Eldercare (Halifax) Limited

Elm Royd

Inspection report

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Date of inspection visit: 6 August 2014
Date of publication: 23/01/2015

Ratings

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

Overall summary

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

We inspected Elm Royd Nursing Home on 6 August 2014 and the visit was unannounced. Our last inspection took place on 3 March 2014 and, at that time, we found the regulations we looked at were met.

Elm Royd Nursing Home is registered to provide nursing and residential care to up to 50 older people and people who may be living with dementia. This included seven intermediate care beds. These places were commissioned by the Calderdale Clinical Commissioning Group (CCG) and used to provide people with additional support on discharge from hospital, before they could return home; or sometimes as an alternative to a hospital admission. An external multidisciplinary team which included occupational therapists, physiotherapists and nursing staff were involved in supporting these placements. On the day of our visit there were 34 people using the service..

Summary of findings

The registered manager left the service in September 2013. The current manager told us they would be applying for registration with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

We found people's safety was compromised in some areas. People told us there were not enough staff to give them the support they needed and this was confirmed by our observations.

We found staff were making sure people who were at risk of losing weight received fortified meals and snacks. People told us the food was OK and we found people only had a limited choice of meals.

Although people spoke positively about staff, we found caring relationships varied between individual staff members. We observed most staff to be warm, compassionate and caring in their approach. In contrast we saw some staff members show a lack of regard for the people they were caring for.

Although there were systems in place to monitor the quality of the service, we saw there was a lack of direct supervision of staff members working practice. Many of the issues we found during our visit should have been picked up by the nursing staff leading the shifts or by the acting manager.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe. There were not enough staff on duty to meet people's needs in a timely way.

Staff we spoke with knew how to recognise and respond to abuse correctly. They had a clear understanding of the procedures in place to safeguard vulnerable people from abuse.

We noted there were a number of methods being used, which may have constituted a deprivation of liberty for people who lived at the home. For example,the front door was locked and an internal door segregating two parts of the home was locked using a digilock; the number was only known to staff. However, measures had been put in place to make sure the service was meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS).

Is the service effective?

Requires Improvement

The service was not always effective. Staff training was up to date; however, staff were not receiving regular supervision or annual appraisals. This meant there was no formal support system to look at individual practice and professional development.

There were good systems in place to make sure people who were at risk of losing weight had fortified meals and snacks. Choice of meals was limited and people described the food as OK. The dining experience was poorly organised and some people had to wait a long time for their meals.

There were a range of health care professionals visiting the home to make sure people's health care needs were being met.

Is the service caring?

Requires Improvement

The service was not always caring. People and relatives told us the staff were kind and patient. However, we saw people being ignored and spoken to in an inappropriate way.

We found information was available in the care plans about people's life histories and personal preferences. Staff knew about people and used the information to engage people in conversation or to inform their care and support.

Is the service responsive?

Requires Improvement

The service was not always responsive, to people's needs. Care plans did not always identify people's specific needs or what support staff needed to offer to meet those needs.

Summary of findings

There were activities for people to participate in but these were done 'to' and 'for' peoples' benefit rather than 'with' them.

People told us if they had any concerns they would tell the staff. We saw complaints that had been made had been responded to appropriately and resolved to people's satisfaction.

Is the service well-led?

The service was not always well-led. The acting manager told us a lot of their time had been taken up with staff recruitment. This had resulted in them having less time for direct observation of staff practices within the home.

Although audits were in place and being completed we found these were not all effective. For example, relatives had been asked for their views about the home but no information was available about their comments or what had been done in response to any issues raised.

Requires Improvement

Elm Royd

Detailed findings

Background to this inspection

The inspection team consisted of one inspector, a specialist advisor in mental health and dementia 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.

Our last inspection took place on 3 March 2014 and, at that time, we found the regulations we looked at were met.

Before the inspection we reviewed the information we held about the home. This included information from the provider, notifications and speaking with the local authority contracts and safeguarding teams. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make

On the day of our inspection we spoke with 13 people who lived at Elm Royd Nursing Home, 10 relatives who were visiting the home, 10 members of staff, the acting manager. We also spoke with two nurses who were involved with the intermediate care unit, who were not employed by the home.

We spent time observing care in the dining room and lounges and used the short observational framework (SOFI), which is a way of observing care to help us understand the experience of people using the service, who could not express their views to us.

We looked around some areas of the building including people's bedrooms, bathrooms and communal areas. We also spent time looking at records, which included five people's care records, three staff recruitment records and records relating to the management of the home.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Requires Improvement

Is the service safe?

Our findings

We asked people living in the home and relatives if there were enough staff on duty to meet their needs. Generally the opinion from both groups was staff seemed to be 'rushed' which in some cases led to delays in people receiving the assistance they requested or needed. One person told us, "Sometimes when I press my buzzer it takes staff a long time to come." One visitor told us the delay in night staff responding to the buzzer had resulted in their relative, " wetting the bed." They went on to explain their relative had been upset and felt humiliated. Another visitor told us of a similar experience, they reported a delay in staff responding to their relative's toileting needs had resulted in them wetting their bed during the daytime. A third relative told us, "The staff are first class. The only trouble is there are not enough of them. With them having their own summer holidays right now, staff are covering, running back and forth, far too busy and struggling to cope."

A fourth relative told us, "Staff have a lot to do and there are not always enough of them. There is always a member of staff in 'Woodlands' lounge, but they can't always get other staff when people need the toilet." We spent time in this lounge which confirmed this observation. For example, the nurse wanted to leave the lounge to give someone their medication in their bedroom. No staff were available and the nurse had to wait until another member of staff was available delaying this person medication.

We also observed a staff member telling a colleague to respond to a call bell that had been ringing for some time. The staff member, who was already engaged in dealing with another task, then did so promptly.

In one dining room we saw three people were sitting at dining tables for 25 minutes before their lunch was served. Four people started eating their lunch and spilt food on their clothing before staff provided them with clothing protectors. Three people who required staff support to eat their lunch tried unsuccessfully for several minutes to eat before staff came to offer assistance, resulting in what should have been a hot lunch becoming considerably colder.

This meant people's needs were not being met because staff were not responding in a timely way or there were not enough staff available. This breached Regulation 22 (Staffing), of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This is because the provider had failed to maintain appropriate staffing levels.

We looked at the recruitment records for three staff members. We found recruitment practices were safe and relevant checks had been completed before staff had worked unsupervised at the home. We spoke with two members of staff who had recently commenced employment. They confirmed the provider's application and interview procedure had been adhered to. We also found checks were made on the nursing staff to make sure they were legally entitled to practice. This meant people who lived at the home were protected from individuals who had been identified as unsuitable to work in a care home.

People we spoke with said they felt safe and secure in the home. Generally relatives felt the same way. One person told us, "I feel safe here, but I felt insecure when I was in hospital."

Staff we spoke with told us they had received training in safeguarding vulnerable adults and were clear about how to recognise and report any suspicions of abuse. Staff were also aware of the processes for taking serious concerns to appropriate agencies outside of the home if they felt they were not being dealt with effectively. This showed us staff were aware of the systems in place to protect people and raise concerns.

During our visit we looked at the systems that were in place for the receipt, storage and administration of medicines. We saw a monitored dosage system was used for the majority of medicines with others supplied in boxes or bottles. We looked at the medication administration records and found some gaps in the recording, where nurses had not signed to acknowledge medication had been given. We examined the packs of medicines and found no medication present for the days and times correlating to the missing signatures. This meant people may have received their medication but this could not be confirmed in the absence of a signature.

We found medicines were kept securely but not stored safely. We looked at records that showed the temperature of the medication fridge had been maintained at the correct temperature. However, the recording of room temperatures indicated that medicines were stored at a

Is the service safe?

temperature in excess of the upper safe limit. This situation had been known to the provider for some time yet no remedy had been found. This meant the effectiveness of people's medication could have been compromised as it had not been stored at the correct temperature.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which apply to care homes. The DoLS are part of the Mental Capacity Act 2005 and aim to make sure people in care homes are looked after in a way that does not inappropriately restrict their freedom. We noted there were a number of methods being used, which may have constituted a deprivation of liberty. The front door was locked and an internal door segregating two parts of the home was locked using a digilock; the number was only known to staff. Some people had sensitivity mats in their beds to alert staff if the person was vacating their bed. Other people had mats at the side of the bed to perform a similar function and some people carried a monitor around their neck to alert staff to falls. Some bedroom doors were alarmed to signify to staff the occupant may be vacating their bedroom. The main staircase was guarded by a gate to discourage but not prevent access. Some people were under half-hourly observations with people's activity recorded and others had been assessed as needing two hourly observations during the night. The accumulation of restrictions being experienced by people may amount to unauthorised deprivation of their liberty. We judged that the provider may be exercising complete and effective control over people's care and movements. It was also the case that people were under continuous supervision and control and may not be free to leave. However, there was no evidence to suggest people would be stopped from leaving should they choose to do so.

We discussed our observations with the acting manager who said they had recently assessed the restrictions people may be under and had asked themselves a question relating to the first principle of the Mental Health Act 2005, "A person must be assumed to have capacity unless it is established that he/she lacks capacity." We were told the safeguarding team were due to meet with the acting manager in the very near future. This meant steps were being taken to make sure no one would be unlawfully deprived of their liberty.

During our inspection of medicines we were informed that one person with dementia received their medicines covertly. Our subsequent scrutiny of the persons care plan showed evidence that mental capacity assessments had been conducted by the acting manager and general practitioner. Discussions with the person's relatives had taken place and the person's general practitioner had written a letter supporting the giving of medicines by covert means. This meant the decision to administer covert medication had been made in the person's best interest.

We looked at five care files and saw risk assessments had been completed in relation to moving and handling, falls, nutrition and tissue viability. These provided guidance about what action staff needed to take in order to reduce or eliminate the risk of harm.

We recommend that the management of medication is reviewed in line with the National Institute for Health and Care Excellence (NICE) guidance.

Requires Improvement

Is the service effective?

Our findings

We were unable to find evidence in staff files of a structured approach to formal supervision and annual appraisal. Discussion with the acting manager confirmed that supervision was not conducted at regular intervals and that appraisals were overdue. The acting manager told us that letters had been sent to staff to start the appraisal process and they had plans to give appraisals a high priority. We were further told by the acting manager they would make a concerted effort to facilitate supervision.

Staff we spoke with confirmed that supervision and appraisals were not a regular feature of their employment. This meant staff were not being provided with a formal support system to look at their individual practice and professional development.

This breached Regulation 23 (Supporting workers); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff we spoke with told us they received training that was relevant to their role and told us their training was up to date. We looked at a sample of staff training records and found staff had access to a programme of training. Mandatory training was provided on a number of topics such as safeguarding vulnerable adults, manual handling, first aid and fire safety. Additional training was provided on specialist topics such as behaviours that challenge and dementia care.

During our visit staff gave examples of obtaining additional training to meet the needs of the people who used the service. Staff said they thought the quality and method of training had always been good but had become even better recently.

Two newer members of staff told us they had spent a week at head office for their induction training. They said trainers were really good, there were lots of practical sessions and they found the whole experience enjoyable. Staff confirmed the induction training had provided them with the skills and knowledge to enable them to meet the needs of the people who used the service.

When we looked at the recruitment records we saw the registered nurses had supplied proof of current registration with the Nursing and Midwifery Council (NMC). We also saw there was a procedure in place to make sure annual checks were made with the NMC to make sure the nurses remained on the register to practice.

In three of the care plans we looked at we saw people had been assessed as being nutritionally at risk. We saw the actions staff needed to take in order to reduce these risks had been recorded. For example, foods needed to be fortified and high calorie snacks needed to be provided. We saw people's weights were being monitored closely to make sure the care plan was effective.

We spoke with the chef who told us how they fortified foods with cream, butter and cheese for example. They also told us they made fudge and that crisps, biscuits and chocolate were available for snacks between meals.

During the morning we saw people were given a variety of snacks. Relatives and staff confirmed these were always available for people. We spoke with two relatives who told us they had eaten meals at the home and found the food reasonably good. However, people who lived at the home described the food as 'acceptable' or 'ok.' One said, "It's edible but nothing special."

There was a choice of meal at lunchtime but people had to make the choice prior to the meal being prepared. We asked staff how people living with dementia were assisted to make a choice of two meals. We were told no pictures of the meals were available, so the choice was often made by the staff member's knowledge of the individual's preferences.

We spent time in each of the dining rooms at lunchtime and found the organisation of the mealtime in both was poor and did not provide people with a positive dining experience. In Woodlands dining room people were served their meal by preference. People who had selected chicken and leek bake were served first. This meant some people spent a long time watching others eat at their table before they received their meal. We heard one person ask for their lunch but had to wait a further 10 minutes before they were served. Not enough plates or soft diets had been delivered in the hot trolley which further delayed people getting their meal.

Once staff began assisting people with their food it was done with patience, care and sensitivity. One staff member

Requires Improvement

Is the service effective?

used their own face to clearly mirror and model to the person the chewing and swallowing process. This together with their verbal reassurances appeared to help the individual.

Throughout the period we observed lunch in this dining room, a CD of Matt Monroe music was being played loudly in the room (the same CD had also been playing at breakfast time). This clearly made it difficult for staff to communicate effectively with some people and gave no opportunity for people who wanted either silence or relative quiet whilst they ate.

We spoke with the acting manager about the mealtime experience and they told us they were disappointed by our observations as this was an area they had worked hard on to improve. They told us they would go back to monitoring mealtimes more closely.

In the five care plans we looked at we saw people had been seen by a range of health care professionals, including, specialist nurses, community matrons and podiatrists. Care staff we spoke with told us the nursing staff were quick to respond if people's needs changed. We spoke with one of the community matrons' who told us they had only had limited contact with the service but staff had contacted them appropriately and followed any instructions they had been given.

Requires Improvement

Is the service caring?

Our findings

We looked at the care plans for five people who lived at the home. They all contained some information about people's personal preferences and likes and dislikes but one did not contain a life history. We asked staff about this and they told us they were working with the family to make sure this information was recorded. Two members of staff we spoke with told us how important this information was to them. They explained it provided valuable information they could use to engage people in conversation about their families and interests.

People we spoke with and relatives spoke highly of staff. People's comments included: "The staff are very pleasant. I was unwell recently and the staff were very comforting." Relatives comments included: "Whatever time of day I visit I notice staff being consistently good with all of the people living here." "Staff always have a few nice words with me when I arrive, update me on any news and developments since my last call or visit and if asked join me and my relative for a quick chat." "This home has a nice 'feel' to it and it's got lots of good staff."

Some people who had complex needs were unable to tell us about their experiences in the home. So we spent time observing the interactions between the staff and the people they cared for. We saw in the main staff approached people with respect and support was offered in a sensitive way.

For example, we saw two staff help hoist a person in the dementia unit from a wheelchair into their chair in the lounge. It was done gently and with care. The person, with no obvious cause, started trying to hit one of the staff and talked derogatively about them. Their colleague quickly distracted the person with suggestions for a suitable snack and drink. This momentarily allowed both colleagues the time to complete the hoisting manoeuvre safely, following which the targeted staff member withdrew discreetly allowing her colleague to settle the person into her chair.

However, there were occasions when staff approach was not appropriate and showed a lack of regard for people. We heard one member of staff refer to people as "My little pets." At lunch time another member of staff said "I'll do X, whilst I'm sat with Y." This related to assisting someone with their meal. We also saw occasions when people tried to engage with staff and were ignored.

At breakfast time there was no staff supervision in the main dining room. The chef took people's orders for breakfast as they arrived. We saw one person had jam all down one side of their face and although staff came in and out of the dining room to take breakfast trays to people's bedroom no one took time to assist this individual. We heard one person ask three different members of staff if they had an appointment that day. Each said they would check the diary. The third member of staff was the only one to respond and said there was nothing in the diary. The individual did have a review meeting later on in the day.

We went to see one person who was in bed. Their care plan clearly stated they needed to wear their glasses. We found them in bed with the TV on but were not wearing their glasses. We passed them their glasses which they put on immediately.

There were seven intermediate care places at the home. These places were commissioned by the Calderdale Clinical Commissioning Group (CCG) and used to provide people with additional support on discharge from hospital, before they could return home; or sometimes as an alternative to a hospital admission. An external multidisciplinary team which included occupational therapists, physiotherapists and nursing staff were involved in supporting these placements. We spoke with two of the intermediate care nurses who told us staff had recently provided exceptional care and support to someone at the end of their life.

We recommend that the provider looks at dignity in care best practice.

Requires Improvement

Is the service responsive?

Our findings

In the five care files we looked at we found assessments had been completed before people moved into the home to make sure staff could meet the person's care needs. In addition where people had a social worker a copy of the multi-disciplinary assessment (an assessment made by a team of health and social care professionals) was also in the care file and provided staff with additional information about the person.

Generally, we found the care plans gave staff the information they required to care for people safely and in the way they preferred. For example, we saw one person had sustained a number of falls. The person had been referred to a specialist falls service where an assessment had been performed by healthcare professionals with appropriate skills and experience. Their advice had been followed and the incidence of falls had decreased.

However, we saw in one care plan the person was a diabetic who took medication to control their diabetes. There was no detail about what action staff should take if the person's blood sugars became too high or too low, which could result in a diabetic coma. We saw the GP had been contacted as the person's blood sugar levels had been low. There was no detail in the care plan about the normal blood sugar range. This meant there was a lack of guidance for staff in relation to the management of the person's diabetes.

In another care plan we saw on the daily records staff had recorded concerns about 'red mark' on various parts of the individual's body. Although staff had recorded that the person needed to be seen by their GP this had not happened. This meant although staff had identified concerns they had not taken action to get a medical opinion.

A visitor told us that after their relative had "wet the bed" because staff didn't respond quickly enough to the buzzer; staff had provided them with a zimmer frame, to give the necessary freedom and sense of independence to visit the toilet as required. However, the relative told us that when they visited recently they found the zimmer frame was not in the bedroom. This meant the relative was again dependent upon staff to assist them to the toilet.

This breached Regulation 9 (Care and welfare); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The home employed an activities co-ordinator who mostly worked on weekdays. We saw activities were on offer during our visit to keep people occupied. During the morning some of the people in Woodlands lounge were involved in a game of giant dominoes and one person was given the choice of three DVD's to watch. A visiting relative told us activities were usually held in the other lounge as Woodlands was usually the quiet room.

In the afternoon we saw the activities co-ordinator in the other lounge throwing a light soft beach ball for people to catch and return to her. We saw people were enjoying this activity. However, the co-ordinator was interrupted three times by other staff and left the activity on all three occasions. This resulted in people losing interest. We also noted throughout the visit a music video of Tina Turner was playing constantly and loudly. A staff member told us this was in response to people's requests. However, the music was so loud and persistent one person told us it stopped or interfered with their and other people's preference to read, talk or just be quiet.

People weren't offered any choice of activity and not everyone wanted to join in the activities that were offered. Our observation was activities were done 'to' and 'for' people, rather than 'with' them. Whilst we saw the activities co-ordinator speak with people there was no meaningful conversation or engagement about individual interests. One visitor said, "They put their heart and soul into it, but my relative finds them a bit much."

We saw the complaints procedure was on display. People who lived at the home and relatives said that staff were very approachable. One person said, "If I've had any issues, concerns or complaints to make they sort them out fairly quickly and let you know what happened." One relative said, "If I had any concerns I would feel able to raise them with staff."

We looked at the complaints and concerns log and saw what action staff had taken to resolve any issues that had arisen. This meant staff were recognising complaints and taking action to resolve them. We also saw there was a 'suggestions' box in the main hallway, however, the acting manager told us none had been received.

Requires Improvement

Is the service responsive?

Relatives we spoke with told us the home had an open access visiting policy and that they were made to feel welcome whenever they came. Two visitors said they often had a meal with their relative when they visited.

Requires Improvement

Is the service well-led?

Our findings

The registered manager left the service in September 2013. On the provider information return the service provider told us the acting manager would be applying to the Care Quality Commission for registration as soon as possible.

The acting manager told us a lot of their time had been taken up recently with staff recruitment and this had impacted upon other management tasks for example, keeping formal supervision and appraisals up to date. It had also detracted from day to day observation of staff practices. For example, meal times, activities and staff members interactions with people.

We spoke with the acting manager about the inappropriate way one member of staff was speaking with people. They told us the individual spoke to everyone like that and was well meaning. This meant the issue had not been addressed.

During the morning we saw the two nursing staff on duty spent approximately two hours completing the morning medication round. This was at the time people who lived at the home were receiving a lot of direct care. We saw no evidence of the nurses leading the shift or questioning staff practice.

We saw incidents and accidents were recorded and there was some analysis taking place. However, the acting manager told us this did not include the time of day or where accidents or incidents happened. This meant no trends around where or time of day incidents or accidents occurred would be identified.

The acting manager told us relatives had been sent surveys in January 2014 to get their opinions about the service. However, the results from the survey's had not been analysed.. This meant people's views had not been acted upon and people had been given no feedback from the survey.

This breached Regulation 10 (Assessing and monitoring the quality of service provision); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There was a system of audits in place that included; complaints, medication, infection control and equipment. We saw care plans and risk assessments were reviewed and amended to reflect people's changing care needs.

We saw an audit had been completed against The Care Quality Commissions 'Essential Standards of Quality and Safety'. Where an issue had been identified the action to be taken had been identified. For example, one area identified for improvement was that the details of one to one meetings with people who lived in the home needed to be included in the care plans.

The two nurses involved with the intermediate care told us improvements had been made at the home. Two members of staff told us; "Things are improving," and "There have been improvements in care."

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing** **The registered person did not ensure there were enough staff on duty to meet people's needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting Workers** **The registered person did not ensure staff received appropriate supervision and appraisal.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare** **The registered person did not ensure care was always planned to meet individual needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers

This section is primarily information for the provider

Action we have told the provider to take

Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision

The registered person did not have effective systems in place to monitor the quality of service delivery.