Alexandra Court Care Centre Limited

Alexandra Court Care Centre

Inspection report

340 Southcoates Lane
Hull
North Humberside
HU9 3TR

Tel: 01482376702
Website: www.alexandracourtcare.co.uk

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Ratings

Overall rating for this service	Inadequate

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?	**Inadequate**

Summary of findings

Overall summary

About the service: Alexandra Court Care Centre is a residential care home that can provide personal and nursing care to a maximum of 72 people. There were 61 people using the service at the time of the inspection, some of whom were living with dementia.

People's experience of using this service: The provider took over the running of the service in February 2019. Until very recently there had been insufficient staff on duty; the new provider had used a care staffing tool which was not sufficiently accurate when calculating people's complex health care needs. Staffing levels had been reduced and this had impacted on the delivery of care to some people and affected their health and welfare.

For example, people had not always received their medicines as prescribed, which affected their treatment. Risk had not always been managed to ensure people's safety. This had impacted on their safe care, health and wellbeing. In one instance a person's pain and distress had not been well-managed and another person had not been provided with the correct pressure relieving cushion.

People had not always had their needs met in ways they preferred, and in a timely way; this had resulted in one person being admitted to hospital for treatment that could have been provided in the service. The reduction in staffing numbers also impacted on the way the service was managed and the time available for the new registered manager to have oversight of the care of people with nursing needs.

There was a delay in the introduction of the new provider's own quality monitoring system. There was also a crossover regarding documentation, which left a newly registered manager and staff team managing different systems of recording. Records were not consistently accurate and up to date. The initial transition from previous provider to new provider could have been managed much more effectively. The provider's audit system will need time to be fully carried out.

Complaints had been received about the levels of personal care and health care and treatment delivered to people; these had resulted in safeguarding investigations. Some of these were still being investigated by the local safeguarding team. In discussions, staff knew the different types of abuse and knew to report concerns to management.

There were positive comments about the care staff approach but there were also comments from relatives that this could be improved to be more caring and sensitive. Staff had not consistently gained consent before carrying out tasks such as placing clothes protectors on people. However, people were supported to have maximum choice and control of their lives were possible and staff supported them in the least restrictive way; the policies and systems in the service supported this practice.

People's nutritional needs were met and menus provided them with choices for the main meals. Those people on textured meals such as pureed, due to swallowing difficulties, had limited choices for desserts.

Staff received training and supervision. There were gaps in training records when staff required courses or updates in training. However, these had been identified by the registered manager. A supervision and appraisal system had just been started following the new provider's way of working. The provider had a safe system of staff recruitment.

Following the inspection, the registered manager and senior management had reflected on the concerns raised by relatives, the local authority contract monitoring team and the inspection findings. They told us they will produce an action plan and lessons learned document to share with staff and improve practice going forward.

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

Rating at last inspection: This was the first inspection of the service since the new provider was registered with the Care Quality Commission (CQC) in February 2019.

Why we inspected: We received information from the local authority regarding an escalation of concerns about the service; they had been completing monitoring visits. We completed this inspection based on these concerns. At the time of the inspection, we were aware of incidents being investigated by another agency.

Enforcement: The service met the characteristics of Inadequate in two key questions of safe and well-led, and Requires Improvement in effective, caring and responsive. There were breaches of regulations in delivering person-centred care, safe care and treatment, staffing and good governance. We have issued four Requirement Notices for these breaches. These can be found at the back of the full report.

Follow up: We will continue to monitor the service closely and discuss any ongoing concerns with the local authority. We have requested specific information about what action the provider is to take to make improvements and regular updates on this action.

The overall rating for this registered provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC. The purpose of special measures is to:
• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Another inspection will be conducted within six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

Full information about CQC's regulatory response to the more serious concerns found during inspections is

added to reports after any representations and appeals have been concluded. We will have contact with the provider following this report being published to discuss how they will make changes to ensure the service improves their rating to at least Good.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our Safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our Effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our Caring findings below.

Requires Improvement

Is the service responsive?

The service was not responsive.

Details are in our Responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our Well-Led findings below.

Inadequate

Alexandra Court Care Centre

Detailed findings

Background to this inspection

The inspection: We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, 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 concerns raised by the local authority following a series of monitoring visits to the service.

Inspection team: The inspection team consisted of two inspectors on both 2 and 3 May 2019. There was also one pharmacy inspector and an Expert by Experience on 2 May 2019. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service. The Expert by Experience had expertise in caring for someone living with dementia.

Service and service type: Alexandra Court Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

There was a manager in the service who was registered with CQC. They and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: The inspection was unannounced on the first day. The provider's representative and registered manager were informed we were to return on the second day.

What we did: Before the inspection we attended a meeting with local authority safeguarding, contracts and commissioning teams to discuss concerns. We reviewed notifications of incidents received from the provider since they were registered with CQC in February 2019. The provider had not yet been asked to complete a

Provider Information Return (PIR). This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection, we spoke with five people who used the service and eight of their relatives. We spoke with the provider's representative, the registered manager, a nurse, a senior care worker, five care workers, a cook and two activity coordinators.

We looked at care records for nine people who used the service and medication records for 17 people. We looked at a range of other records used for the management of the service. These included, quality audits, the staff rota and training records.

Following the inspection, the registered manager and provider's nominated individual reflected on the concerns raised and produced a 'lessons learned' document to share with staff. An action plan was produced to move the service forward and improve delivery of care to people.

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management
- Risk was not managed safely and effectively for all people who used the service.
- People had risk assessments in place and written directions to guide staff. However, these had not always been followed in practice including for people with moving and handling needs and those who used wheelchairs. One person had been left unattended in their wheelchair and sustained a fall. The local safeguarding team were investigating a moving and handling issue for another person.
- One person was sitting on a cushion that did not match the one they had been assessed for; they had developed two small areas damaged by pressure.
- One person's drinks did not have the required thickener in them to assist swallowing. This was noted by their relative and added to the drinks. This posed a risk of choking or aspiration.
- People's food allergies were not consistently identified to remind staff. Three people had dietary allergies but only one of them was highlighted on the form. This could pose a risk of people given foods they were allergic to.
- Two people's call bells were out of reach, which meant they could not summon assistance.
- There were risk areas noted in the environment that required improvement. For example, the sluice door did not lock properly when it swung closed; we found it unsecured twice during the inspection and on both occasions mentioned it to staff. The door to the nursing office, which was a fire door, was wedged open; the nursing office had oxygen stored in it.

The evidence indicates there was a failure to assess and manage risk to ensure the safety and wellbeing of people. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
- Systems to ensure the safe management and supply of medicines were not always effective and placed people at risk of harm.
- Staff failed to follow up instructions on the medication administration record and seek appropriate advice for one person. There had been a significant failure to ensure the person received adequate pain relief which left them in pain and distress.
- There had been several medicines errors and people had not received their medicines as prescribed. There were concerns with how staff administered medicines to people, for example, leaving them in pots for people to take later. Staff had received supervision and updates in training. However, the errors persisted. A member of staff said, "There were errors due to staff pulled in different directions."
- Guidance for staff to safely and consistently administer medicines prescribed 'as and when required' (PRN) lacked important detail. This meant staff may not have full guidance to help them when making

decisions about when and how much medicine to give to people. There was also limited information about how people preferred to take their medicines.

The evidence indicated there was a failure to ensure the safe management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● There had been staffing changes when the new provider took over the management of the service. These changes had resulted in a reduction in staffing numbers. This had significantly affected the quality of care delivered to people, had resulted in complaints from relatives and staff and adversely affected the management of the service. People were placed at risk of harm due to important care being missed.
● Relatives told us, "We have issues with getting up times and concerns they [staff] don't have the time to feed them" and "There is a severe staff shortage."

The evidence indicated there was a failure to ensure there was enough staff on duty at all times. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had responded to concerns raised by the local authority about staffing numbers and increased staffing levels to an appropriate level.
● Staff said, "I had wanted to leave but it is better since the increase" and "It is better now compared to what we had; we couldn't give the care at all" and "I did raise concerns as I got upset and I felt I couldn't do my job and care for them; I didn't want to be here."
● The provider had a safe staff recruitment system. Recruitment was underway for care staff vacancies currently filled by agency staff.

Systems and processes to safeguard people from the risk of abuse
● There had been three minor safeguarding incidents that had not been discussed with the local safeguarding team. The registered manager confirmed these would be addressed straight away.
● There were systems in place to protect people from the risk of abuse. Staff had received training and had policies and procedures to guide them when they became aware of concerns.
● There were several safeguarding alerts under investigation by the local safeguarding team. These referred to concerns raised by relatives and staff in connection to shortfalls in care delivery because of insufficient staffing levels mentioned above.

Preventing and controlling infection
● The service was clean and tidy.
● Staff had access to personal protective equipment to help prevent the spread of infection.
● There had been a recent infection prevention and control audit completed by a specialist nurse. Some shortfalls had been addressed straight away and others included in the provider's action plan and ongoing refurbishment plan.

Learning lessons when things go wrong
● Following concerns raised by the local authority contracts monitoring team and the inspection findings, the registered manager and provider had developed a lessons learned document. This was to be discussed with staff to ensure care practices were improved.

Requires Improvement

Is the service effective?

Our findings

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

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- Staff had not always been proactive in identifying changes in needs and subsequent health concerns. This meant some people's needs had not always been met effectively. For example, one person had not received care and treatment in a timely way. Another person's restricted fluid intake had not been managed well, which could impact on their health condition. We had to prompt staff to seek medical attention for a third person and also ensure they had the correct pressure relieving cushion.
- We were provided with examples by several relatives, of occasions when they felt care had not been delivered in line with good hygiene standards and respect for choice. This included support with continence care and personal hygiene.

The evidence indicates a failure to monitor and manage people's health concerns. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People had assessments of their needs completed before admission to the service. Staff also obtained assessments completed by health and social care professionals.
- The relatives did state some improvements had been made in the last few weeks. One relative described how a change in the time of care support had led to their family member looking happier and their continence needs were more effectively met.
- Other people's records showed lots of involvement with a range of health professionals.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

● The provider acted within the MCA when people had been assessed as lacking capacity to make their own decisions. Mental capacity assessments had been completed, best interest meetings held, and applications made for DoLS.
● On some occasions, staff lacked an understanding about capacity decisions. For example, some people had been assessed as lacking capacity to make their own decisions, but they had signed a consent form for specific issues such as photographs, medication and sharing information.
● Staff did not consistently gain consent before carrying out tasks for people such as putting on clothes protectors. This was also observed by a relative who fed this back to us. There were other occasions when staff were observed asking people if they could support them at meal times and checking out discreetly if they needed support to go to the toilet.
● People who used the service said staff ensured they had choices. People said, "Nobody orders you to go to bed. I do my own thing when I want" and "I'm showered when I choose."

Supporting people to eat and drink enough to maintain a balanced diet
● People's nutritional needs were met, The menus provided a variety of meals and choices at each meal. People had nutritional risk assessments and were weighed in line with any risk; this could be weekly or monthly. People had been referred to dieticians as required.
● There were limited choice of desserts for people who required a pureed textured meal. For these people, the main meal on the menu was textured to the right consistency but desserts consisted of yoghurts or ice cream.
● At lunchtime on the first floor, there were missed opportunities for staff to engage with people during support to those with more complex needs. For example, moving a person to sit with other people so they did not eat their meal alone after everyone else had finished.

Staff support: induction, training, skills and experience
● Staff told us they had sufficient training. There were gaps noted on the training records but these had been identified by the new provider and were to be addressed.
● An appraisal and supervision system was underway.

Adapting service, design, decoration to meet people's needs
● The environment was suitable for people. There was a range of aids and adaptations to support people's physical needs and those living with dementia.

Requires Improvement

Is the service caring?

Our findings

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

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; respecting equality and diversity

- Positive comments from people who used the service included, "I get on with them very well. They are all very good." Relatives said, "They are caring, friendly and helpful". They told us they had noted improvements in the way people had been looked after in the last few weeks since staffing levels had been increased. We observed staff providing smiles, hugs and reassurance to people.
- Other comments from people included, "There's such a variation. Some staff are more caring than others" and "They rush me a bit but I let them know I can't be rushed." A relative said, "There have been times when care and compassion have been lacking."
- A health professional told us, "Some staff have been dismissive of [Name's] relatives, insensitive and have not had a caring approach." They provided examples of why they made these comments to inspectors.

Supporting people to express their views and be involved in making decisions about their care

- Staff supported people to make their own decisions as much as possible. People had reviews of their care so they, and their relatives, could discuss what was working well and what needed changing.
- People told us they were able to make decisions and had choices regarding meals, activities and where to spend their day.
- Health professionals told us they had seen people making decisions about meals and activities.

Respecting and promoting people's privacy, dignity and independence

- Staff understood how to maintain people's privacy and dignity and provided examples of how this was achieved. However, due to staff shortages and some care practices, there had been times when people's dignity had been compromised.
- One person who used the service described how they were able to use the microwave in the small satellite kitchen when required, which helped them maintain their existing skills.
- A health professional told us they had seen staff promoting people's privacy and dignity.
- Records were stored in lockable cabinets in offices. However, there were times during the inspection when office doors were propped open and cabinets were unlocked.

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- People's care preferences had not always been met. Important care information had been overlooked when staff formulated their care plans.
- People did not always receive person-centred care, which placed them at high risk. A specialist nurse had to be contacted to provide guidance to nurses on pain relief. The specialist nurse told us the person's pain management had fallen short of acceptable standards. There was an additional concern when staff could not locate an appropriate sling to move them safely.
- Another person required a more person-centred approach to supporting them with specific behaviour, which potentially affected their dignity and placed them at risk. A third person was seated on a cushion that did not match their assessed and individual needs.
- There were some people whose preferred time of getting up in the morning and going to bed had not been met. Some people told us they had to wait a long time for call bells to be answered.
- Several people had long finger nails in need of cleaning and filing.
- People who used the service had mixed comments about the delivery of person-centred care. Comments included, "Staff used to bring two dry Weetabix and I put the milk on when I was ready. I prefer it dry so I can do it when I'm ready. Others [staff] will just bring it with the milk already on" and "Sometimes I don't have my buzzer and I can't get any help unless you hear someone talking, then it's shouting or banging until someone hears me. Once I don't have it [call bell], I don't have it for quite a while."
- The person went on to say it was their preference that relatives completed their laundry to prevent items from going missing. However, they said clothes still went missing and at times other people's clothes were brought to their bedroom.

The evidence indicates a failure to ensure the delivery of person-centred care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There were signs around the building to help people find their way around. There were menus with pictures of food to help people make choices.
- One health professional told us senior staff reported concerns to them when they visited the service each day.
- Some examples of responsive care were seen. For example, staff were supportive in reducing a person's anxiety during use of a hoist. They also arranged a change of bedroom at another person's request.
- There were activities provided for people to participate in. There were two activity coordinators who had designed a range of activities, which included group work, one to one sessions with people and visiting entertainment. People who used the service told us there was enough for them to do. Relatives said, "There are a lot of activities, but they only join in what they want – they like the flower arranging" and "This has improved. They love the choir and anything where lots of people are participating."

Improving care quality in response to complaints or concerns

● The provider had a complaints policy and procedure. Complaints were documented, investigated and complainants responded to.

● People who used the service and their relatives told us they were able to raise complaints and concerns. Comments included, "Complaints have been raised but also dealt with."

End of life care and support

● People could remain at Alexandra Court Care Centre, for end of life care. Generally, people had experienced good end of life care. A health professional said, "I feel the end of life care is good. For example, they inform nurses if the person is in pain, keep relatives informed and residents are kept comfortable and clean."

● During the inspection, the relatives of one person felt their family member's end of life care needs would be better met in a hospice. The registered manager has completed a 'lessons learned' from this incident so that staff practice could be improved.

Inadequate

Is the service well-led?

Our findings

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

- When the new provider took over, there were delays in an action plan and quality assurance systems being developed and effectively addressing issues of concern.
- There were concerns regarding how the provider monitored changes within the service. Changes were implemented, which included a decision to reduce staffing levels. This had impacted on how person-centred care was delivered to people and resulted in episodes of poor care, and complaints from relatives and staff. The local authority had suspended placements at the service and a remedial action plan was in place.
- The registered manager was clear about their role in delivering a quality service. However, there had been shortfalls in the support systems needed to achieve this.
- Although people's care plans provided staff with information about how to deliver care to them in ways they preferred, this had not always happened in practice. The shortfalls in the delivery of person-centred care highlighted during the inspection had not been identified by management systems.
- There was a lack of clinical oversight at manager level to the part of the home that delivered nursing care to people. This meant that shortfalls in nursing practice had not been highlighted and addressed effectively.
- There were basic communication shortfalls, which impacted on care delivery. For example, staff told us they had not had time to read care plans and did not always receive a good handover of information following shift changeovers. There was a situation where nursing staff had only one set of keys to share, which impacted on their time.
- There were shortfalls in the quality of recording information. For example, the wound care documentation for two people who used the service was very disorganised. This made it difficult to audit how the wounds were assessed and evaluated, and how dressings were planned and reviewed.
- There were other recording shortfalls such as monitoring charts, records of how people preferred to take medicines and when creams were applied. These included a lack of recording and inaccurate recording.
- There was a lack of management oversight and organisation of shifts, especially on the nursing unit. Staff reported not getting proper breaks to have lunch or drinks, which had the potential to affect their concentration and practice.

The evidence indicates a failure of good governance to assess, plan, monitor and improve the quality of the service delivered to people and to maintain appropriate and contemporaneous records. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider has since made it clear they want to improve the service and deliver quality care to people.
● Quality monitoring systems were being implemented. Action plans identified issues to be addressed as a priority to be completed within specified timescales.
● The registered manager told us they felt very supported now and were confident improvements would be made. They said, "It's not unsafe care but we need better practice embedded in the way we do things."

Continuous learning and improving care; Working in partnership with others
● There was partnership working with other health professionals regarding assessments of people's needs and delivery of care. For example, speech and language therapists, physiotherapists and dieticians.
● Staff completed forms to accompany people to hospital to provide nursing and medical staff with information about their needs and the care required to meet them.
● Staff liaised with specialist nurses for specific conditions such as motor neurone disease and end of life.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Meetings took place for people who used the service, their relatives and staff. There were also six-monthly surveys, which had been completed in February 2019. The meetings and surveys helped people express their views about the service.
● Relatives told us they could speak with the registered manager when needed and said improvements were being made. Comments included, "Three weeks ago the atmosphere was miserable, now it's improving."

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had not ensured all service user's needs were met in a safe and person-centred way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not ensured there was a safe system of medication management to ensure people received their medicines as prescribed. The registered provider had not ensured risk was properly assessed and taken steps to mitigate the risk of accidents and incidents occurring.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had not established systems and processes to effectively monitor the quality of the service and respond to shortfalls. The registered provider had not ensured accurate and contemporaneous records were in place.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation 18 HSCA RA Regulations 2014 Staffing

The registered provider had not ensured there were sufficient numbers of suitably qualified, competent, skilled and experienced staff on duty at all times.