Mrs Reepaben Patel

Victoria House Residential Home

Inspection report

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Ratings

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

Overall summary

The inspection took place on 9 and 10 November 2015 and was unannounced.

Victoria House is registered to provide accommodation and personal care for up 16 older people. There were 13 older people or people with a dementia type illness living at the service on the day of our inspection.

The service was managed by the registered provider. Registered providers are 'registered persons'. Registered persons have the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act, 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect

Summary of findings

people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. This is usually to protect them. The management and staff understood their responsibility and made appropriate referrals for assessment, but no one at the time of our inspection had a current DoLS authorisation.

The provider was not meeting the requirement of the regulations with regard to assessing and monitoring the quality of the service, cleanliness and infection control and safe staffing levels.

Standards of cleanliness were not always maintained throughout the service and there was a risk of cross contamination from soiled and damaged equipment.

People received their medicines safely but not always at a time that was convenient to them. Staff were aware of safeguarding issues and knew how to raise concerns with the registered provide, but were unaware of the local safeguarding authority.

People were cared for by staff that were not always supported to undertake training to improve their knowledge and skills. Staff did not always receive feedback on their performance through supervision and appraisal

People were provided with regular meals. People were able to access healthcare professionals such as their GP and district nurse.

People and their relatives told us that staff were kind and caring. However, we found that people were not always involved in making decisions about their care. People did not always have their right to their personal space respected.

People were not always enabled to follow their hobbies and pastimes and were not supported to maintain their independence. Some relatives felt that their loved ones were bored. Staff provided care centred on tasks rather than the person.

People, their relatives and staff found the provider approachable. The provider did not have systems in place to monitor the effectiveness of the care and treatment people received. The provider was not meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

People were not always cared for in a clean environment.

People did not always have their risk of harm assessed appropriately.

Staff knew how to keep people safe from the risk of abuse.

There was not always enough staff on duty to meet people's care needs.

Requires improvement

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

People were not always cared for by staff that were supported to undertake a programme of induction that prepared them for their role.

The provider was not meeting the requirements of the Deprivation of Liberty Safeguards. Staff had not received appropriate training, and did not have an understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

Requires improvement

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

Staff did not always involve people in decisions about their care.

People's dignity was not always maintained.

Requires improvement

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

People received care that was task orientated rather than person centred.

Staff did not support people to take part in meaningful activities and past times.

Requires improvement

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

Staff had access to policies and procedures to help them undertake their roles.

The provider did not inform CQC about statutory notifications.

Requires improvement

Summary of findings

People, their relatives and care staff found the provider approachable.

Victoria House Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

The inspection took place on 9 and 10 November 2015 and was unannounced.

The inspection team was made up of one inspector and an expert by experience 9 November 2016 and one inspector on 10 November 2016. An expert by experience is a person who has personal experience of using services or caring for someone who requires this type of service.

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 what improvements they plan to make. We used this information to help plan our inspection.

We also looked at information we held about the provider. This included concerns raised by members of the public and staff.

During our inspection we spoke with the provider who is also the manager, the deputy manager, one member of care staff, the cook, one staff member who had joint care and housekeeping duties, the housekeeper, eight people who lived at the service and three relatives. We observed staff interacting with people in communal areas, providing care and support. We also spoke with the local fire safety and rescue officer.

We looked at a range of records related to the running of and the quality of the service. This included four staff recruitment and induction files, staff training information, meeting minutes and arrangements for managing complaints. We looked at the quality assurance audits that the provider completed. We also looked at care plans for six people and medicine administration records for five people.

Requires improvement

Is the service safe?

Our findings

We looked at all areas of the service and found evidence that standards of cleanliness were not maintained and people were not protected from the risk of cross infection from contaminated equipment. For example, we saw bars of soap at communal sinks, soiled toilet cleaning brushes, limescale on taps and damaged and rusty bathing equipment that increased the risk of bacteria growing.

Although the deputy manager was the infection control lead, care and housekeeping staff were not aware of this or the policies and procedures available to support them. For example, they did not have access to guidance on the safe use of personal protective equipment. In addition housekeeping staff did not protect themselves from the risk of contamination. We found that staff did not have access to protective eye goggles to reduce the risk of splashes from cleaning materials or body fluids and the housekeeping staff told us that they wore single use plastic gloves but not protective aprons. There was a daily cleaning checklist for each room, but there was no evidence that this was completed on a regular basis. Housekeepers were not provided with a rota for deep cleaning bedrooms and this impacted on the frequency of this task. For example, we saw that one bedroom had not been deep cleaned since April 2015.

We found that the procedure to clean hard surface floors was inadequate. Housekeeping staff were not provided with mops to clean the floors or wipe up spills and were dependent on a steam cleaner to clean all hard surface floors. One housekeeper told us that this was not effective and said, "I go down on my knees to hand wash the toilet." Staff did not have access to a sluice and there was no guidance on where and how commodes should be cleaned. There was a risk of cross contamination from body fluid splashes to both staff and people as commodes were cleaned in the toilet and hand wash facilities in a person's bedroom.

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

There was one member of care staff on duty overnight, between 10.30pm and 8am. The provider was on call if they needed assistance. We found that four people required assistance of two carers for personal care and mobilising. We were told that they wore incontinence pads and slept all night and therefore required the support of one staff member. However, we found that having one staff member on at night impacted on the standard of care a person received. For example, we looked at the care plan of one person who was assessed as needing two hourly position changes at night from two staff, but the person did not receive position changes at night. Another person had an evening and night time care plan that recorded their need for two care staff. The care recorded in people's care plans did not reflect the care that they received at night. The provider told us that people slept all night and therefore did not require care from two staff and that they were seldom called in to assist. Finally, a member of care staff who occasionally worked night duty told us that they did not have the competency to administer medicines and if a person complained of pain at night they would contact the on-call manager or provider who would visit the service to administer the pain relief medicine."

We noted that people thought that there were not always enough staff to meet their care needs. For example, one person told us that they often fell out of bed at night and if they could manage to get back into bed they did so without calling for assistance. They added, "I don't like to bother the staff as they are always so busy." The minutes from the last "resident meeting" supported this person's opinion. They recorded that people said that they were well looked after, but due to staff being busy they sometimes had to wait for attention. Another person told us that they could hear call bells ringing at night. The provider told us that they did not have a dependency tool to calculate the correct staffing levels to meet people's needs. Staffing levels depended on the number of people living in the service rather than their care needs. There was no evidence to support that dependency levels were being adjusted.

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

Most people told us that they felt safe. One person said, "I'm safe and secure. Nothing worries me. I would speak to the provider or my daughter, [if I had a worry]."

With the exception of the maintenance person, staff had recently attended fire safety training and the fire evacuation policy was reviewed in October 2015. However, this was not always evident in daily practice. We saw that the list of people living in the service was not kept up to date and recorded that there were 16 people living at the service, rather than 13. This would put people at risk in

Requires improvement

Is the service safe?

event of an evacuation as emergency services would be looking for people who no longer lived at the service. Furthermore, a safe and timely evacuation would be slowed down as the front door was locked with a key. People did not have a personal emergency evacuation plan and the provider had not identified where people would be evacuated to in an emergency. In addition, the laundry fire proof door was propped open throughout the first day of our visit. If there was a fire in the laundry, the open door would increase the risk of the fire spreading to other areas of the service. We brought this to the provider's attention on the second day of our inspection and it was closed.

There were systems in place to support staff when the provider was not on duty. Staff had access to a business continuity plan to be actioned in an emergency situation such as a fire or electrical failure. Staff had access to the provider out of hours for support and guidance.

Staff recognised the signs of abuse and told us that they would report their concerns to the provider or CQC. However, staff were unaware of the role of the local safeguarding authority and told us that they did not have access to their telephone number. One staff member said, "If they [people] were not treated right I would tell [the provider]. Treat like you would treat your own mum." Another member of staff said, "I would report to CQC if people were not getting the care, if they were not treated properly."

A range of risk assessments had been completed for each person for different aspects of their care such as nutrition and falls. However, we found that some risk assessments were incomplete, did not record the impact on the person or had not been reviewed in the last 20 months. For example, one person had conflicting risk assessments, one to say that they could not weight bear and another recorded that they could walk short distances.

There were no window restrictors on the stair landing window. The landing window opened directly onto a flat roof and was accessible to people. The lack of window restrictors imposed a risk to people's safety. We brought this to the provider's attention and the landing window was locked. There was no risk assessment to determine the risk to people's safety from the lack of window restrictors.

A visitor shared a concern they had about people's safety. They said, "Sometimes when the staff have been in to tidy the room the call bell and drink are not left within reach." We noted that most people who remained in their bedrooms during the day did not have their call bell within their reach. We were told this was because they would not know how to use it. There was no alternative system in place for people to call for assistance.

We observed medicines administration at lunchtime. One person told us that they were unsure of the medicines that they took and said, "They just give them to me." We saw that when the person was offered pain relief that they asked what the medicine was called and the staff member told them. We noted that the staff member did not routinely tell people what medicines they were taking.

We looked at the medicines administration record (MAR) for six people and found that any known allergies were recorded. However, we noted that two charts did not have a photograph of the person for identification purposes. When a person was prescribed medicine through a patch to be applied to their skin, a body map was in place and identified the areas where the patch was to be applied, to minimise the risk of errors and maintain healthy skin.

We looked at the safe storage of medicines and found they were stored in accordance with legal requirements. All medicines were stored in locked cupboards, medicines trolleys or fridges. We saw there were processes in place for the ordering and supply of people's medicines to ensure they were received in a timely manner. Furthermore, people had an annual medicines review from their GP.

Although oral medicines were disposed of appropriately, we found several out of date topical creams in bathrooms and a store cupboard. One person had a cream that was prescribed for a person who no longer lived at the service.

Requires improvement

Is the service effective?

Our findings

We saw that there was an induction for new staff however this was not effective. It was only a one day induction and a newly appointed member of staff was not clear about how this would support them in undertaking their role. For example they told us they had not been trained how to support people with their food and drink. When we observed them providing support at lunchtime they stood over the person they were supporting which could make the person feel uncomfortable. In addition, although softened food had been well presented by the chef, the staff member mixed all the portions together which could make them appear less appetising.

The chef on duty had been in post for one week and had shadowed another chef and the deputy manager. They told us that they had received training in food hygiene and health and safety and their other training needs had been identified. All other staff had recently received training in the care of a person living with a dementia type illness and falls prevention. However, training records were poor and there was no evidence that staff had received mandatory training in nutrition, dignity, record keeping or communication. The maintenance person had not received mandatory training or training in subjects relevant to their role.

People's consent to care and treatment was not always sought by staff, although some people or their next of kin had signed their consent to have treatment from the chiropodist or have their hair done by the hairdresser. However, we did not see that consent had been requested when a person had bed rails in place. Where a person lacked capacity to give their consent staff did not fully follow the principles of the Mental Capacity Act 2005 (MCA). For example, we did not see a two stage capacity assessment and best interest meetings were not undertaken. Therefore, there was no recorded evidence that aspects of care were delivered in a person's best interest. We asked care staff how they would obtain consent from people. One member of care staff said, "I would ask them if they lacked capacity, I would try to coax them but not force them."

The 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.

We saw where some people lacked capacity to consent to their care that they had a lasting power of attorney to make decisions on their behalf or court appointed deputy. A court appointed deputy is someone appointed by the Court of Protection to make decisions on behalf of a person who is unable to do so themselves.

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 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 were being met. We found that the provider had followed the requirements in the DoLS and applications had been submitted to the local authority for authorisation. The provider had not properly trained and prepared their staff in understanding the requirements of the MCA and staff were unfamiliar with the DoLS authorisation process. Less than 50% of staff had been trained in MCA and the MCA policy did not include current legislation with reference to DoLS.

Some people had chosen to make advanced decisions about the care they did not want to receive in a medical emergency or at the end of their life. We found that they had a do not attempt cardio pulmonary resuscitation (DNACPR) order stored at the front of their care file. This ensured that their wishes were respected. A DNACPR is a decision made when it is not in a person's best interest to resuscitate them if their heart should stop beating suddenly.

People were restricted in where they could use the toilet. The doors to the shared toilets were locked to encourage people to use their ensuite facilities. However, the provider could not explain the reasoning behind this. At a recent meeting staff were given the following advice on the care of one person. "Encouraged to stay out of their room, door locked and the toilet door to be locked." The reason for this

was to prevent the person from urinating on the floor. There was no evidence that alternative toilet facilities were provided for this person or that the decision to lock their toilet door was taken in their best interest.

Most people told us that the food was good. One person said, "Lunch is very nice. We have tea in the dining room and there is always a selection. Sometimes beans, spaghetti or sandwiches followed by cake and tea or coffee. You don't have to eat what is in front of you. They [care staff] will think up something else." We saw that two people did not like the pudding on offer and were given an alternative." We saw a person with dexterity problems was provided with special adapted cutlery to help them maintain their independence. Another person with memory problems said, "Very nice lunch, but no choice, they [care staff] just give it to you. I always enjoy my food. I don't know what is for pudding. Just wait and see." There were no written or pictorial menus on display to help this person recall what they had ordered for lunch.

We observed lunchtime and found that people took their meal in the dining room, lounge or their bedroom. People who took their meal in the lounge were not offered a choice of drink at lunchtime and were given orange squash. However, people in the dining room were offered a choice of drink. We found that several people sat in the lounge without a drink, and we noted that most people cared for in their bedroom did not have a drink. We did not see care staff help people who required assistance to have a drink between meals.

We spoke with the provider and recently appointed chef. They explained that there was a four week menu plan and alternatives were available. We were informed that food choices were discussed at residents meetings. Catering staff had access to a record of people's likes, dislikes and any known food allergies. We asked about the availability of snacks between meals and the chef said, "People will ask for fruit, drinks or cheese between meals." However, we noted that it would be difficult for people to make choices as there were no menus available or information on snacks between meals or alternatives to the main choices.

We saw that people had access to healthcare services such as their GP, community psychiatric nurse (CPN) and district nurses. Staff told us that they accompanied people to see their GP. One person said, "They always get a doctor in when I am not feeling well."

We saw that one person with a long term condition was at risk of a developing a chest infection and breathlessness. We found that care staff had worked in partnership with their GP and medicines had been prescribed in anticipation of deterioration in their condition to ensure they were treated in a timely manner.

Requires improvement

Is the service caring?

Our findings

People were happy with the care they received and told us that they were well looked. We heard comments such as, "Care is wonderful." and, "Staff are wonderful" and, "I would give the home 110 out 100 for looking after me." One person's relative said, "My loved one couldn't be looked after any better." Most staff treated people with kindness and respect and at lunchtime we observed positive interactions between staff and people.

We observed staff assist people to the dining room for their lunch. People were supported to walk at their own pace and staff chatted with them in a friendly manner. We saw that most people sat in friendship groups to have their lunch.

However, there were no systems in place to enable people to be orientated to the day of the week or seasons." Signage throughout the service was poor and there was no evidence of pictorial signs to support people with a dementia type illness. In addition, some people had difficulty communicating their needs verbally but there were no systems in place to support them.

We found that people had individual care plans. However, we found no evidence that people had been involved in writing their care plans or their monthly or annual reviews. Care staff told us that they did not read people's care plans and we observed that care staff were not always aware of people's likes and dislikes. For example, we saw two staff members give a person a drink at lunchtime and the person did not like either of the drinks provided.

Housekeeping and care staff told us that they always knocked on a person's bedroom door before they entered.

One staff member said, "I knock on the door and call out good morning or afternoon. Be jolly." However, we observed that this was not upheld in practice and that people's right to their privacy and personal space was not respected.

We found that people's dignity was not always maintained. For example, people may not receive the care they need when they want it, because several people did not have access to call buzzers when they were in bed at night.

Another example of undignified care was observed during the lunchtime medicine round. One person was eating their meal and a staff member gave them their medicine rather than wait until they had finished their meal. In order to take their medicine the person had to remove the food from their mouth. This happened in the company of other people sitting at the table with them. This person did not have a napkin to put the chewed food into and placed it on their dinner plate.

In contrast, a member of care staff told us that they gave people dignified care and said, "I treat people the way I would treat my grandmother." Staff were unaware if there was a designated dignity champion in the service. We found that no one had been appointed as a dignity champion.

People and their relatives did not have access to information leaflets on the role of an advocate. An advocate can be appointed to support a person through complex decision making, such as permanently moving into the care home. We found no evidence that people had an advocate appointed to assist them through the transition for home to the service.

Requires improvement

Is the service responsive?

Our findings

People had their care needs assessed and care plans were introduced to outline the care they received. However, we found the content of the care plans was basic and reflected daily care routines rather than a person's individual care needs. Some care plans were not kept up to date and did not always record a true account of a person's care needs. For example, we found where a person had a fall and grazed their knees that their body map did not record the areas injured and there was no information on their care plan for action to take to prevent the risk of further falls. Another person was assessed in September 2015 as at low risk of becoming undernourished, however, they had not been weighed since April 2014. Therefore their nutritional risk rating may not be a true indicator of their dietary needs. In addition, there was little recorded evidence that people had been involved in discussion about their care needs. In contrast we saw where a person was receiving oxygen therapy that their care plan and risk assessment clearly identified all of their needs.

Three care staff told us that they did not look at care plans. A recently appointed member of staff said, "I've not seen or read the care plans. I just know because I watch the girls [senior care staff] do care." Another staff member said, "I don't do risks or care plans, I occasionally write in the daily notes."

We found that some aspects of personal care were task related rather than person centred. For example, one person told us, "My bath is Wednesday morning." They added, "I sleep like a log and wake at 6.30am, I have an alarm [call buzzer], but don't need it, I wait. I'll be next on the list sort of thing [to receive personal care.]"

Some people invited us to look at their bedroom. We found that they were supported to personalise their bedroom with items from home such as photographs and keepsakes.

Some people were supported to maintain contact with the local community. One person regularly went to church; two people attended a day centre once a week and others went into the local town with family members. A religious service was held once a month and members of the local church visited the home. Children from the local school sang to people at Christmas. We looked at the daily activity records for several people and saw that the only activity recorded was when the person received a visit from a relative or friend.

However, there were no systems in place to record people's likes and dislikes. Also, most people had not been supported by staff to record their life story to help them reminiscence and recall important events prior to moving into the service. Staff told us that they sometimes played a game with people, but otherwise people were not provided with activities, entertainment or outings.

Overall, people were not supported to follow their interests and pastimes. There was not an activity coordinator in post and relatives voiced their concerns about the lack of stimulation for their loved ones. One relative said, "We're happy with the care, but the home does lack stimulation." Another relative said, "[Name of person] spent most of their life outside and gardening, but does nothing in the home."

After lunch we noted that most people dozed in their armchair. We asked people how they passed their time and one person said, "That's all I do." [Reference to dozing in their arm chair].

One relative told us that the deputy manager had dealt with a complaint satisfactorily after they had raised some issues regarding their loved one's care.

There was a copy of the statement of purpose at the reception area that gave information how to make a complaint. We looked at a recent complaint and saw that it had been actioned and resolved. Staff told us if a person made a complaint to them they would pass it on to the provider.

Requires improvement

Is the service well-led?

Our findings

We found weaknesses in the management of the service. On the first day of our inspection, the provider was unable to locate policies and procedures and other requested documents for us. When we returned on the second day the deputy manager was able to provide us with the requested documents. Furthermore, the provider did not meet all of their CQC registration requirements. The provider is required to notify us of any events; such as those that cause harm to people or disruption to the service. The provider showed us copies of statutory notifications that they had completed. However, these had not been received by CQC since November 2013.

The provider did not audit the care files; therefore errors were not identified or put right. For example we saw that one person had a recorded nutrition score that should have alerted staff to refer the person to their GP for assessment by a dietitian, but this was not done. We saw a copy of an external pharmacy audit conducted in September 2015. Areas for action had been identified. There was a rolling programme of bedroom audits and decoration and furniture replacements were identified on an action plan.

Housekeeping staff told us that there was a daily cleaning routine and daily checklist for each room. However, we were unable to confirm if this was carried out as the checklist has not been completed since 21 October 2015. Housekeeping staff informed us that they were not involved in any audits or quality checks and were unware if these were carried out.

The storage and safe keeping of care records was not robust. People's care files were stored in an unlocked filing cabinet in the dining room. The dining room was accessible throughout the day to people and their visitors. We looked at six care files and found that all contained scraps of paper with roughly written notes with information such as a person's next of kin details. The information was not recorded on the appropriate document and there was a risk that this information could be lost or staff would be unable to find it in an emergency.

Although the provider sought feedback from residents though residents' meetings, they did not act on the issues identified. For example, we found shortfalls in the provision of activities and access to the garden and people who lived at the service had previously raised this with the provider but it had not been addressed.

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

Staff told us that they were aware of whistleblowing and would raise concerns with the provider, local safeguarding team or CQC. They told us that the provider and deputy manager were approachable and supportive.

Relatives told us that the provider was approachable and could go to them with any problems they had. Five relatives gave their feedback on the service through a quality assurance questionnaire in March 2015. Feedback was positive and relatives made comments such as, "Care is very good, clean home, friendly staff." And, "Very satisfied. Have peace of mind." However, we found that there were no meetings for relatives to come together with the provider and senior staff to share their views.

The last recorded staff meeting was held in August 2015. The topics discussed included, cleanliness, the summer menu, and the use of continence aids. Staff told us that they could not recall having received supervision or feedback on their performance. However, we saw that a recently appointed staff member had received an appraisal and we found that most of the issues raised had been actioned by the provider.

We saw that there was a mission statement that set out the values of the service and this was included in the statement of purpose.

Staff had access to electronic and hard copies of policies and procedures on a range of topics relevant to their roles. For example, we saw policies on safeguarding and privacy and dignity.

There was a shift handover system in place where staff exchanged important information about people. We looked at the daily handover diary and saw that staff recorded information to share, such as when a person had a change made to their medicines.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How they regulation was not met: The provider did not operate effective systems and processes to make sure that they assess and monitor their service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The provider did not assess the risk of preventing, detecting and controlling the risk of infections.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The provider did not ensure that there were sufficient numbers of suitably qualified, competent, skilled and experienced staff on duty at night.