us of any actions that had been taken to reduce the number of falls this person had, or if the appropriate health teams had been contacted. We reviewed plans for this person and found no risk assessments to minimise risk or actions staff should take if the person fell. Because this risk had not been responded to we were not assured that people were safe from falls or that other risks had been properly identified and reduced.

People's care records contained information that indicated they were at high risk of developing pressure ulcers. The assessments associated with reducing this risk had not been completed with all of this information and indicated that people's level of risk was lower than it was. For example one person's care records indicated that they should be assisted with personal care every two to three hours although there were no entries to show this had occurred. However we observed that this person had not been assisted with personal care nor had their position changed for six hours. We saw that staff members did not discuss whether the person had received personal care or not during the handover period. A staff member told us they had assumed staff on the earlier shift had completed this care. Consequently, the person's risk of developing a pressure ulcer was not adequately managed.

The care manager said that when people came home from hospital care records were adjusted to reflect any change in need. When we reviewed the records of a person who had been into hospital, assessments had not been reviewed to determine whether there had been any change in the person's level of risk or need.

We saw two people whose care records said they needed to be supported throughout the day both with mobility and personal care. One person's relative told us and staff confirmed that the person's level of continence and mobility had deteriorated. However, this deterioration was not fully reflected in the care plan. For example the person became distressed when using equipment to mobilise and this was not reflected in the care records. Therefore staff were not supported to manage the risk. In addition the deterioration in continence was not reflected in the risk assessment to support the person to maintain healthy skin.

There were a lack of effective assessments for risk for people living at the home, and they did not reflect people's changing needs.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us that they had to go to bed earlier than they would do at home due to there being a single member of staff on at night. They said, "I go to bed a lot earlier here. I just accepted what they said and go at

9.45pm. I have to be in bed when they all go." A relative we spoke with said there was always staff around when they visited.

Staff gave us varying opinions of staffing levels, but told us that they were not always able to meet people's social needs. Staff told us that there were, "Not always enough staff to do activities have to find time to see those that don't want to come down from room". They also told us, that on some occasions, if a person was calling staff regularly throughout their shift, it was hard to do activities as well as respond to people. Staff indicated in the handover period that a person living at the home had been calling staff all day, this we saw to be the case, and meant staff were under additional pressure to meet everyone's needs.

The registered manager told us that they had not completed a formal assessment of the number of care staff needed at different times of the day to keep people safe. On the day of our visit there was one senior and two care staff on duty in the morning and two care staff in the afternoon. This was consistent with the rota that we saw. Usually the care manager was normally on duty Monday to Friday. There was only one member of staff on duty at night. The registered manager explained that if they needed support this could be accessed by either calling for the member of staff who lived on the premises or if they were unavailable then ringing the care manager who lived close by. However, the registered manager was unable to show us that in an emergency this process would be sufficient to keep people safe.

The registered manager also explained that there was a cleaner in the mornings, however due to annual leave the care staff were covering some of these duties in the short term. In addition to the care staff there was a cook. They cooked the midday meal and prepared any tea time food which could be made in advance. However, they only worked until 1pm so care staff were required to prepare some of the food at tea time. This meant that staff were busy throughout their shifts, and additional tasks of preparing tea and cleaning meant they were not able to spend time with people.

At least three people required two staff members to help them change position. The registered manager told us that a second night staff member was available on call only. Both of these staff members were also employed to work during the day and one of them was not on the premises during their on call shift. This placed people who needed two staff to assist them were at risk of not receiving appropriate support with their mobility or of having to wait considerable time for support, at night. In addition we saw one person who needed two members of staff to provide personal care was routinely supported to get up by the member of night staff there was no record that a second member of staff had been called for assistance. Care records showed that this person had a preferred time to get up of 7.30am to 8.00am but was routinely assisted to get up before 7.00am we saw this impacted on their day as they spent time asleep during a relatives visit.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe living at the home. We asked one person if they felt safe, they said, "Oh yes, no one bothers me and no one wanders into the room at night". A visitor we spoke with told us that they felt their relative was safe at the home.

Staff working at the home told us they understood how to safeguard people from abuse and had received training about it. This was seen when we reviewed the training logs. Staff knew how to report any concerns that they may have to senior staff, and where to find the policy. However, we found the policy to be out of date and whilst accessible the content contained incorrect information about who should be contacted at the local authority. Which meant referrals may not be received by the appropriate agencies.

The registered manager had systems in place to ensure they checked that prospective staff had the appropriate skills and qualifications to care for people before offering them employment at the service. For example, we saw people had completed application forms and the care manager had completed and documented interviews. The required checks had been completed to ensure that staff were safe to work with people who live at the home.

People told us that they received their medicines on time. Staff who dispensed medicines were trained appropriately and they dispensed medicines in a way that enabled staff to make accurate records, with coloured coded systems. This reduced the risk of any errors. Medicines were stored appropriately and records were up to date and accessible.

Requires Improvement

Is the service effective?

Our findings

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found that the registered manager and the staff could have better knowledge around MCA and DoLS, and therefore people could not always be assured that their human rights were always protected. The registered manager told us that everyone living in the home had capacity to make their own decisions. However, we observed that there were people living at the home for whom expressing their decisions was clearly difficult. In addition we noted that only one person had a legally binding Lasting Power of Attorney, which is the only legal route, that one person can provide consent for another person. This can only be enacted once a person is unable to make decisions for themselves.

We reviewed people's care records and mental capacity assessments for information about assisting people to make their own decisions or for staff to support with making decisions if this was not possible. Assessments for these people had not been completed and there was no information in care records regarding communication difficulties. The service had no MCA or mental capacity assessment policy in place, only a copy of the assessment for reference. Staff therefore had no written guidance to ensure they enabled people to make as many of their own decisions as possible.

People living at the home had a section of their care plans to sign to consent to the care outlined. However, we found some instances when people's relatives had signed on behalf of a person.

We checked whether the service was working within the principles of the MCA and at this time found that no person had an application for a DoLS. People living at the home had a section of their care plans to sign to consent to the care outlined. However, we found some instances when people's relatives had signed on behalf of a person.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People living at the home told us that they were happy with the quality of the meals they were given. One person said, "Oh the food is excellent" and another person told us, "The food is very very good and nicely presented".

In the afternoons we saw that staff spoke to each person to ask what they wanted for their tea, there was a wide choice and each person was given what they asked for. People told us they were happy with the meals they received. We saw that people had access to hot and cold drinks, and were given a choice by staff as to which they would prefer.

One person required some support to eat their meal and we saw this was not available until all the meals had been served. Although they had eaten some of their food the rest had been going cold on the plate. When the member of staff supported the person they presented the food to the person quickly and did not engage the person in any conversation about the meal. We saw the same member of staff returned to the person and assisted the person to wash their hands but they still did not talk with the person.

We saw that where people had been prescribed nutrition supplement drinks, these were available. Where people were at risk of poor nutrition the amount and type of food and drink they received was not recorded, which meant that an assessment of their nutritional intake could not be made.

Where people were unable to stand up without the use of aids or equipment their weight had not been monitored, staff had recorded this as unable to stand. This meant the person's risk of poor nutrition was not completely assessed. The registered manager was not aware that staff were not using special scales in the home or other methods to monitor people's nutritional health. We saw that one person had lost a stone over a very short period of time, however no action was taken about this for a further two months. Following a request from this person's GP to weigh the person for a specific number of days we saw that this had also not been carried out. Following this, the person again lost another considerable amount of weight and it was not until three months after their initial weight loss that the person started to receive nutritional supplements.

We visited the home on Shrove Tuesday and saw that people were offered pancakes for dessert. They were offered a choice of toppings. We saw one person said they did not want a lot of sugar and the cook said they would put in a separate bowl so they could add their own. The person also complained that the pancake was cold so the cook took it back to the kitchen and warmed it up for them. This helped people to maintain traditions that they would have followed if they lived in their own homes. The lunch table was nicely set with a tablecloth, napkins and salt and pepper. The cook ensured that the people who chose to sit at the table were served together so that they were eating at the same time.

We spoke with a visiting health professional and they told us that staff were always available to support them when they visited and they thought instructions for a person's care were usually followed. One person told us they were visiting the dentist the next day and people told us the chiropodist visited.

The registered manager told us that the staff received regular supervision on an eight week basis; this was confirmed by staff who also told us they did not need to wait for supervision if they had issues or concerns. Formal supervision enabled the member of staff to review their work with their manager and discuss any training needs.

The registered manager told us that staff were appropriately trained in the relevant areas and this was confirmed when we reviewed the training records, however staff were yet to undertake equality and diversity training and staff had poor knowledge of the mental capacity act training. Staff told us that if they needed additional training they could just ask and this would be sourced. If people living at the home had specific needs then training was also delivered to ensure staff understood those particular needs, for example staff received diabetes training when a person at the home was diagnosed with the condition. Staff told us that they had supported people with shadowing when they were new to help them learn and if they needed any

information about a person living at the home, they knew where to find the persons file.

Requires Improvement

Is the service caring?

Our findings

People told us they were happy with the care provided by staff. One person said, "They are good girls… they are really good and will do anything for you." A visitor said that staff always ensured their relative looked nice and that their clothes matched. Staff told us that they painted peoples nails for them if they wanted it, and one person liked to wear gloves. When it was noticed that the person did not have any they were fetched quickly. One person told us they were supported by the manager when they needed to buy anything.

People told us that the staff were always kind and gentle when providing care. People told us that they had built trusting relationships with the staff, the registered manager told us that there was a very low staff turnover in the home. One person said, "I treat the staff as my friends." People told us that they were supported to maintain family relationships, for example, one person said that staff supported them to call relatives if they wanted to talk to them.

However, there were times when staff did not stop to consider people's feelings. For example, one member of staff encouraged people to play a game; however, they hung the game on a person's frame and moved it away from them without asking permission. We saw this annoyed the person and the person asked the member of staff who had said they could do that. The member of staff did not return their frame and continued to use it for the game until another person living at the home presented them with an alternative. They did not realise how important it was to the person to have their frame within reach and that without it they were restricted.

We also saw that there were occasions when staff members ignored people. At the lunchtime meal we saw a staff member reheat a person's meal and provide basic hand hygiene to the person without speaking to them at all.

We found that staff members were not always respectful when they discussed people in speech or writing. For example, written records included unnecessary exclamation marks when describing a situation which made records appear disrespectful towards those living there.

People we spoke with were not always aware of their care plan and what their identified care needs were. One person told us, "I have no idea what is in my care plan. We did speak about care needs but that was a long time ago." Another person said, "I don't know what is in my care plan." The registered manager told us that a senior care worker undertook individual monthly reviews, , but did not involve people receiving care. People's views were sort on a six monthly basis when their care was discussed with the care manager

Despite this, people told us they were supported to make choices about their daily lives. For example, people said that they could choose to go to the dining room for their meals and we saw many people chose to eat in their bedroom. They were able to choose where they spent their time. One person who mainly stayed in their room said, "I'm happy with my own company and I have my radio, television and books. I usually find something to occupy myself."

One person said, "They certainly are looking after me properly." Staff told us when the delivered personal care they encouraged people to do what they could do for themselves. People's rooms were decorated with their personal belongings so that they were comfortable and the area was made into their own space as much as possible. People in their bedrooms had access to their call bells and were able to ring for staff at any time.

Two people were sharing a bedroom and we saw that their privacy was protected with the use of a dividing curtain. Records showed that one person had wished to share a bedroom. However there was no information in the other person's care plan to say they had consented to be in a shared room. Another person told us that they had been living in a shared room and hadn't liked it, so they were moved to a single room as soon as one became available.

Where people were able they were supported to be independent, one person told us how they went out to community groups. A visitor told us that if staff had any concerns about their relative they [the staff] would contact them and keep them informed of any changes.

Requires Improvement

Is the service responsive?

Our findings

We reviewed the care plans of six people who lived at the home. The care records did not always contain dates and therefore it was difficult to determine when changes had taken place.

The care record for one person said they could use the stand aid but got distressed, we saw in the daily notes that the person had used the stand aid with one staff member to assist; but how they coped with this was not recorded. The care records did not identify any alternative forms of equipment to better support the person or staff during this procedure. In addition this person was also recorded as displaying behaviour which people may find challenging when receiving personal care. There was no information in place to provide guidance to staff on what to do when the person was upset during either of these times.

Staff relied on daily records and six monthly reviews for information about changes to care. Information in these records had not been transferred to care planning records and subsequent risk assessments were not completed. This meant that the care needed when there had been changes to people's needs was not planned or personalised for people who lived at the home. For example we saw one person's risk assessment for pressure damage recorded their continence ability remained the same since admission; however staff and relatives confirmed that their level of continence has declined.

One person told us how they were supported to access books, they told us, "The manager arranged for a visit from the library lady and so I get books every so often." We also saw that books were available in the lounge area for people to borrow.

There was an activity plan on the wall and we saw that activities were scheduled for one hour a day. However, one person told us that the activities listed on the notice board often did not happen as people were not interested.

Staff told us they were responsible for carrying out activities and tried to follow what was on the board. However one staff member told us that they, "Try to do something every day, follow the boards, can't on Mondays as we have deliveries from Bookers and hairdresser so we are too busy". We saw there was a folder for recording what activities had been done and this was sporadically completed, and some activities were listed as 'watching Emmerdale' which may not be inclusive to all people living at the home.

People living at the service were invited twice a year to a 'resident's meeting', where their views of the care; the home and the activities were discussed. This could be done as group or on a one to one basis. We observed at lunchtime that there was only one main meal to choose from on the menu; however people told us that if they did not like the meal they could choose an alternative. One person told us, "They [the cook] come and ask if you would like the meal and if it's something I don't want you can have something else".

People told us that they knew how to complain. Most people we spoke with told us they had never felt the need to raise any concerns about the care they received. However they said they knew if they were not happy they could speak to the registered manager or the care manager. One person said, "I have never

made a complaint as I never need to. If I did I would complain to the care manager." Another person told us, "I can't think of anything I have to complain about." Another person told us they had spoken to the registered manager about a concern and they were happy with the outcome of the discussion

We saw information advising people how to complain was available to people in the service user guide and statement of purpose available in the entrance. However, we saw that the advice given to people regarding the action to take if they were not happy with the outcome of a complaint was out of date, for example the Local Government Ombudsman was not listed as a point of contact.

Requires Improvement

Is the service well-led?

Our findings

People told us they had completed a questionnaire to gather their views about the home they received. One person said, "I had a form to be completed, [senior carer] brought it round." People also told us they were able to raise any concerns or ideas at 'residents' meetings'. One person said, "We have residents' meetings where we can make suggestions. I have made suggestions and changes happen."

Staff told us that they had regular staff meetings and they told us they could approach the management team and discuss issues and felt listened too. A staff member told us that, "We [the staff] ask residents what they think of care, and they can talk to them [staff] at any time, we [the staff] would report to management and record it in the communication book". However, when we reviewed the communication book in line with daily records and monthly reviews, we did not always find information that matched and therefore it was unclear what had been undertaken with the person and what had not. For example we saw where some falls had been recorded in falls records but not all in daily notes, which meant staff did not always know if a person had fallen recently and action taken. This was not audited by the registered manager or the care manager, and we were not assured that the management team had a clear understanding of what care was needed and where.

We saw that information available to people in the entrance hall was out of date. For example, the registered manager was still displaying their registration certificate under legislation which was replaced in 2010. Their current registration was not on display; instead the old certificate was there with written additions made by the registered manager. In addition information in the statement of purpose and service user guide around complaints was out of date, giving reference to the CQC and not the Local Government Ombudsman.

We saw that health and safety audits had been carried out in a number of areas. These were dated on the front sheet as reviewed annually however this was on the original form and it was unclear if any risks had been reassessed. We saw the care manager had also completed an infection control audit, the original form had been completed in 2010 and each year since it had been noted that there were no changes, again there was no evidence of how the risks had been reassessed. The home looked tired and in need of some attention. For example, the foam in the dining room chairs has disintegrated leaving them with hard backs that were uncomfortable to sit on, and wall paper was peeling away from the wall near the kitchen doorway. In addition, the daily menus were old and tatty and had been updated with stickers over some of the choices. There was no evidence that audits identified any of the areas of concern that we found during this inspection visit or had developed a strategy or action plan for improvement of the home.

The service had a number of policies and procedures in place, however these were all dated 2009 and alike to the audits, a date and note to say no change was on the front of the file. When we reviewed certain policies in more detail we found them to be out of date and holding incorrect information, for example the safeguarding policy made reference to CQC and not to local authority professionals and the whistleblowing process was not accurately recorded. The training policy gave examples of the Common Induction Standards rather than the Care Certificate and information on notifying CQC of incidents was under a

previous regulatory body (Commission for Social Care Inspection) and identified contact details that were out of date. Additionally we found information on the Liverpool Care Pathway and no Mental Capacity Act (MCA) policy was in place. This meant that staff did not have access to up-to-date guidance and legislation, should they need to refer to it when caring for people that lived at the home. Staff told us they did not understand certain areas, for example staff understanding of the MCA and Deprivation of Liberty Safeguards was poor, meaning individuals were not appropriately assessed. This was not known by the registered manager. Whilst the service was run daily by a care manager the support for that staff member from a registered manager overview and for policy and procedures was unclear.

We found that at times the registered manager had failed to keep up with changes to legislation and their responsibilities as a registered person. The registered manager had not been aware that there was a lack of effective auditing at the home and had not picked up on issues that we did, during our visit.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that they visited the service every Monday, and they could always be called upon if they were needed. People that lived at the home and staff all spoke highly of the registered manager and senior staff members. A visiting healthcare professional said that the care manager was approachable and they could discuss any concerns with them.

We saw that the registered manager had reviewed how medicines were managed and had changed systems to one which supported staff to manage medicines more safely and in a more timely way.

The statement of purpose listed nine values that the registered manager said was important in providing care. However they were unable to tell us how they ensured these values were embedded into the service they provided, other than at staff appraisals. Likewise when speaking with staff they were unable to identify these values and what they meant to their role.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment was not always delivered with the consent of the relevant person. The Mental Capacity Act 2005 principles had not always been followed. Regulation 11 (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk to people's safety had not always been assessed or action taken to mitigate these risks. Regulation 12 (2) (a) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established or operated effectively to assess, monitor and improve the quality of the services provided or to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Regulation 17 (1) (2) (a) (b) (c) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of staff were not deployed effectively at all times to ensure that people's

needs were consistently met.

Regulation 18 (1)