Achieve Together Limited

Tuscany House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Tuscany House is a care home providing accommodation and personal care for up to seven people with learning disabilities and/or autism spectrum condition. There were six people living at the home at the time of our inspection.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

People's experience of using this service and what we found
The service was not always able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right support:
People's medicines were not always managed safely. Some medicines had been administered after they had expired and there was insufficient guidance for staff about the use of medicines prescribed 'when required'.

Some people did not have opportunities to take part in meaningful activities or to access their community. This meant people were not supported to have the maximum possible choice and control over their own lives.

Staff had not had the guidance they needed to provide support in a way which achieved good outcomes for people. Care plans did not always reflect people's current needs or include guidance for staff about how to support them effectively.

Risk assessments were in place to help keep people safe. Accidents and incidents were reviewed and action taken to help prevent similar events happening again. The home was clean and hygienic, and staff understood how to minimise the risk of infection.

People were supported to maintain good health. Staff ensured people had access to appropriate professional input to meet their healthcare needs.

People's dietary needs were met. People were supported to make choices about what they ate and to maintain a balanced diet.

Right care:

Staff did not have all the skills they needed to meet people's communication needs. We have made a recommendation about this.

There were enough staff available to keep people safe. When agency staff were needed, the provider used the same staff regularly, which minimised the impact of this on people's care. The provider's recruitment procedures helped ensure only suitable staff were employed.

Staff knew how to recognise and report abuse or poor practice. When safeguarding concerns had been raised in the past, these had been reported and investigated.

Staff were kind and caring. They treated people with respect and engaged with them in a friendly yet professional manner. Staff had worked with people to help them overcome anxieties, which had achieved positive outcomes for them. People were encouraged to be independent where possible.

Right culture:
Inconsistent leadership had affected the quality of care people received and the support provided to staff.

The culture within the service did not always achieve good outcomes for people. People were not involved in developing their support plans to ensure they reflected their needs and wishes.

Quality monitoring systems had not been effective and did not include seeking the views of people who lived at the home, their relatives and staff.

Staff kept relatives up to date about their family members' health and well-being. Relatives told us that any concerns they raised had been resolved to their satisfaction.

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

Rating at last inspection
The last rating for the service under the previous provider was outstanding, published on 16 August 2019.

Why we inspected
The service was registered under the current provider on 1 December 2020. This was a planned inspection based on the date of the service's registration under the current provider.

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

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Tuscany House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Inspection team
The inspection was carried out by an inspector, a medicines inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Tuscany House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure the manager would be available to support the inspection.

What we did before inspection
We reviewed information we had received about the service since its registration, including notifications of significant incidents. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with the manager, a senior service manager and five members of care staff. People who lived at the service were not able to tell us directly about the care and support they received. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We checked two people's care records, including their risk assessments, support plans and mental capacity assessments, recruitment records for three staff and the arrangements for managing medicines.

We spoke with three people's relatives to hear their views about the care provided to their family members.

After the inspection
The manager and senior service manager sent us supporting documentation including training records, quality assurance checks and audits, the business continuity plan and the development plan for the service.

Requires Improvement

Is the service safe?

Our findings

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

This is the first inspection under the current registered provider. This key question has been rated requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

- Staff supported people with their medicines. However, they did not always follow systems and processes to look after medicines safely. For example, we found some medicines had been administered after they had expired. This meant we were not assured that all medicines were safe or effective when administered.
- One person was having most of their medicines crushed and given overtly (with their knowledge and consent). However, the service was unable to demonstrate that these medicines were safe to crush and be given this way.
- Some people were prescribed more than one medicine to be given 'when required' to treat a condition. The guidance for these medicines did not describe when to use which medicine. This meant we were not assured the person's condition would be treated consistently by different staff.
- Staff had assessed one person as requiring a variable dose 'when required' medicine on a regular basis at the higher dose. However, this regular use had not been clarified with the prescriber. This meant we were not assured that concerns were consistently followed up with prescribers.
- Some people were prescribed medicines to manage anxiety and distressed behaviours. The use of these medicines was described in each person's 'when required' guidance. However, these medicines were omitted from the behaviour support plans. This meant we were not assured staff would access all the relevant information for each person when deciding if a dose needed to be given.
- Weekly medicines audits were carried out at the service. However, the concerns identified on this inspection had not been identified by these audits.

Failure to manage medicines safely was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff understood and implemented the principles of STOMP (stopping over-medication of people with a learning disability, autism or both).
- Staff explained how they had reduced the need to administer some medicines to some people. Staff also described how they had identified a potential medicine's side effect and raised this with the person's GP. The GP had then been able to reduce the prescribed dose.
- People received support from staff to make their own decisions about medicines wherever possible. Staff assessed whether it was safe for people to administer their own medicines. Where this was not safe, people were encouraged and supported to take part in other medicines tasks.
- People could take their medicines in private when appropriate and safe.

● Staff followed national practice to check that people had the correct medicines when they moved into a new place or they moved between services.
● Staff reviewed each person's medicines regularly to monitor the effects on their health and wellbeing. They provided advice to people and carers about their medicines.
● Staff made sure people received information about medicines in a way they could understand.

Staffing and recruitment
● There were enough staff on each shift to keep people safe. There were vacancies on the permanent staff team and high levels of staff absence, which meant agency staff were regularly used. The effects of this on people's care were mitigated as much as possible by using the same agency staff regularly.
● The provider's recruitment procedures helped ensure only suitable staff were employed. These procedures included carrying out pre-employment checks and obtaining a Disclosure and Barring Service (DBS) certificate. DBS checks provide information including details about convictions and cautions held on the Police National Computer. This information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse
● Staff understood their responsibilities in protecting people from abuse and knew how to report any concerns they had. They were able to describe the signs of potential abuse and the action they would take if they observed these.
● Staff attended safeguarding training in their induction and regular refresher training. Staff said they would feel confident to speak up if they had concerns about abuse. One member of staff told us, "If I raised a safeguarding concern, I feel strongly that it would be listened to." Another member of staff told us, "I don't feel you would be singled out if you raised a concern."
● When safeguarding concerns had been raised in the past, staff had notified appropriate agencies and investigated the concerns when asked to do so. For example, in 2021 money had gone missing from the service. The provider had informed the police, the local authority, CQC and people's relatives. People's money was reimbursed by provider and an investigation carried out.
● The investigation identified the member of staff most likely to have carried out the financial abuse and, although there was insufficient evidence for prosecution, the member of staff had been dismissed for unrelated reasons. The temporary manager had improved the security of monies held at the service since the incident and increased the frequency of balance checks. There had been no further incident of monies going missing.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● Assessments had been carried out to identify any risks involved in people's care. Where risks had been identified, plans had been developed to manage and minimise them. Risk assessments addressed areas such as travelling by car, accessing the community and taking medication.
● Accidents and incidents were recorded and reviewed to identify any actions that could reduce the likelihood of a similar incident happening again.
● There was a business contingency plan for the service to ensure people would continue to receive their care in the event of an emergency.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● The provider was facilitating visits for people living in the home in accordance with the current guidance.

Good

Is the service effective?

Our findings

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

This is the first inspection under the current registered provider. This key question has been rated Good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2002 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- Staff told us they sought people's consent before providing their care on a day-to-day basis and our observations confirmed this. Applications for DoLS authorisations had been submitted to the local authority where people were subject to restrictions in their care, such as being able to leave the home unaccompanied.
- Although people were not unlawfully restricted, some documentation relating to people's care under the MCA had not been completed appropriately. For example, one mental capacity assessment identified a person did not have capacity to give informed consent to COVID-19 testing. The decision to take part in testing had been made on the person's behalf but had not been supported by a best interests process.
- Mental capacity assessments should be carried out in relation to a specific decision. However, we found some mental capacity assessments considered a number of decisions simultaneously. For example, one assessment considered a person's capacity in relation to medicines, finance and staff supervision when in the community.
- We have reported further on this issue in the Well-led section of this report.

Staff support: induction, training, skills and experience
- Staff had had an induction when they started work, which included mandatory training such as first aid, health and safety, and nutrition and hydration.
- Most staff had completed the Care Certificate, which is an agreed set of standards that define the knowledge, skills and behaviours expected of staff working in health and social care.

● The temporary manager told us some staff supervision had not happened as often as it should have in recent months. The temporary manager had put a plan in place to address this and scheduled supervisions for staff.
● Although staff knew people's needs well, they had not had training in a form of communication used by two people at the home. We have reported further on this issue in the Responsive section of this report.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs had been assessed before they moved into the home. Relatives told us they had been involved in their family members' assessments and able to give their views.
● People's care was provided in line with relevant national guidance. Any changes to guidance that affected the way in which care was provided were shared with staff.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People were supported to maintain good health. Relatives told us staff supported their family members to access treatment if they needed it. One relative said, "[Family member] had problems with his teeth a few months ago. It was sorted fairly swiftly." Another relative told us that, when their relative needed dental treatment, "They made sure he saw a dentist who was good with him. The dentist phoned me and kept me up to date, which was good."
● If people developed healthcare needs, staff ensured they had access to appropriate professional input. For example, one person had recently been referred to a urologist. People who had ongoing healthcare conditions were monitored by relevant healthcare professionals. For example, one person who had epilepsy was reviewed every six months by a neurologist and epilepsy nurse.

Supporting people to eat and drink enough to maintain a balanced diet
● Relatives told us their family members' dietary needs were met. One relative said, "[Family member] enjoys all food. They take care over his diet." another relative told us, "[They look after [family member] appropriately from a diet point of view."
● People were supported to make choices about what they ate and to maintain a balanced diet. Staff knew people's likes and dislikes and encouraged people's input into planning the menu.
● None of the people living at the home had specific dietary needs and all were able to eat a regular diet. There was guidance in place for staff to ensure people were supported to eat safely. For example, one person's support plan stated, '[Person] should be encouraged to be seated while eating all his meals. [Person] should have staff within the area with him while eating to prompt to slow down if needed."

Adapting service, design, decoration to meet people's needs
● The home was domestic in character, which was in line with the principles of Right support, right care, right culture. All areas of the home were accessible to the people who lived there.
● Communal areas were comfortable, and people were able to personalise their bedrooms according to their individual tastes and interests. The home had a well-maintained garden.

Good

Is the service caring?

Our findings

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

This is the first inspection under the current registered provider. This key question has been rated Good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

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

- Relatives told us staff were kind, caring and friendly. They said their family members had established positive relationships with staff. One relative told us, "[Family member] takes a while to get to know them, but the ones that have been there a while he laughs and jokes with and gets on well with." Another relative said, "[Family member] is happy to go back [to the home] when he's been at mine. That's the most important thing, he is one hundred per cent happy."
- There was a relaxed atmosphere at the home during our inspection. Staff engaged with people in a friendly yet professional manner. They spent time talking to people and were respectful and engaging when they did so.
- People's religious and cultural needs were met. One person's relatives had arranged access to a TV channel which enabled the person to watch religious programming. The person's relatives had provided recipes from their culture, which staff prepared.
- Staff understood and respected people's needs in relation to their sexuality.

Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence

- Relatives said staff respected their family members' decisions about their care. One relative told us, "A year or two ago there was a change of carers; they gave [family member] and the other residents a choice of which carers worked with them. They showed photos and asked them who they wanted to be their keyworker."
- Relatives told us staff maintained their family members' dignity when supporting them and respected their right to privacy. One relative said of staff, "They are respectful." Another relative told us, "They give him time to himself in his room. They are respectful if he uses the toilet or gets changed."
- Relatives told us staff encouraged and supported their family members to be independent. One relative said, "[Family member] can make a coffee, that is encouraged, and he helps prepare food." Another relative told us, "[Family member] does cooking and washing up if he wants to." We observed during our inspection that staff supported people to do things for themselves, such as make drinks and snacks.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection under the current registered provider. This key question has been rated Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Some people had access to activities they enjoyed and to their local community. For example, one person attended a resource centre three days each week and other people enjoyed walks, shopping, bowling and visiting the local pub.
- However, people with higher support needs did not have sufficient opportunities for engagement in activities that met their needs and preferences. Two people had been assessed as needing two staff to support them when in the community and to travel in the home's vehicle rather than using public transport.
- High levels of unplanned staff absence, and a subsequent lack of authorised drivers, meant planned activities for people with higher support needs were often cancelled, which sometimes led to distressed behaviours.
- As a result of a lack of activities, two people spent the majority of time in their bedrooms and, although encouraged by staff to get up, were reluctant to do so. One person was reluctant to receive personal care, which negatively affected their quality of life.
- Staff had not had the guidance or support they needed to achieve better outcomes for the two people who chose to remain in bed for most of the day. People's support plans did not reflect their current needs or include guidance for staff about how to support people effectively.
- One member of staff said it was, "Frustrating" that, despite their best efforts, they were not able to support the people to improve their quality of life. Another member of staff told us, "We need support from people with more experience."
- The senior service manager said, "When people first moved to the house, there was a lot of input from CTPLD [community team for people with learning disabilities] and PBS [Positive Behaviour Support]", although there was no evidence of recent input from specialist professionals. The temporary manager told us they had requested input from the provider's Positive Behaviour Support team but that this had not yet been provided.

Failure to provide personalised support that met people's individual needs and preferences about their care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability,

impairment or sensory loss and in some circumstances to their carers.
● People's communication needs were recorded during their initial assessment. Any needs identified were documented in people's support plans. Staff received training in communication and each person had an individual communication passport.
● Relatives said staff had provided important information to their family members in ways they could understand. For example, one relative told us staff had worked with their family member to help them understand the benefits of having COVID-19 vaccinations. The relative said, [Family member] has a needle phobia and they went to great lengths to explain about the COVID vaccinations. They drew pictures of how it would happen and he agreed. I don't know how they managed it."
● The relative told us staff had also worked with their family member to overcome their anxieties. The relative said, "[Family member] has a phobia of strange dogs. Some staff worked hard with him. He went out with us and he wasn't scared and even stroked a dog. I asked if they had worked with him and they said, 'Yes, it's made a distinct difference.'"
● Two people living at the home used Makaton, a form of communication that uses symbols, signs and speech. A relative told us, "[Family member] does Makaton, so if staff use Makaton he benefits massively. A year or two ago some staff were learning Makaton, but I am not sure if the staff are still there. It would be good if staff could do Makaton."
● Training records indicated staff currently working at the home had not received Makaton training.

We recommend the provider make training available to ensure staff have the knowledge and skills to communicate with people effectively.

Improving care quality in response to complaints or concerns
● The provider had a complaints procedure which set out how complaints would be managed. The complaints procedure had been made available in an accessible format for people with different communication needs. A plan had been put in place to ensure people living at the home knew how to make a complaint and what to do if they felt their complaint had not been resolved.
● Relatives told us they knew how to complain and said they would feel comfortable raising concerns if necessary. Relatives who had raised concerns in the past told us these had been addressed satisfactorily. One relative said, "If I raise concerns, they are dealt with swiftly and effectively." Another relative told us, "I have raised a couple of issues; they were dealt with to my satisfaction."

End of life care and support
● No one at the home was receiving end of life care. A plan had been put in place to support people to express their wishes about end of life care if they wanted to do so. The temporary manager told us the home would access support from specialist healthcare professionals in the event that anyone required end of life care.

Requires Improvement

Is the service well-led?

Our findings

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

This is the first inspection under the current registered provider. This key question has been rated requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The service had not had consistent leadership, which had affected the quality of care people received and the support provided to staff. The last registered manager left in November 2021. Another manager was appointed but left after approximately two months. A temporary manager had been put in place in January 2022 but left the provider's employment on 31 March 2022.
- The provider had asked a senior service manager to oversee the service until a permanent manager was recruited. However, the senior service manager was responsible for 10 of the provider's services, which meant they envisaged being able to spend only two or three days a week at Tuscany House. The deputy manager post had been vacant since the previous postholder left in July 2021.
- The frequent changes in management had led to expected standards not being maintained across a number of areas. For example, some documentation required review and staff supervision and team meetings had not been taking place as often as the provider's policies stated they should have.
- Although applications for DoLS authorisations had been submitted to the local authority regarding any restrictions in people's care, some documentation relating to best interests decision-making under the MCA had not been completed appropriately.
- An internal quality audit carried out by the provider's Quality Assurance Adviser on 16 March 2022 assessed the service as 'Amber', which, 'Denotes areas for improvement, with some potential risks to the people we support that may have some impact on their wellbeing or quality of life.'
- The quality audit identified that some people's care plans and risk management plans required review to ensure they reflected their current needs and linked into their PBS plans. The audit also noted that people were not involved in developing their support plans, stating, 'There was little evidence to suggest that the people being supported contribute towards planning of their care and support.'
- The culture within the service did not always achieve good outcomes for people. The quality audit identified some concerns about the culture within the staff team, including high levels of unplanned staff absence, which affected the quality of people's support. The audit also noted there was no evidence the service had a clear vision and a set of values or that staff were encouraged to be involved in developing the service.

The failure to assess, monitor and improve the quality of the service, including the quality of people's experience, was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care; Working in partnership with others

● The temporary manager understood their responsibilities under the duty of candour and the requirement to act in an open and honest way if concerns were raised.

● Notifiable incidents had been reported to relevant agencies, including the local authority and CQC, when necessary.

● Relatives told us they were kept up to date about their family members' health and well-being and were informed about any incidents affecting their family members. One relative said, "They keep us updated. They let us know about anything important." Another relative told us, "If anything crops up, they let us know. [Family member] comes home every two weeks; if anything needs sorting, they speak to me when I pick him up."

● The temporary manager had improved procedures to ensure learning took place when incidents occurred and that this was shared with staff. For example, the temporary manager had introduced debrief sessions following incidents to enable staff to reflect on events and how these could be manged differently in future to improve outcomes for people.

● The service had established effective working relationships with other professionals involved in people's care and sought their input when needed. For example, a referral for assessment had recently been made for one person whose needs and behaviours had changed.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to provide support that met people's individual needs and reflected their preferences about their care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure medicines were managed properly and safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and improve the quality of the service, including the quality of people's experience.