Stepping Stones Resettlement Unit Limited

Riverside 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
Riverside House is a residential care home providing personal care to 12 people living with learning disabilities and autism. The home is in a rural setting and accommodates everyone in one building.

People's experience of using this service and what we found
People were at risk of not receiving personalised care that met their physical and emotional needs as their care, risk and medicines management plans had not been kept up to date to reflect their current support needs and prescribed medicines.

The provider had possibly missed opportunities to review the staffing levels of the service and changes in people's needs to help prevent incidents and ensure people's care remained inclusive and personalised. However, we observed staff effectively speaking to people and reassuring them when they became anxious.

Staff were aware of people's prescribed medicines and administered them in line with people's prescription. However, we have made a recommendation about the principles of STOMP (stopping over-medication of people with a learning disability, autism or both) to help reduce the risk of people being over medicated.

People were supported by a staff team that had been safely recruited and knew them well. However, from our observation and speaking to staff we were not fully assured that sufficient numbers of staff were available to ensure people's individual care needs were consistently being met. The provider had not ensured that effective infection control measures had been put in place to help reduce the risk of spread of infection.

The manager was aware staff morale and making progress in supporting staff with their professional development and support which was acknowledged and commented on positively by staff.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

People had lived at Riverside House for many years and enjoyed the family atmosphere of the home. However, the service was not fully able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture. For example, it was not always clear how the provider had considered this guidance to ensure people were empowered to have maximum choice and control of their lives such as being supported to have greater and continued integrated access into the wider community.

Staff supported people in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. People looked relaxed and happy living at Riverside House. Relatives reported and we observed that staff engaged with people in a friendly but professional manner.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Riverside House on our website at www.cqc.org.uk.

Rating at last inspection (and update) The last rating for this service was Good (published 17 October 2017).

Why we inspected
We undertook this inspection as part of a random selection of services rated Good and Outstanding to test the reliability of our new monitoring approach.

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.

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to people not consistently receiving personalised care based on their assessment of needs.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will 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? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was effective. Details are in our effective findings below.	**Good**
Is the service caring? The service was caring. Details are in our caring findings below.	**Good**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below	**Requires Improvement**

Riverside 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
This 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
Riverside 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.

The service did not have a manager registered with the Care Quality Commission. A registered manager and provider are legally responsible for how the service is run and for the quality and safety of the care provided. However, a manager had been deployed by the provider to manage the home and planned to register with CQC.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. 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. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service and seven relatives about their experience of the care provided. We spoke with eleven members of staff including the manager, nominated individual and five staff members. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with the providers behavioural therapist and referred the home to Gloucestershire Fire and Rescue Service to assess the fire safety of the home. We also received feedback from one relative by email and a health care professional.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to 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.

Assessing risk, safety monitoring and management,

- People's risks associated with their health and well-being had been assessed and were managed well such as people's epilepsy management and support. Staff worked in partnership with other agencies to ensure they fully understood the management of people's risks.
- Throughout the inspection, we observed that staff on shift worked as a team to ensure people received their one to one support without becoming too dependent on certain staff members. We observed that staff had developed a good understanding of people's needs and risks and formed a friendly but professional relationship with people.
- Staff were able to describe how they supported people to reduce their anxieties and frustrations such as triggers which may impact on people's emotions and the actions they should take if people became upset.
- Risk in relation to fire had been assessed and plans were in place to reduce this risk. A review of people's missing person profiles and personal evacuation plans was needed to ensure they were current and provided staff with accurate information in the event of an emergency.

Using medicines safely

- People received their prescribed medicines in a person-centred way. Staff followed systems and processes to safely administer, record and store medicines. Staff used appropriate PPE and infection control measures when preparing and administering medicines.
- Staff were very knowledgeable and assessed as competent to administer medicines, however the manager did not have access to the staff training records which meant they could not be assured that people were supported with medicines by staff who had current medicines training.
- Medicines to control people's behaviour were only used as a last resort, for the shortest time and in situations where people were a risk to themselves or others. However, the provider had not put systems into place to ensure the principles of STOMP (stopping over-medication of people with a learning disability, autism or both) were being maintained and to prompt a GP review where necessary.
- People's medicines were not always regularly reviewed to monitor the effects of medicines on their health and wellbeing. However, since our inspection the manager has contacted the GP surgery to clarify people's medicine reviews.

We recommend that the provider seeks additional guidance in the principles of STOMP (stopping over-medication of people with a learning disability, autism or both).

- Our feedback about people's care, risk and medicines support plans had been recognised by the manager who planned to review each person's care records with them, their key worker and family members where

required.

Staffing and recruitment

● From our observations, speaking to staff and reviewing staff rotas, it was unclear how the current staffing levels enabled people to live a life which provided them with maximum choice and control of their lives as well as managing any incidents which may require the attention of more than one staff member.

● Staff spoke of being short staffed on occasions which was confirmed by staff rotas. We found there had been the occasional day (or part of days) when there had been less than the required staff numbers on duty. This potentially put people at risk of not receiving timely and personalised care and support.

● The provider was actively recruiting for new staff and agreed to review their staffing levels to limit the risk of people not receiving personalised and individual care.

● Safe recruitment practices were being used which ensured that staff with the right skills, character and values were employed. However, people were not routinely involved in the decisions about the staff who may be recruited to support them.

We recommend that the service review their staffing in accordance with current best practice guidance in relation to personalised care.

Preventing and controlling infection

● Records showed that there had been an increased cleaning schedule to ensure the home was regularly cleaned. However, some outstanding maintenance and refurbishment works (due to the pandemic restrictions) meant that people could not always be assured that they were living in a home that was effectively being cleaned to prevent the spread of infection. We looked at the home's infection control practices and found:

● We were not always assured that the provider was preventing visitors from catching and spreading infections as best infection control practice was not being used when visitors entered the home.

● We were not assured that the provider was using PPE effectively and safely as clear low risk pathways had not been established to enable staff to easily access new PPE and dispose of soiled PPE.

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises as hand gels and hand towels were not always readily accessible for people, staff and visitors to maintain good hand hygiene.

● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider's infection prevention and control policy was up to date, although the COVID 19 risk assessment held in the home was not the provider's current version.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

● We have also signposted the provider to resources to develop their approach.

Learning lessons when things go wrong

● The provider recognised that the timeliness of the systems to monitor accidents and incidents needed to be re-established to ensure people's needs were being met by staff who had been debriefed on new strategies and had access to people's current care plans and risk assessments.

Systems and processes to safeguard people from the risk of abuse

● People and their relatives told us that people felt safe living at Riverside House. One person told us, "Yes I like living here." One relative said about their family member who lived at the home, "If he's worried he'd go

to the manager, or the care worker if the manager was not there, and they're fully receptive to that." Another relative said "150% safe, I can always tell."

● Staff had received appropriate training and had a good understanding of safeguarding policies and procedures. They were clear of their responsibilities to report any suspicions of abuse or harm and if anyone disclosed any information of concern to them.

● The new manager told us they were getting to know people and were vigilant in monitoring people's welfare and would investigate into any concerns or unknown bruises. They were aware of their legal requirement to report any safeguarding concerns.

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.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- The provider had recognised that people had not continually received effective care based on current best practice for people living with a learning disability in a care home during the pandemic. The nominated individual provided assurances that they were committed to working with the new manager and staff to ensure people receive good outcomes based on current guidance.
- Staff applied their experience and knowledge of people to help promote their well-being.

Staff support: induction, training, skills and experience

- Staff told us they felt trained and supported in their role. The manager was aware that further improvement was needed in addressing the training and support needs for some staff. They had started to implement a schedule of staff supervisions in line with the provider's staff development policy and book outstanding classroom based practical training and refresher courses to support the eLearning courses.
- All staff were required to be trained in restrictive interventions which helped to ensure any interventions were safely used and only used in the last resort. The provider confirmed that the training used to train staff in restrictive interventions met the national standards set out by the Restraint Reduction Network. These standards provide a benchmark for training in supporting people who are distressed in education, health and social care settings.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People had been supported to access health professionals as required and in emergencies. This included physiotherapist, GP's and speech and language therapists.
- The manager told us how the pandemic had impacted on some people being able to access and receive their routine health checks such as dentistry checks. Progress was being made to schedule health care appointments and reviews with the aim to ensure that people's health's action plans and hospital passports were current and reflect the outcome of the appointments

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 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.

● We observed staff supporting people in line with the spirit and principles of the MCA and code of practice such as asking permission to access their bedroom.
● People had mental capacity assessments in place relating to aspects of their care and support. The manager was able to describe decisions which had been made in people's best interest when they lacked mental capacity to make an informed decision for themselves such as medical interventions.
● There was evidence that the manager had applied to the relevant local authorities to gain authorisation to restrict people's liberties and were waiting for a reassessment of people's needs.

Supporting people to eat and drink enough to maintain a balanced diet
● Through resident's meetings, people were encouraged and supported to make decisions about their meals. People were provided with home cooked foods and offered alternative meals if requested. We observed people being offered drinks and food throughout the day and being able to eat when and where they wanted to.
● People's care plans provided some details of their nutritional needs and likes and dislikes which were known by staff.
● We observed staff following good hygiene practice and food checks when working in the kitchen.
● Staff told us that where possible they supported people to be as involved as they wanted to be in preparing and cooking their meals.

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.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. 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

- People had lived at Riverside House for many years and formed friendships with their housemates and staff. We observed staff to be considerate and friendly throughout the inspection. One person said, "The staff here are nice. I like [name]. I like it when he is on duty."
- Staff ensured people had the information they needed at an appropriate time to help reduce people's levels of anxiety which may result in them experiencing heightened emotions and anxieties.
- Staff engaged with people in a respectful and kind manner. They were unhurried in their interactions with people and consistently used positive body language when communicating with people.
- Relatives confirmed that the approach of all staff was consistently caring and respectful towards themselves and their family member. They praised the friendly but professional manner of staff and the managers. A relative told us, "It always feels homely and calm when I'm there, friendly and relaxed." Other comments from relatives included "They [staff] really care for her and can see the warmth when they're with her, and they like her as you can tell" and "He's happy enough as I can tell. He's okay definitely."

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

- People were supported and encouraged to make decisions regarding their day to day routines such as when they want to get up and go to bed.
- People were supported by staff who had the skills to understand the importance of involving people as much as possible in decisions about their care and support.
- Staff supported and communicated with people in a manner that they understood. They were aware of people's verbal and non-verbal expressions to determine their views and wishes.

Respecting and promoting people's privacy, dignity and independence

- Staff respected people's dignity and respected their views. They understood the importance of listening to people and respecting their wishes or feelings.
- Staff showed patience when communicating with people. They spoke to people with heightened emotions in a calming manner to help provide them with reassurance.
- People's dignity was being maintained. For example, staff were observed helping people to style their hair and change soiled clothes as needed.
- Different communal and sitting areas in the home and garden allowed people to have the opportunity to have some privacy and have some time away from their housemates and the noise of a busy home as required.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to requires improvement. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- The provider was not able to demonstrate how the care being provided at Riverside House had been underpinned by the Right Support, Right Care and Right Culture guidance and the actions they had taken to ensure people received personalised care when living in a large care home.
- We observed and received comments from relatives that people's care was not always personalised to their requirements. For example, recommendations from health care professionals which were recorded in people's care plans had not always been updated or embedded in care practices such as recommendations of using social stories and living in a low noise environment to help reduce people's anxieties or how another person was to be supported to maintain their weight.
- We identified that people's care plans needed further development to demonstrate a 'strength-based approach' with people's involvement and which reflected their aspirations and levels of independence. People's care plans did not show how they had been involved in decisions and the management of their own care and support or when decisions had been made in their best interest. We received mixed comments from relatives about the frequency and their involvement of reviewing people's support needs and care plans.
- Timely and effective reviews of people's support requirements had not always occurred when people's behaviour changed. There had been possible missed opportunities to review people's needs and seek appropriate support which may reduce further incidents and improve the dynamics between people. Where new strategies had been implemented to help prevent further incidents and shared with staff these were not always reflected in people's care plans to ensure people would always receive the same support from all staff.
- Staff were knowledgeable about people's medicines and a person-centred approach was taken. However, people's medicine care plans and Health Action Plans were not always up to date. This meant health professionals might not have the correct information to inform their treatment decisions.
- The provider had not effectively ensured that reasonable adjustments had been made to give people opportunities to explore and follow their interests as a result of the easement of the pandemic restrictions. An external activities coordinator visited the home three days a week which gave people opportunities to engage in activities in the home such as crafts and baking. However, staff stated that due to staffing levels, it had been difficult to maintain this level of activities in the home for the rest of the week and to support people to re-engage with the wider community.
- Technology had not always been explored and implemented to help people to communicate or promote independence such as the use of digital security devices on people's bedroom doors to allow them to gain independent access into their bedrooms if they were unable to use a traditional key.

We found no evidence that people had been harmed. However, people did not always receive care and support that met their needs and reflect their preferences. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We discussed the above with the nominated individual and manager. They stated they were aware that people's needs were not consistently being met during the pandemic and had plans to review the service to ensure people were empowered and more involved in decisions about the care. The manager told us they were currently reviewing each person's activity plan to identify their activity preferences and aspirations to try out new activities.
● We found staff were knowledgeable about people's specific needs and knew how to care for people and their preferences. For example, people ate at a time and a place of their choice. We observed people eating either at the large dining table or at the garden table. Staff understood and supported people with their personal hygiene preferences such as hot bubble baths.

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.
● Staff were aware of people's individual communication needs and spoke to people in a manner that met their needs such as using short sentences. Easy read and pictorial cards had been used to help people understand important information.

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
● One person showed us around the garden and told us about the craft activities and said they were' great'. Another person said, "I like it when the activity lady comes."
● Additional communal areas around the home and garden had been developed to allow people to have their own space, carry out individual activities and to allow them to have some private time with visitors. One relative said, "The place is friendly, inclusive, and even outside we sat in a tented area and they [staff] all stopped to have a chat with us."
● Staff shared with us that the quality of life for some people had been impacted due to COVID-19 pandemic and restrictions. There had been an escalation in some people's anxieties due to lack of structure in their day and limited contact with their relatives. The manager told us they had plans in place to review people's activity plans to ensure they were personalised and sustainable.

Improving care quality in response to complaints or concerns
● The manager was not aware of any recent complaints. They were aware of how to implement the provider's complaints policy and stated people would be supported to complete an easy read complaints and grievance form if they wanted to raise a complaint.

End of life care and support
● Further development of people's end of life care plans were needed to ensure the right information was in place about people's end of life wishes.
● The provider's policies promoted end of life care that should be delivered with compassion, dignity, comfortable and be pain free in a familiar environment.

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.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to 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

- The provider's systems to promote people's well-being and safety had not fully been sustained throughout the pandemic. The provider had not fully maintained their own oversight and governance processes to ensure the quality of care being provided, care records and staff development was being maintained. For example, delays in the providers oversight of Riverside House meant that health and safety checks and staff training and supervision meetings had not always been continued in line with the provider's policies.
- However, the risks to people were reduced as they were supported by regular staff who knew them well and were knowledgeable in their role. The manager also regularly visited the home and had a good understanding of people's needs and risks.
- We discussed the above with the nominated individual and manager who stated that their priority had been to ensure people's safety during the pandemic and improve staff morale. They were aware that their governance systems had not recently been fully sustained.
- The manager had recently carried out their own quality assurance report which had helped them to identify areas that needed improvement or further development.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- A new manager had been deployed by the provider to support and manage the home with the aim to become the registered manager of Riverside House and drive improvements.
- The provider understood the inherent risks and the environmental barriers of meeting the Right Support Right Care and Right Culture guidance at Riverside House. They acknowledged the challenges of fostering a person-centred approach which met the needs of people living in a large rural home. We were told that they had engaged with an external consultant to help them in identifying areas that required further development and to ensure that people's care remained personalised and inclusive. More time was needed to ensure the care people would always receive care that promoted their independence and reflected their choices.
- The recruitment of new staff had been challenging for the provider which meant the manager had often been scheduled to work as part of the staff team and deliver care. They stated this had negatively impacted on their ability to carry out their managerial duties.
- Being on duty had helped the manager to understand people's needs and the skills set of staff. However,

they were unable to demonstrate how the numbers and deployment of staff had been decided to ensure suitably qualified staff were on shift to manage high priority risks such as fire safety and first aid.
● Staff stated that the current levels of staff meant that people's safety and personalised care could be compromised if they were required to redirect their attention to provide immediate support to people who required immediate one to one support.
● This was discussed with the manager who provided assurances that they would take prompt action to review the staffing levels to ensure enough staff were on duty to deliver consistent and effective personalised care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People were communicated with about their views of the home and there was evidence that some people had been consulted through resident meetings. Changes had been made as a result of people's wishes to the décor and use of the basement which now provided people with an alternative decorative area to relax or socialise in.
● Staff told us staff morale had improved as the new manager was very responsive to their suggestions and views about the quality of care being delivered at Riverside House and the pressures on staff. One staff member said, "She listens and takes on board our suggestions. Things are improving slowly."
● Relatives provided mixed feedback about the communication from the home. Some relatives praised staff and told us they were always approachable whilst others commented that communication from the service could improve especially when staff had started to identified changes in people's needs.

Continuous learning and improving care; 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
● The manager was aware of their responsibilities and role under the duty of candour. They told us about the importance of being transparent and how they managed and shared incidents and significant events

Working in partnership with others
● The manager had a good working relationship with the provider and felt well supported.
● Staff worked closely with health and social care professionals and sought advice and specialist support if changes in people's health and care needs were identified.

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 not ensured that people always receive care and support based on their needs and preferences.