Oxtoncare Limited

Oxton Grange 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**

Summary of findings

Overall summary

This inspection was unannounced and took place on 07 and 08 November 2017. At our last inspection on the 23 and 24 March 2017, the service was required to improve the governance of the service by improving the records they kept in relation to the care they were providing to people.

Following the last inspection, asked the provider to complete an action plan to show what they would do and by when to improve the key question of Well-led to at least 'good'. At this inspection, we found that they had not met this requirement or implemented a procedure to update and monitor care plans and associated records.

Oxton Grange Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Oxton Grange Care home is a purpose built home providing care to elderly people who require personal care. The home can accommodate up to 60 people with dementia type conditions and physical health needs. At the time of our inspection, there were 48 people living in the home.
The accommodation is provided over four floors with several communal areas and the building was purpose built. It is surrounded with gardens, has a large car park and is on a main road in a residential area.

The home required a registered manager and one had been in post for several months, having previously worked at the home as a 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.

We found breaches in relation to Regulations 10, 12, 14, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities). Regulations 2014. These breaches related to dignity, safe care and treatment in relation particularly, to staffing levels and medication administration, nutrition and hydration, good governance, and staff support.

We saw that during our inspection, at times, there were no staff apparent on one of the floors or in one of the lounges. We saw that people had been left alone in precarious positions in one lounge. There appeared to be a shortage of staff overall, medication rounds were not able to be completed in a timely or possibly safe way due to the staff administering medication being frequently interrupted and the staff were not able to meet people's dependency needs.

Medication administration was not adequate; dates of opening of some medication were missing and other records were not completed properly and were misleading.

We saw that although the care documentation was designed to be person centred, it had not been correctly or comprehensively completed and there were omissions and contradictions in the care records. We saw that care records were incomplete, contradictory or missing important information. Monitoring was not done or recorded appropriately. Food and fluid charts were not completed properly and when a person was noted in the records to have lost a lot of weight, there were no records to show that suitable action had been taken.

Although the management had completed audits of policies and procedures, there were no action plans created to address any issues and no root cause analysis of the problems had been undertaken.

There was no effective overview of the home and its practices and records, or actions to address issues found, by the managers in the home and by the provider.

It was not obvious to the inspection team that there was good partnership working and the records indicated that some referrals to external health professionals had not been made.

The provider followed the Mental Capacity Act 2005 and its guidance although records showed that some staff needed refresher training.

We found that overall, the care was good and that generally, staff treated people with kindness and respected their dignity and privacy. People and their relatives were happy with the staff and the care they provided.

There was a good range of activities available and some innovative practices were being followed by the activities coordinators.

The management team were open and transparent during out inspection.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were insufficient staff to meet people s needs.

Medication administration was poor and inappropriately recorded.

Care records did not record the correct information to inform staff.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff training records showed gaps in staff's refresher training, including the Mental Capacity Act.

People's nutrition and hydration records were not completed and action not taken when there was an issue.

The provider followed the requirements the Mental Capacity Act.

Is the service caring?

Requires Improvement

The service was not always caring.

Most staff we observed interacting with people, treated them with kindness and respected their dignity and privacy. However, we heard verbal abuse from staff to a person living in the home.

There were insufficient staff to meet adequately meet people's care needs.

Most staff communicated well with the people they were supporting and showed patience and understanding and gave them information and explanations about what they were about to do.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Although the care plan documents were designed to be person-centred, they were not completed properly and so did not achieve the aim of being person-centred.

People were offered choice about their food, clothing and how they spent their day and were able to experience activities they preferred. However, staff did not have time to respond to people's choices and most people were placed in the lounges during the day.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a registered manager in post but they and the provider, did not have over-sight of the service and its issues.

We found that the probable cause of all the issues we found was poor staffing levels, record keeping, the lack of robust management and effective auditing and quality assurance procedures. Some auditing had occurred, but issues had not been addressed by either the registered manager or by the provider in a timely or effective way.

Oxton Grange 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 checked 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.

The inspection was prompted in part by information of concern from a whistle-blower and the local authority and by many statutory notifications from the provider which told us about a high level of falls in the home. There had been allegations that staff treated some people who lived in the home, with disrespect. There were also allegations about medication administration and a shortage of staff. This inspection examined those risks.

This inspection took place on 07 and 08 November 2017 and was unannounced on the first day.

It was carried out by two adult care inspectors and a specialist advisor. The specialist adviser was a registered general nurse also had knowledge about people living in care settings, the elderly and about people who had dementia type conditions.

We checked with the local authority, the local infection control team and the local fire officer and also looked at our own records to see if there was any information we should consider during this inspection. We looked at the information the service had sent to us as statutory notifications. We also looked at the local Healthwatch website to see if they had recorded any concerns about the home.

We used the short observational framework for inspection (SOFI). SOFI is a tool developed and used by CQC inspectors to capture the experiences of people who use services who may not be able to express their views for themselves.

We used pathway tracking to follow four people's care through from its planning to its delivery and also looked at an additional three care records. We looked at five staff recruitment files, five training records, eight medication records and other records relating to the running of the service.

We spoke with four people, with four relatives and eight staff including the operations director, the registered manager, the deputy manager and the activities co-ordinator. We toured the home and observed some care, checked a medication round and observed lunch and other social activities.

Inadequate

Is the service safe?

Our findings

We spent time talking with four relatives all who told us that they thought their relatives were safe living at Oxton Grange. A staff member told us, "No, I don't think there are enough staff".

We talked with four people who indicated they were safe. Their communication was difficult to understand and we were not sure that they fully understood the discussion around safety we had with them.

As we toured the building, it was apparent that there were issues with a lack of staff. One floor had no staff obviously present and on one floor, a lounge had eight people in it, with no staff member available for support. In this lounge there were two people in the chairs which appeared very uncomfortable or potentially unsafe. One was lying on a sofa, but in a precarious way, with their head falling towards the floor and another person was sitting in a chair in such a position as to potentially cause some injury to their neck or head. Another person was moving about the lounge, aided by a stick, with random direction.

We spoke with four relatives; two relatives told us there was sufficient staff on duty to care for their relative and two relatives said there should be at least one more on each floor. Their comments included, "They [staff] are always busy but we feel our relative well cared for" and "The staff are very good with our relative, we have no issues at all". The registered manager told us that they believed there should be more staff on duty and had requested this from the provider. The registered manager sent us a copy of a request to the provider for more staff which had been made on 31 October 2017 and agreed on 02 November 2017. This permitted the use of one additional staff member during the day. It was difficult to see that this had happened and it was not clear from the rotas that this had been planned for. We saw that there was an absence of staff on some floors and communal areas and we observed that with the authorised increase there were still insufficient staff to support the dependencies of the people living in the home.

We discussed staffing levels with a staff member and a senior staff member. The first staff member told us that there were not sufficient staff on duty. The senior told us that they thought there were sufficient staff on duty.

This was a breach of regulation 18 of the Health and Social Care Act 2008, (Regulated Activities) Regulations 2014, due to having insufficient staff to meet people's needs.

In one of the lounges, we saw a person with a head dressing, waiting for an ambulance. We were told that this person had fallen about 30 minutes prior to the time we saw them. We checked the person's care plan and risk assessment, which stated that they should be monitored regularly when in their room as they were prone to falls. The records showed they had not been monitored from 07.30 until 10.15, when staff were alerted by the sensor mat alarm being activated. This person was found on the floor.

There was an accident and incidents policy. We saw that monthly audits had been completed for falls, but there was no evidence of any root cause analysis, even though there had been 55 un-witnessed falls in the seven months since our last inspection in March 2017.

We found that other people's records contained conflicting information and did not tell staff about how the person should be supported in a safe way, or their condition monitored, recorded or managed. An example was fluid balance charts, which were erratically completed and had incomplete information as there was no target fluid intake on them. This meant that people's fluid intake could not be adequately assessed or actions taken to address any concerns.

We saw that risk assessments were in place, but in some of the entries we found in in the care records; it did not appear that they were always adhered to.

We accompanied a staff member who was administering medication on the ground floor, for the morning medication round. They wore a red tabard which did not have the usual 'Do not disturb' written on it. We were told that new tabards were on order. The staff member observed safe hygiene practices and treated people with dignity and respect and explained to each one what the staff member was about to do. However, we noted that the medication round took a long time. The morning medication round on the ground floor did not take place until 11 to11.30. This meant that this could possibly affect the efficacy of the medication administered and also could be dangerous, as some drugs had strict time limits for their administration. The staff member had already administered medication on the first floor. They told us that they were often called away to attend to an issue and that they would like to see a third senior, who could attend to any other issues and oversee staff and residents whilst the medication round is underway.

Staff administering medication should have their training refreshed and competency checked periodically. The training records were incomplete and one staff member's competency assessment could not be found.

The medication administration records (MAR) were not always accurate as there were discrepancies on them. An example was that one person was prescribed a drug to be taken every 12 hours, but for the previous five days, the time of administration had not been recorded. Another drug was to be administered on the same, single day, each week, but the MAR sheets recorded it had been given each day from 02 November 2017. When we counted the drug it was evident that the drug had not been given, but had been signed that it had.

These above are examples of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, due, regulation 12, due to un safe care and treatment.

We were provided with the records for two people who were currently receiving covert medication. All of the relevant documentation was seen to be in place.

We saw that there were pressure relieving mattresses and sensor mats in some rooms, but there did not appear to be any system for checking Air mattress settings. We asked one staff member if the pressure settings were checked daily and they replied, "No, but we will know when we do the personal care." We asked what would happen to the pressure on the mattress if there was a power cut and they said, "I don't really know. Maybe there are back up batteries".

A weekly fire alarm test was carried out and monthly and fire drills. Fire evacuation aids were provided for staircases. We saw good records of fire drills. A fire exit door was observed to be open on both days of the inspection even though it had a sign on it stating 'to be kept closed at all times'. A 'grab file' was available on each floor and this contained a personal emergency evacuation plan for each of the people using the service. We saw that the maintenance person checked water temperatures appropriately and that there had been a legionella bacterial check carried out in February 2017. Records showed that hoists, slings and other equipment were checked and serviced regularly.

During our inspection we saw staff using appropriate personal care equipment except one staff member who did not follow the universal hand hygiene good practice. We saw sufficient hand sanitizer throughout the home. There was hand washing signage and infection control signage throughout the home. We looked at the last Infection control monitoring audit completed on the 5 June 2017 that gave an overall score of 99%. We discussed this with the manager who told us that they went on all floors daily to observe practices of staff. We were informed that there were two people with pressure wounds and that there was a tissue viability nurse involved with their care.

Staff were recruited using safe practices, such as obtaining two suitable references and having a check made of any criminal record. They received an induction with the provider's mandatory training and were able to tell us about how to keep people safeguarded. There were appropriate employment policies in place, such as disciplinary and grievance and whistleblowing.

Staff were able to tell us about abuse and what they would do if they suspected or witnessed abuse. One said, "I would never allow any abusive behaviour, I would challenge any bad practice and report directly to the management".

Requires Improvement

Is the service effective?

Our findings

People's weights were recorded monthly or more frequently if required due to ill health and malnutrition universal screening tool (MUST) records had been implemented. One relative told us that their relative had put weight on whist being at the home and told us they really enjoyed the food. However, we looked at people's MUST records and saw that one showed that the person had lost nearly 4kg in the last month. There was no reason given for the weight loss or action noted about what had been done to address this, such as a referral to a dietician. Other charts had not been filled in correctly or totalled as required. This meant that staff were not able to see if there was any problem with people's nutrition and hydration.

This was a breach of the Health and Social Care Act 2008, regulation 14 (Regulated Activities) Regulations 2014, due to the service not meeting nutritional and hydration needs of the people living in the home.

Newly recruited staff received an induction with the provider's mandatory training and completed a probation period, before being confirmed in post. Staff then went on to complete other training, as necessary. We saw that there were gaps in the training matrix which did not evidence refresher training in some areas, such as safeguarding or MCA. One staff member us that the training was e-learning and they felt they were not learning and that it was an "Exercise by them [the provider] to tick boxes". Another staff member said about e-learning, "I do not rate it; who monitors our learning and we don't get any feedback".

Supervision and appraisals were scheduled regularly, however one staff member stated that due changes in staffing, they had been supervised by three different seniors in recent months, which the staff member found unhelpful. Another staff member said that they did not feel supported by the management and had not received an appraisal in over a year. They told us, "The management don't' listen". However, a third staff member told us that they felt supported in their role and had regular supervision meetings with one of the management team.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. 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 was 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).

The registered manager was knowledgeable about the MCA and had implemented a procedure for complying with the Mental Capacity Act with records in place to show what actions had been taken in relation to people's mental capacity. There was evidence of MCA 'best Interest' meetings in the care records we reviewed. No person living in the home had an authorisation in place, but there were several applications pending to the local authority.

We observed people having lunch on the third floor. The tables were laid with a table cloth and cutlery; there were no place mats or paper napkins or condiments. There was a choice of main course and on sampling it we found it to be tasty and hot. The chef told us that all the food was prepared and cooked in the kitchen from fresh ingredients. Most of the people appeared to enjoy their meal. People were provided with a choice of water, squash and hot drinks were readily available. The dining room was very quiet as people did not talk to each other. One staff member was supporting a person to eat and did not at any time in 20 minutes talk to them.

Tea, coffee and biscuits were served in the morning and afternoon and after the midday meal. People told us they enjoyed the tea and cakes as they were homemade. We spoke with four relatives who told us that they had been at the home at different meal times and that they thought the food and drinks provided was good.

Menus had recently been changed; the menus were rotated every four weeks. The menus were observed to be on notice boards in each of the four dining rooms. We discussed with the chef and registered manager that the menus were difficult to read as the writing was very small.

The care records we looked at showed that people's nutritional status was assessed and monitoring was required for people on diets. For example, there were currently 10 people receiving a fortified diet. The chef told us this was provided directly from the kitchen.

We walked around all areas of the home and saw that most bedrooms were personalised to the occupants own choice. However, we found that the décor in some communal areas was not conducive to people with dementia. We discussed good practice guidelines for colour schemes to provide an environment suitable for people with dementia, with the registered manager and operations manager.

Requires Improvement

Is the service caring?

Our findings

One person told us, "Its lovely here, the staff are lovely".

We had been alerted by a whistle-blower that some staff were treating people who lived in the home, with disrespect.

On one floor, we overheard two staff members loudly and aggressively talking to a person in their room. The person clearly was not able to follow their instructions, from the responses we heard. Through the opening of the door, we saw the person had been incontinent. Upon seeing us, the staff members moderated their tone. This person was then wheeled by one staff member in a wheelchair with their head lolling backwards over the backrest, to the lounge and the wheelchair was returned to the bathroom without being cleaned.

We informed the managers of all our concerns about this incident and they took action to address them

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, due to people not being treated with dignity and respect.

We walked around the home at different times on the two days of the inspection. The staff approach we observed was rushed most of the time.

We found that there had been a high volume of falls. Vulnerable people fall for a number of reasons, but staff were not given consistent instruction to monitor or prevent falls by their presence or interaction. They were unable to be consistently caring as they did not have sufficient time to check on the most vulnerable people in the home.

However, people were supported by staff the majority of the time with kindness and respect, even though the staff appeared to be rushed. For example, when we watched a medication round we noted that the medications were administered in a polite, patient and dignified manner. Some people took longer than others to take their medication and the staff member administering the medication stayed with the person until they taken it. The staff member did not rush the person and assisted them to take their medication with a drink.

It was clear that staff knew people well and that they treated them as individuals. We saw that staff respected people's privacy. Staff knocked on their doors and called out, introducing themselves, before entering a person's bedroom. We heard staff explaining what they were about to do.

We saw when members of staff were talking with people who required care and support; they were respectful to the individuals and supported them appropriately with dignity and in a respectful manner. We observed staff reacting to call bells mostly in a timely manner.

People were able to lock their bedroom doors if they chose.

People had been enabled to personalise their own rooms. They were able to use the local community for shopping trips and entertainment independently if they wished.

Staff told us that if any of the people could not express their wishes and did not have any family/friends to support them to make decisions about their care they would contact an advocate on their behalf.

People were supported to attend healthcare appointments in the local community; however, the manager informed us that most healthcare support was provided at the home. The registered manager told us that the doctors visited the home as required.

One staff member told us, "Nice home, compared to other homes I have worked at".

Requires Improvement

Is the service responsive?

Our findings

We looked at care records and found that they were intended to be person centred but they were erratically completed and often had contradictory or missing information in them.

An example was that we were provided with the care plan records for one person. The care plan recorded that the person was unable to use call bell and required constant monitoring day and night. They were a wheelchair user and required transferring by two staff at all times. We requested the monitoring records to see when staff had done the monitoring checks, but none were available. We looked at the daily records completed by staff on each shift, these records were not informative and did not show how staff were monitoring and ensuring the safety of this person.

Another example was that a second person's record said that they should be monitored whilst they were asleep and another record for the same person said they should be monitored whilst they were in their room. Other records were not completed, such as MUST charts. A 'Do Not Attempt Pulmonary Resuscitation' (DNAPR) record in place on one person's file was not relevant as it was related to another location the person lived at. DNAPR's are location specific.

The care records for a third person showed that the dependency levels did not work in conjunction with the care plans. The person had low outcomes for their dependency that had an overall scoring of 18 from January 2017 to November 2017 which identified they had moderate to high dependency needs. The last dependency record in November 2017 identified they had a score of 26, which indicated that they had low dependency needs. We discussed this with the manager. The person required support from staff as they had dementia and when in their room were unable to use the call bell and required monitoring, which indicated they actually had a high dependency. Throughout the recent records, an incorrect spelling of the person's first and preferred name was seen, which was inappropriate and disrespectful.

These examples demonstrate that staff could not securely follow a care plan or risk assessments as the records did not reflect or meet the individual's needs.

Care plans were reviewed regularly, but as there seemed to be many repetitive review comments, it was not clear that these reviews had been comprehensive.

The provider did use assistive technology for some people, but we saw in the care records that one person had had the need for a sensor mat identified some weeks prior to our inspection, but at the time of our visit it still had not been provided.

The care files contained a 'This is me' section but we saw that many of these had been incompletely filled out. There was no 'hospital' or health care ' passport or document to provide other external agencies, such as an ambulance crew or other health care professionals, with the basic health care, communication and mobility needs of the person with their next of kin contact details.

We found that some of the information for people living in the home was in a print font and size which for many would have been difficult to read, an example was the menu. People living with dementia also benefit from pictorial information, but we did not see that this had been adopted by the home.

People were able to choose how they spent their day; for example we were told that one person chose to spend their time in bed, although they were able to be mobile. Other people had their meals in their rooms or in the dining rooms, as they wished and people chose what they wanted to wear if they could. Where they couldn't, staff chose clothing appropriately for them.

There was a complaints policy and information about complaints was available in the 'Service User Handbook'. We saw an audit of recently received complaints. There had been four complaints since April 2017 and all had been dealt with appropriately. There was also a record of compliments, of which we noted there were 13 in the same time period.

There were two activity coordinators who provided the activities at the home. We spoke with one activity coordinator who was very positive and passionate about the role they played at the home. We discussed what activities were provided; we were given a copy of the daily programmes that included armchair exercises, church groups, poetry reading, baking club and arts and crafts. The coordinators had also initiated external visits to the home from Pets as Therapy (PAT) dogs, where dogs were bought into the home. A local nursery visited monthly, where children were bought in to meet and talk with the people who lived at Oxton Grange Care Home. We were told that the people got very involved and that the children also really enjoyed their visits. Other activities for individuals were two weekly visits from a hairdresser, manicures and also outings.

One to one activities were provided with people who did not want to join the group activities. We were told that the other coordinator was, 'brilliant at the 1-1 meetings as they were fantastic at arts and crafts'. We observed the activity coordinator talking to lots of people at various times over the two day inspection. They were seen to be happy and very calming and comforting to people; all of them appeared to enjoy the interactions.

One innovative piece of reminiscence equipment had recently been introduced, which used virtual reality headsets. These enabled the wearer to experience various 'realities', such as people's homes, or shopping, when they were younger. Participants wear a headset which gives them a 360-degree view of a location from a point-of-view perspective and is able to track head movements, making for a fully immersive experience. It allowed for people to reminisce about their lives and afforded new material for on-going conversations. The equipment also enabled people with limited mobility to 'experience' other settings and landscapes. The activities coordinator told us that many people had been happy to try these headsets and that with some, they were very popular.

At the time of our inspection there was no one on end of life care. We were told that the home would instigate the 'six steps' programme, which was originally developed in the North West as a programme of learning for care homes to develop awareness and knowledge of end of life care, should a person become at their end of life.

Requires Improvement

Is the service well-led?

Our findings

The registered manager, the operations director and the operations manager were very courteous over the two day inspection and provided all the records requested during our visit and some after.

Audits were carried out, but in many cases there was no action taken as a result of the audits. Also, some of the time scales for audits was erratic, such as medication audits which were carried out in May, June and October 2017. Care plan audits took place, but they had not revealed the issues we found during the inspection.

Services which provide health and social care to people are required to inform the CQC of important events that happen in the service. The registered manager of the home had informed the CQC of some significant events in a timely way. However, we found that some safeguarding concerns had not been reported to us, but had been appropriately referred to the local social services.

We were concerned about the nutrition and hydration concerns we found, which the management had not identified.

The level of staffing at the home was not sufficient to meet people's needs and records such as the falls monitoring records, indicated there was a lack of staff in the home. There was no falls 'root cause analysis' in place to show what the management had done to protect people. The home used a dependency tool which was not used appropriately and the management had been remiss in not requesting additional staff, earlier.

We found that care plan records were not completed in full, had omissions in the information and contained contradictory information and instructions. One person's entries showed a lack of respect in the spelling of their name.

The monitoring room records for people, had gaps and a lack of information recorded by staff, to inform what care they had provided. Food and fluid charts were incomplete and the required liaison with other health and social care professionals did not always happen.

Medication errors were numerous and there was doubt about some staff's competency to administer medication. Training records were incomplete and a competency assessment could not be found.

We found that the registered manager and senior managers of the provider did not have the necessary oversight of the service and that they failed to ensure that there were robust systems in place in order to provide safe and effective care for the people in the home. They did not assess, monitor or mitigate the risks and failed to keep contemporaneous and accurate records for each service user.

These examples are breaches of the Health and Social Care Act 2008, regulation 17 (Regulated Activities) Regulations 2014, due to a lack of good governance.

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 10 HSCA RA Regulations 2014 Dignity and respect People were spoken to with a lack of dignity or respect

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Records were not maintained about people's nutrition and hydration, nor action taken to address any weight changes.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered manager and senior managers of the provider did not have the necessary oversight of the service and they failed to ensure that there were robust systems in place in order to provide safe and effective care for the people in the home.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The service did not use sufficient staff to meet the needs of the people living in the home.