Pencombe Hall Ltd

Pencombe Hall

Inspection report

Pencombe
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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**

Summary of findings

Overall summary

This was an unannounced inspection carried out on the 24 November 2017.

Pencombe Hall is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates 32 people in one adapted building. At the time of the inspection there were 26 people living at the home.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

This home was last inspected on the 23 May 2016, where we rated the service as 'Good.' During this inspection, we identified three breaches of regulation under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to safe care and treatment, person-centred care and good governance.

Risks to people's health and well-being had not always been assessed and action had not been taken to reduce such risks. People were at risk falling down the stairs, which could be easily accessed from the bedroom floors. These people were described as living with dementia, they walked around independently and were at risk of falls. Measures taken to keep these people safe were limited.

People's care was not always person centred to meet their specific needs. For example, the care file of one person we looked at indicated the person had diabetes and nocturnal epilepsy; and experienced simple focal seizures. There was no epilepsy care plan in place to guide staff on individual risk factors, such as triggers for seizures and the specific care required. We saw there was a system for reporting of seizures, but when this was cross-referenced with the accident and incident records, it showed not all seizures (or suspected seizures) had been recorded . Failure to record or monitor seizures accurately, placed the person at risk of not having any changes to their condition/needs identified and acted on.

The provider had failed to effectively assess, monitor and improve the quality of services provided. Audits were not carried out in key areas such as environmental risk assessments, provision of choice at meal times, the suitability of environments for people living with dementia, and person centred care. Feedback from people was neither captured, nor used as a way of continually improving the service.

The provider was not able to demonstrate what processes they had in place to address people's requirements in respect of equality, diversity and human rights. For example, training had not been provided for staff in equality, diversity and human rights and specifically in respect of lesbian, gay, bi-sexual and transgender issues (LGBT). The registered manager was not aware of the 'accessible information standard,'

nor of its requirements.

We have made a recommendation about dementia friendly environments.

People were not always offered a choice in support of their individual wishes and preferences.

Staff were able to explain the principles of the Mental Capacity Act (MCA) legislation, however, they were unable to tell us who was the subject of an approved Deprivation of Liberty Safeguard (DoLS) and whether there were relevant conditions they needed to be aware of.

The provider continued to protect people from avoidable harm and abuse. There were appropriate recruitment procedures in place, which ensured staff were suitable to support people who used the service. However, the registered manager had not always followed procedures to ensure safe recruitment.

Arrangements to manage people's medicines were safe.

Staff knew people well, with people being comfortable and relaxed in their presence. On the whole, people were supported by staff in a way that was kind, respectful and compassionate.

People's needs had been identified and addressed when nearing the end of their life.

Staff felt valued and supported by both the management team and the provider.

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.

Risks to people's health and well-being had not always been assessed and action had not been taken to reduce such risks.

The home was not always clean and free from unpleasant smells

People were supported by a staff team who knew how to recognise signs of abuse and knew what to do if they suspected something was wrong.

There were enough staff to meet people's health needs and keep people safe. There were appropriate recruitment procedures in place, to ensure staff were suitable to support people who used the service.

Is the service effective?

Requires Improvement

The service was not always effective.

People's dietary requirements were assessed and appropriate care plans and risk assessment were in place. However, people had not been consulted about what they wanted to eat and were not provided with a choice at meal times.

Little regard had been given to the design and signage features within the home that would help to orientate people living with dementia.

Staff sought consent from people before undertaking any tasks.

People were supported to access other health professionals when required.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always provided with an opportunity to make a choice, such as at meal-times.

The provider did not always promote an inclusive culture within the home, and showed a lack of understanding in respecting and valuing differences.

People were involved in decisions about their care and support they received.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care provided was not always appropriate and did not reflect the needs of the person.

Care plans had not been regularly updated to ensure they reflected people's current health and wellbeing needs.

People's needs had been identified and addressed when nearing the end of their life.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider had failed to effectively assess, monitor and improve the quality of services provided.

Feedback from people was neither captured, nor used as a way of continually improving the service.

Staff told us they felt valued and supported by both the management team and provider.

Pencombe Hall

Detailed findings

Background to this inspection

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

This was an unannounced inspection visit carried out on the 24 November 2017. The inspection was carried out by two inspectors.

Before the inspection visit, we reviewed the information we held about the service. We contacted representatives from the local authority and Healthwatch for their views about the service and looked at the statutory notifications the provider had sent us. Healthwatch are an independent national champion for people who use health and social care services. A statutory notification is information about important events, which the provider is required to send to us by law.

As part of the inspection, we spent time with people in the communal areas of the home and spoke with four people who used the service and five relatives. Many of the people at the home were living with dementia and therefore conversations were not in-depth. We spent time observing interaction between staff and people who used the service. As some people were unable to speak to us, we used the Short Observational Framework for Inspections (SOFI) to help us understand their experiences of the support they received. We also spoke to a visiting health care professional, who provided us with information regarding their engagement with the home.

We reviewed a range of records about people's care and how the home was managed. We looked at four care records, medicine administration records, personnel records and records relating to the management of the service.

As part of the inspection, we spoke with the registered manager, the deputy manager, two team leaders, three members of care staff, and the cook. Some of these interviews were conducted over telephone.

Requires Improvement

Is the service safe?

Our findings

Risks to people's health and well-being had not always been assessed and action had not been taken to reduce such risks. People were accommodated over three floors at Pencombe Hall, with bedrooms situated on the first and second floors. Access to bedrooms was mainly via a lift, though several stairways were available for people to use. We were told the majority of people at Pencombe Hall were living with dementia, a number of whom were at risk of falls. Alarm sensor mats had been installed in their rooms to notify staff of their movements particularly during the night to promote their safety.

The upper stairways were extremely steep and difficult to negotiate and were open to the bedroom areas. We were told that there were three people on the second floor who walked around independently and were risk of falls. One of these people was described in their care file as 'wanders at night, concerns with nocturnal epilepsy and dizziness, which affected their mobility.' This had resulted in a sensor mat being installed in their room. When their pressure mat was activated, staff would make their way from the ground floor to respond to the person to ensure they were safe. We found people were therefore potentially at risk of falling down the stairs if they walked away from their bedrooms. One member of staff told us they believed people were safe at the home apart from the concerns they had about the stairways. Another member of staff told us they believed the environment was generally safe. However, they were concerned about the stairways and the potential for people with dementia falling down the stairs and sustaining serious injuries.

We spoke to the registered manager about our concerns and specifically where people at risk had been provided with rooms near the stairways. We found that the potential for people falling down the stairs had not been risk assessed or any action taken to reduce these risks. We asked the registered manager to take immediate action to ensure people were safe. The registered manager subsequently told us action had been taken to address these concerns, which included installation of coded safety locks and stairway gates to the stairways.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014, because the provider had failed to assess the risk to the health and safety of people and had not taken any action to mitigate those risks.

On the whole, we found the home was clean and free from unpleasant smells. We were told by the registered manager the home was subject of an improvement programme by the provider, which involved upgrading carpets, decoration and adding en-suites to people's bedrooms. However, in one room we visited, the carpets were in poor condition and the room smelt strongly of an unpleasant odour. The deputy manager acknowledged our concerns and told us the room was awaiting upgrading. We asked that action was taken to address the unpleasant odour. Staff we spoke to could describe measures they took to prevent cross infection including the use of personal protective equipment (PPE).

There were appropriate recruitment procedures in place, to ensure staff were suitable to support people who used the service. However, the registered manager did not always follow these procedures or demonstrate a full understanding of safe recruitment processes. One member of staff had been recruited

without suitable references having been obtained, which was not in accordance with the provider's own recruitment process. On the whole, we found appropriate Disclosure and Barring Service (DBS) checks had been undertaken and suitable references obtained for most staff. A DBS check is a legal requirement and is a criminal records check on a potential employee's background. Staff told us they underwent pre-employment checks before starting work at the home.

Both people and their relatives consistently told us they or their family members were safe living at Pencombe Hall. One person told us, "I do feel safe and secure living here. If I use my call-bell they usually come quickly." Another person said, "I feel safe, there are plenty of staff. If you have to be here, it's the place to be." One relative told us, "We are very satisfied with the level of care here. The home provides a high standard of care and our relative is very safe. Their [relative] well-being and safety are well catered for." Another relative told us they had no concerns about their loved one's safety, and felt they were in the best place given their situation.

The provider continued to protect people from avoidable harm and abuse. Staff had received training in how to recognise, respond to and report abuse. Staff were able to describe confidently what action they would take if they had any concerns that people were being abused. One member of staff told us, "If I thought someone was being abused, I would report to the shift boss. If I felt nothing was being done, I would report my concerns to CQC or 'whistleblow.' I have never experienced any issues here."

We looked at how the service managed people's medicines and found the arrangements were safe. The service mainly used a 'blister pack' system for people to store their medication. 'Blister pack' is a term for pre-formed plastic packaging that contains prescribed medicines and is sealed by the pharmacist before delivering to the service. The pack has a peel off plastic lid and lists the contents and the time the medication should be administered. We found all medicines were stored securely. Where medicines required cold storage, daily records of temperatures were maintained. Staff administering medication confirmed they had received training, and had received competency checks to ensure they were safe to administer medicines. We looked at a sample of medication administration records (MAR), which detailed when and by whom medicines were administered. We found accurate records were maintained without any signature gaps in any of the records we looked at.

Controlled drugs (prescription medicines that are controlled under the Misuse of Drugs legislation) were stored as per legislation. They were stored in a locked storage unit. We saw a controlled drugs register was signed and countersigned by staff confirming that drugs had been administered and accounted for. We undertook a stock take of controlled drugs and found them to be accurate.

People, their relatives and staff felt the staffing levels maintained at the home meant people's individual needs could be met safely. One person told us, "I think there is enough staff, they even check on you at night time." One visiting relative said, "There is enough staff, you never have to wait too long." One visiting health care professional told us they felt there was always enough staff on duty to meet people's needs, who were always available to support them during their visits. Staff also confirmed that they had no concerns about staffing levels at the home. One member of staff said, "There is enough staff always. The manager will always step in if required."

Requires Improvement

Is the service effective?

Our findings

We found people's dietary requirements were assessed and appropriate care plans and risk assessment were in place. People told us they were happy with the food they received and said they had more than enough to eat and drink. We observed the lunch time experience. The lunch time meal was divided into two sittings, with the people who required support receiving their meal first. On the day of our inspection, people were provided with two 'ice cream scoops' of mashed potatoes, baked beans and two fish fingers. The meal was also pureed if required to meet people's specific dietary needs. Though staff were attentive and kind, the meal did not look appetising and no other choices were available. Only when two people had declined to eat the meal provided, were they offered an egg sandwich as an alternative. The menu on display in the reception area offered no alternative choices. There were no alternative means of communication, such as picture references for people living with dementia. People were not rushed and were given plenty of time to consume their meals. The atmosphere was calm and relaxed and people were at ease with staff supporting them.

We spoke to the cook, who showed us the three week menu they worked from, which included nutritious meals such as a roast meal twice a week. They explained that Friday was a 'fish day,' hence the fish fingers, though confirmed no chips were offered as an alternative to mashed potatoes. They confirmed only one choice of meal was provided, though alternatives would made available if people did not like the option. The cook was knowledgeable and knew people's dietary needs. We spoke to the registered manager who told us there had been no consultation with people regarding the menu or the absence of choice available. Following the inspection, the registered manager told us they had spent time with people discussing menu options, their likes and dislikes. People had indicated their approval of fish fingers, which would now be an option at tea time and not as a main meal. Moving forward, we were assured by the registered manager, people would now take part in agreeing a menu, which offered a wider range of choice.

A number of people living at the home were living with a diagnosis of dementia and some had a Deprivation of Liberty Safeguard (DoLS) in place. We saw no evidence of dementia friendly resources or adaptations in any of the communal areas, dining room or lounge. We found the home did not have adequate signage features that would help to orientate people with this type of need.

We recommend that the service explores the relevant guidance on how to make environments used by people with dementia more 'dementia friendly'.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff we spoke with confirmed they had received training in the MCA and stated they would welcome further refresher training. Though most staff were able to explain the principles of the MCA legislation, they were unable to tell us who was the subject of an approved DoLS and whether there were relevant conditions they needed to be aware of. Most staff assumed everyone at the home was subject to a DoLS. We saw there were procedures in place to guide staff on when a DoLS application should be made. We spoke to the registered manager, who was able to demonstrate that the service had submitted a number of applications in line with guidance from the local authority. The registered manager confirmed that they had submitted 20 applications, of which four had been approved to date by the appropriate authority. They told us they intended to ensure staff were fully aware of people subject of an approved DoLS.

We looked at one Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) for a person, where the GP stated cardiopulmonary resuscitation (CPR) would be "futile." We saw no evidence of this decision being made in the person's best interests. The registered manager told us they were aware that this matter needed revisiting to ensure family members had been fully consulted.

Throughout the day we observed staff seeking consent from people before undertaking any tasks. This included routinely asking people whether they wanted to wear an apron during meal times, or whether they need personal care or snacks and drink. One member of staff told us, "A number of people have limited capacity here. I will always seek consent by showing them what I want to do. You know by their response whether they are consenting or not. Normally they will indicate their consent."

People and their relatives told us they thought staff had the appropriate skills and training to support them effectively. One person told us, "I think staff are well trained. I think they are competent and know what they are doing." One relative said, "The staff are very good and competent. They are very pro-active in engaging with residents." Staff told us that they received training relevant to their roles and they felt supported by the management team at the home. However, we found that a number of staff were yet to receive training in First Aid and Equality, Diversity and Human Rights. The registered manager told us that they always ensured there was at least one member of staff on duty trained in First Aid, but they would be chasing up training requirements.

Most staff told us they were pursuing nationally recognised qualifications in social care. Training was by way of practical tutorials or on-line learning. One member of staff told us, "I currently doing a National Vocational Qualification (NVQ) at level three. We have an external trainer that comes in and have done end of life and dementia recently. I'm also involved in training new staff practically. We have regular refresher training annually like moving and handling." Staff told us they received regular supervision and one to one support. This provided an opportunity to discuss their individual performance and training requirements with the registered manager. One member of staff said, "I receive regular supervision. I do feel supported and valued. The manager is fair and supportive." Another member of staff told us they had enough training for their role and received regular supervision and support from the registered manager.

People told us that they were supported to access other health professionals when needed. This included the Memory Team; opticians; GPs; optometrists; chiropodists; podiatrists and district nurses. One person told us, "If I'm not well, they will get the GP straight away. I also see the GP often." A relative told us they were regularly updated about their loved one's medical condition and whether they had seen the GP or district nurses. Another relative said, "They [relative] see the GP regularly. They keep me informed of their medical condition and any incidents." One health care professional told us they thoroughly enjoyed visiting the home. Staff were very good at contacting them with any concern. Instructions were always followed and staff were described as positive and stable.

Requires Improvement

Is the service caring?

Our findings

People were not always offered a choice in support of their individual wishes and preferences. As referred to earlier in this report, people were not asked what they wanted to eat at lunch time. People were only provided with an alternative option after they had declined to eat the meal they were given. We saw a member of staff providing hot drinks and biscuits in the lounge after lunch. People were provided with a hot drink and given two biscuits from a container on the trolley. People were not offered a choice of drinks or given the opportunity to select their own biscuits from the container. We saw one person reject one of the biscuits as they didn't like it. This was then subsequently removed by another member of staff. Had the person been offered the container, they could have made their own choice.

People's care plans did not demonstrate sensitivity and consideration about issues around equality, diversity and human rights. Staff also told us there were no processes in place to consider these issues with people and meet their specific needs. Whilst the provider had an Equality and Diversity Policy in place, the registered manager did not assure us how it would be implemented. When asked, for example, whether the home would welcome same-sex couples, we received a negative response from the manager. They also told us they were not sure whether they were ready to meet those needs at this time and were worried about the impact on other people living at the home. This response failed to promote an inclusive approach within the home, and showed a lack of understanding in respecting and valuing differences.

Staff knew people well, with people being comfortable and relaxed in their presence. On the whole, staff demonstrated an understanding of people's individual communication styles and preferences, and they were able to explain to us how each person expressed themselves. However, one relative expressed frustration at the repeated failure of staff to ensure their relative's hearing aid batteries were fitted correctly and advocated further training for staff. They told us that though they had raised the issue with management, the issue had still not been resolved satisfactorily.

On the whole, people were supported by staff in a way that was kind, respectful and compassionate. One person told us, "I'm very happy. They [staff] look after me really well. If I want anything, I only have to ask. They [staff] are very helpful." Another relative said, "We are very happy with the care provided. Staff are very approachable and helpful." Another relative told us, "People are treated with dignity and respect at all times. Some staff know our relative very well, they have become their [relative's] family and they [relative] treats them as their family member."

We asked people whether they or their relatives were involved in decisions about the care and support they received. People told us the care provided reflected their or their relative's wishes. One person told us, "They do listen and I feel involved. I'm more than happy." One relative said, "They always ring up and let us know, they keep us very informed about our relative. We have meetings with the manager to review our relative's care needs." Another relative told us, "Families are encouraged to be involved with their relative's care, and we are always made to feel welcome. Absolutely no concerns, the atmosphere is excellent."

Throughout our visit, we saw staff encouraging people to retain their independence, when mobilising or

eating and drinking for example. Staff told us they would always encourage people to be independent to improve their well-being. One member of staff told us, "I encourage everyone to be independent. I give them all the choices they want and encourage them to eat and dress themselves, especially if I know they can do it."

Requires Improvement

Is the service responsive?

Our findings

People's care was not always planned and delivered to meet their individual needs. For example, the care file of one person we looked at indicated the person had diabetes and nocturnal epilepsy; and experienced simple focal seizures. There was no epilepsy care plan in place, with the registered manager initially stating that the person did not have epilepsy, though both deputy manager and staff were aware. We explained to the registered manager the importance of specific care plans for individual conditions. Staff needed to be aware and have suitable information available, which reflected on individual risk factors, such as triggers for seizures and the specific care required.

In a further example we looked at, we found a person experienced regular seizures, but there was no epilepsy care plan in place. We saw there was a system for reporting of seizures, but when this was cross-referenced with the accident and incident records, it showed not all seizures (or suspected seizures) had been recorded in the person's care file. By not recording or monitoring seizures accurately, this placed the person at risk of not having any changes to their condition/needs identified and acted on. The registered manager subsequently told us action had been taken to address these omissions.

Although individual care plans were in place, these had not been regularly updated to ensure they reflected people's current health and wellbeing needs, as well as people's personal preferences. In one care file we looked at, the diabetes care plan in place did not reflect the person's current needs and treatment. For example, the plan stated their glucose levels were to be checked twice a day. When we spoke to the deputy manager about these checks, they told us the checks had been changed to twice a monthly following a review with the GP a couple of months' ago. The deputy manager said they would review the care plan and ensure it was up-to-date and accurate. There was evidence of monthly care plan reviews. However, these had not ensured the care plan reflected the change in management of diabetes for this person.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 (Part 3), because the provider had failed to ensure care was appropriate and reflected the needs of the person.

People told us they felt comfortable to raise any concerns or complaints with staff or the management team. On the whole, we found formal complaints had been investigated and responses provided. However, not all complaints were dealt with in line with the provider's policy and procedures. In one example we looked at, there was no copy of the original complaint in the complaints file. The registered manager told us it related to a verbal complaint, but the initial response letter referred to a written complaint. They told us the original letter of complaint had been misplaced. The initial response letter to the complaint stated the complaint would be investigated and a response provided by a designated date. There was no evidence of any formal response or an investigation to the complaint. When asked, the registered manager told us the matter been resolved, though this was not apparent from the complaints recording system in place.

We asked people how they were stimulated and encouraged to pursue their interests. One person said, "They do have games and the occasional singer, which I go and see. I'm very happy with what's available. It

suits me." Another person told us, "I suppose they [provider] could do a bit more, but I read a book and I'm quite happy." One relative told us, the home was definitely meeting their relative's needs. There were activities such as arts and music. The local vicar attended monthly. They said that their relative went on the occasional trip to the local pub and to local attractions. Another relative told us they were aware of activities, like music, which their relative enjoyed and that people were encouraged to be involved. We did not witness any organised activities during our visit.

People's needs had been identified and addressed when nearing the end of their life. One visiting health care professional described the care provided as 'fantastic' and said that the district nurses received effective support from staff. The provider used a 'six step programme' in meeting people's needs, which included discussions with people as their end of life approached; respecting wishes and advanced decisions; coordination of care with other health professionals and addressing care after death. Staff told us they received training in end of life and palliative care.

Requires Improvement

Is the service well-led?

Our findings

There were no effective mechanism in place to monitor the quality of care people received, or to monitor their health, safety and wellbeing. Audits were not carried out in key areas, such as environmental risk assessments, provision of choice at meal times, the suitability of environments for people living with dementia, and person centred care. This affected the quality and safety of care people received. For example, the failure by the provider to assess the environment hazards associated with the upper floor stairways, meant people were put at risk. We looked at one infection control audit, which had failed to identify the bedroom that smelt strongly of an unpleasant odour. There were no effective systems in place to ensure care plans had been regularly updated to ensure they reflected people's current health and well-being needs.

Though the provider told us questionnaires had been sent out to people, this was not apparent when we spoke to people. There was no evidence of regular relatives and residents' meetings. Feedback was neither captured, nor used as a way of continually improving the service. There were no systems in place to involve people in decisions about how the home was run, nor of gathering their views or the views of family members, visitors, staff, and health professionals.

The provider was not able to demonstrate what processes they had in place to address people's requirements in respect of equality, diversity and human rights. For example, training had not been provided for staff in equality, diversity and human rights and specifically in respect of lesbian, gay, bi-sexual and transgender issues (LGBT). The registered manager was not aware of the 'accessible information standard,' nor of its requirements. For example, one person living at the home was registered blind. We asked the management team how they ensured key information, such as the complaints procedure and the service user guide were in an accessible format that person. We were told that there was no separate provision for this person, such as audio information.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because the provider had failed to effectively assess, monitor and improve the quality of services provided.

People told us they were happy living at Pencombe Hall, which they believed was well-managed by the provider. Staff consistently told us they felt valued and supported by both the management team and provider. They told us they could approach the manager about any work or personal difficulties, and had confidence these matters would be addressed. One member of staff said, "You can speak your mind and are encouraged to do by the registered manager."

Providers are required by law to notify CQC of certain events in the service such as serious injuries and deaths. Records we looked at confirmed that we had received all the required notifications in a timely way from the service.

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 ensure care was appropriate and reflected the needs of the person.

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 assess the risk to the health and safety of people and had not taken any action to mitigate those risks.

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 effectively assess, monitor and improve the quality of services provided.