Runwood Homes Limited

Blackthorns

Inspection report

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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

Overall summary

This inspection took place on the 14 December 2015 and was unannounced. Blackthorns is a residential service providing accommodation and personal care for up to 62 older people. On the day of our visit there were 57 people living at the service.

A new manager had recently been appointed and was present during the inspection but was not registered. 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.

There were not always sufficient numbers of staff available to meet people's needs which meant that people did not always receive good care. Further work was needed to ensure people needs and preferences were met. Care plans were not always up to date and did not provide staff with sufficient guidance. This combined

Summary of findings

with a new staff team meant that individuals whose needs were more complex were at increased risk of poor care. Staff were generally caring but care delivery focused on the completion of tasks.

The new manager was working to raise morale and develop staff skills but this was at an early stage of development.

Staff received training, but there was a new staff team and the training did not always provide them with the knowledge and skills they needed to meet the needs of people living at the service. Medication administration practice did not always follow the recommended professional guidance.

There were effective procedures in place to ensure that references and other checks were undertaken and to reduce the risk of employing unsuitable staff.

The provider had systems in place to reduce the risk of people experiencing abuse and staff had been provided with guidance in reporting issues of concern.

Audits were undertaken by the manager and area manager but these were not always effective as they did not identify some of the key issues which we found at the inspection.

During this inspection we identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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?
This service was not always safe.

People were not supported by sufficient numbers of staff.

Medication administration practice did not always follow the recommended professional guidance.

Recruitment processes offered protection to people.

Risk were identified and management plans were in place to reduce the likelihood of harm

Requires improvement

Is the service effective?
This service was not always effective.

People were not consistently supported by staff with the right skills and knowledge.

Nutrition and fluid intake was not consistently well managed. The delivery of meals was not well organised and there was no system in place to identify individuals who refused their meal.

People had access to health care support

Mental capacity assessments had been carried out and applications had been made to the appropriate professionals for assessment when people who lacked capacity

Requires improvement

Is the service caring?
This service was not always caring.

Most staff were very caring but care delivery was task focused, and did not always meet individual needs.

Requires improvement

Is the service responsive?
This service was not always responsive.

Care needs were assessed but care plans were not always sufficiently detailed to guide staff

Staff were not always aware of the contents of the care plan and people did not always receive care that was personalised and responsive to their individual needs.

Concerns and complaints are taken seriously

Requires improvement

Is the service well-led?
This service was not consistently well-led.

Requires improvement

Summary of findings

Leadership was supportive but poor practices were not being identified and addressed.

Audits did not address the shortfalls in staffing and inconsistencies in the approach of staff

Blackthorns

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 was planned to check 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 inspection took place on the 14 December 2015 and it was unannounced. The inspection team consisted of three inspectors and an Expert–by-Experience. An expert by experience is a person who has personal experience of care services and caring for an older person

Prior to the inspection we reviewed the information we held about the service including notifications of incidents that the provider had sent to us since the last inspection. A notification is information about important events which the service is required to send us by law. We also looked at safeguarding concerns reported to us. This is where one or more person's health, wellbeing or human rights may not have been properly protected and they may have suffered harm, abuse or neglect.

There were 57 people living in the service and we spoke with 14 people. We also spoke with five relatives, eight staff, the manager and the regional care director. Four visiting professionals were also spoken with about their observations of the care provided. We looked at staff records; peoples care records and records relating to how the safety and quality of the service was being monitored. We observed care practice and medication administration.

As a number of people who lived in the service were living with dementia we used the Short Observational Framework for inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Requires improvement

Is the service safe?

Our findings

People were not supported by sufficient numbers of staff. One person told us, "There have been lots of changes of staff. I'm unsure who is going to assist me. There are more residents with dementia and that has changed the atmosphere. There is more shouting. I'm a lucky one as I need less support and have a degree of independence." Another person said, "They don't always answer the buzzer very quickly. It can be anywhere between five and 20 minutes." One relative said "If you are physically and mentally in reasonable health you will be fine because you can do things for yourself if they don't get done for you. The staff don't have the time to devote to those who need intensive support."

Staff told us that there was not enough staff to meet people's needs. One member of staff said that in one part of the home there were a number of people who needed two staff, "There are 27 people being supported by 3 staff, it gets so stressful for us. There can be up to four people shouting to go to the toilet at the same time, it is not fair on us or on residents, extra staff would make such a difference." We observed people calling out for staff later in the day, three people were calling out simultaneously but staff were already busy assisting other people. Staff looked distressed and one resident was shouting out, "Come to me…" We heard a member of staff say to one person who was calling out, "You are in my queue."

Staff told us that there were two care team managers and seven care staff during the day and one care team manager and three care staff at night. This reflected the staffing rota although we noted that on a small number of occasions the numbers had dropped to below these levels.The manager told us that this was due to staff going off sick at short notice. We noted that some staff were working long hours and up to fifteen hour shifts. Staff we spoke with all told us that the numbers of staff were insufficient to meet people's needs. They said that domestic staff were regularly used to provide care. The two domestic staff who provided care had received the same training as the care staff. Staff told us that they had to do non care duties such as clearing and washing up after every meal. This meant that they were not able to respond to people's individual care support needs at these times.

One member of staff told us, "We're particularly stretched in the morning and at meal times. We're not able to give people the support they need." Another member of staff said, "There's never enough time or enough staff. It's very stressful to know that you can't give the care you want to give. It's impossible to spend time with people on a morning shift." Staff described a very task orientated culture that did not take account of people's individual needs, wishes or preferences. A number of the staff said, "We are told to get everyone up and dressed before breakfast at nine o'clock."

The manager told us that they had 174 vacant care and support staff hours. They also told us they were in the process of recruiting to fill the vacant posts and were using agency staff when necessary to fill the gaps. They said that they always tried to have the same agency staff to provide consistency of care for people. They told us that the staffing levels were calculated to meet people's dependency levels. The provider used the Barthel Index of Activities of Daily Living to calculate the level of dependency. However, the tool did not take account of the layout of the home and the difficulty that staff had in supervising people both in their rooms and in so many different communal areas. Staff told us that nearly half of the people in the home needed two staff to help them mobilise safely and to support them with their personal care. They said that about a quarter of people in the home needed to be closely supervised or assisted to eat their meals in order to ensure an adequate diet.

The shortfalls in staffing demonstrate a breach of Regulation 18 of the Health and Social Care Act 2008 (regulated activities) regulations 2014

People were supported to take their medicines but practice did not always follow the recommended professional guidance. We observed part of a medicines administration round during our inspection and saw that staff signed for the administration of topical creams that they had not administered themselves. We could not see how staff knew if and when the creams had been administered.

A few people were administering some of their own medicines. Risk assessments had been completed. However, one had been completed over a year ago and there had been no reassessments to check that they were still safe to administer the medicines themselves.

Some people were being given their medicines in the form of a skin patch. Staff had records to show the different

positions of the skin patches, in order to reduce the likelihood of skin reactions. However, these were not regularly completed and it was not always clear from the records where staff had placed the patches.

Staff had protocols for administering medicines that were given when the person required them, rather than at set times. For example, these included when to administer painkillers and how to look for non-verbal clues when the person was not able to tell them that they were in pain. The protocols helped staff to administer 'as required' medicines in a consistent way.

Staff received medication training and an assessment of competence. However, staff did not all have a full understanding of how to give some medication and the potential side effects of not doing so. For example, staff were not all aware of how the timing of people's medication for Parkinson's disease could affect their ability to move. There was very brief information on what each medicine was for in the medicine administration records (MAR) folder. However, there was no information on the common side effects they should look out for. This meant that staff may not it would take staff a long time to acquire sufficient knowledge to administer medicines safely.

The shortfalls in medication were a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) regulations 2014

Recruitment processes offered protection to people. We looked at the recruitment files for two new staff. They demonstrated a sound process that included checking criminal records, taking up references and gaining appropriate identification. The manager was supported by the provider's human resources department who were able to provide advice on any visas needed or on any concerns over the suitability of a candidate. This ensured that sufficient safeguards were in place and that only staff suitable to work with vulnerable older people were employed.

People were protected from harm as staff were aware of their responsibilities and were encouraged to raise matters of concern. Staff told us that they had received training and regular updates in safeguarding vulnerable people. They had a good understanding of the different types of abuse that could occur and the signs to look out for. They said that they would be confident about reporting abuse or poor care practices both within the home and to outside authorities. Information about abuse and how and where to report it was displayed in the entrance hall of the home.

People told us that they felt safe. One person said, "I feel completely safe and relaxed."

A relative told us that their relative was,"Settled here and seems happy and content. The staff always seem to deal with them sympathetically."

Risks were identified and management plans put into place to reduce them but these were not always implemented consistently.

A range of assessment screening tools were used by staff to identify risks. The Malnourishment Universal Screening Tool (MUST) was used to identify individuals at risk of malnourishment and Waterlow risk assessments were undertaken to identify those at risk of pressure damage. Where risks such as skin integrity were identified, specialist mattresses and cushions were in place to reduce the likelihood of injury. Checks were undertaken to ensure that these were working effectively and set at the correct level for people. However, not everyone who had been assessed as requiring a pressure cushion was sitting on one. Risk assessments were in place for conditions such as diabetes but they did not provide staff with clear guidance as to how they should respond to issues such as high and low sugar levels.

Accidents and falls were analysed and the manager looked at a range of factors including timings and location which may be a contributing factor. We saw that actions were put into place to reduce the risk of injury. These actions included the used of pressure mats to alert staff to movement. Referrals were also made to the falls service where people had repeat falls.

Health and safety audits were undertaken monthly by the manager and a company representative undertook a comprehensive audit on a six monthly basis. We saw that there were certificates in place to evidence that checks were being undertaken on a range of equipment such as, moving and handling slings, electrical testing and water temperature checks. Lift servicing was being undertaken as well as regular fire drills. The last fire drill records stated, 'Good response time, staff aware of their responsibilities.'

Requires improvement

Is the service effective?

Our findings

Training was provided but it did not always provide staff with the knowledge and skills they needed to carry out their full range of duties.

One person said, "They are nice and gentle with me. They hoist me up very carefully." Another person told us, "The carers know what they are doing but can be a bit rough sometimes." One relative said. "The staff know what they are doing, and are skilled and seem to lift and move residents carefully."

The service has recently employed a number of new staff. Some staff told us that some of the new staff were inexperienced and did not receive enough support when they first started. There was no formal classroom based induction before they started work, regardless of their previous experience. New recruits only had two shifts shadowing a more experienced member of staff. Staff told us that their experience of shadowing was extremely variable with some staff being much more effective at supporting and training them than others. One member of staff said, "I didn't have a long enough induction. I needed to learn to get around the building and to get to know resident's needs." Another member of staff told us, "I was just given paperwork to read and two days shadowing and told to complete the e-learning." New staff completed the Common Induction Standards over a period of three months.

Staff told us that their training was mainly e-learning. One member of staff told us, "I don't like e-learning. You can't have questions and answers like you do with face to face training and get to relate the training to individual residents." There was only a face to face or competency element to moving and handling training, first aid training and medicines management for senior staff. Staff received no training on people's medical conditions. This meant that they were less likely to be able to respond appropriately to people's individual needs. For example, staff would be less likely to recognise signs of medical complications such as high or low blood sugar in a person with diabetes without the appropriate training. The regional care director said that the provider was planning to provide training related to common medical conditions through in-house trainers.

We observed that staff were not always putting their training into practice. We observed two staff assisting an individual to move using a handling belt. However, this was poorly fitting and moved up under the individual's arms which placed the individual at risk of injury and discomfort. We observed a few people being moved in wheelchairs without foot plates and staff were not aware of the risks associated with this. This put people at risk of injury. One person's bandaged foot was dragged along the floor. This did not keep this person safe and could potentially cause further damage to their ulcerated foot. We spoke to the manager about this and they told us that they had recognised that there were issues with unsafe moving and handling practice and they had provided additional training to small number of carers to mentor other staff. We also observed poor infection control practices, a member of staff contaminated clean linen by dropping it on soiled linen and then picked it up and placed it with clean linen.

Staff told us that they had regular supervision. One member of staff described supervision as, "A time to voice any problems or training needs." There was however no formal observation of care practices. This meant that senior staff were not monitoring care standards and identifying areas that needed to be improved.

Nutrition and fluid intake was not consistently well managed as the delivery of meals was not well organised. People gave us variable feedback on the food and drinks on offer, some people told us that they enjoyed the meals but other people were less complimentary.

One person said, "I like the pasties and fish and chips, they have arranged for me to have my own flask of coffee as like my drinks hot and they have to give it less warm to residents in case they spill it." Another person said, "There's lots of mince. Also the menu often doesn't match what is served. There is enough food and it's warm and the choice is OK…..The carers don't tend to check up that we have enough water, but I can look after myself anyway." A relative told us," The food seems good, no problems….there is no drink in the room."

Our observations on the day of our visit were that the food was hot and nicely presented. Picture menus were available and people had a choice of two dishes, although the menu had changed since printing. We observed staff offering people choices, a member of staff told us, "I always try to show people with dementia two plated meals so that they can make a genuine choice at the time." We saw that one person did not like the dish that they had chosen and they were offered the other choice.

Requires improvement

Is the service effective?

Pureed meals were available for people who had been assessed as requiring a soft diet and the items had been separately pureed and looked appetising. There was however a lack of organisation and leadership around the serving of meals and staff were not always clear who had and hadn't been served.

We saw that the people identified at being at risk of malnourishment were weighed on a regular basis. Referrals were made to health care professionals such as dieticians and to the speech and language therapists if there was a problem with their weight or swallowing problems. They also had input from the local mental health team if there were concerns about people's mental health and community physiotherapists where individuals were at risk of falls.

Staff told us that they had good support from the local GP surgery. One GP had responsibility for the home and visited on a regular basis. Staff said that they could request visits at other times during the week. They also received good support from the nurse practitioner at the surgery and the community nurses.

We spoke with a number of professionals as part of our inspection and they told us that they had a good working relationship with the home and staff tried hard to meet people's needs. However, they also told us that staff sometimes struggled with people with more complex needs.

Mental capacity assessments had been carried out and demonstrated that some people had capacity to make day to day decisions The majority of staff had received e-learning in the Mental Capacity Act 2005. Some staff had a better understanding of mental capacity than others. They generally understood that people could have capacity and the ability to make some decisions but not others and that their capacity could vary during the same day. Staff were aware that they should be offering people choices continually through the day but felt that this was not always possible within the time constraints. One member of staff told us, "I always try to show people with dementia two plated meals so that they can make a genuine choice at the time."

Applications had been made to the appropriate professionals for assessment when people who lacked capacity to make decisions and needed constant supervision to keep them safe. This met the requirements of the Deprivation of Liberty Safeguards (DOLS.)

Requires improvement

Is the service caring?

Our findings

People told us that the majority of staff were kind but the feedback was not consistently positive. One person said, "I'm quite happy… they are kind and can't do enough for me…" Another person said, "Everybody's very kind, if they see that you are not enjoying yourself they come and see if they can cheer you up."

One person said "The quality of care varies here. Some of the staff are lovely and give me time for which I am very grateful. Some of the others actually say they are too busy to come and chat and they tend to be ones who do the job for the money rather than the desire to work with us. I have heard them talk about other residents or say things to them in front of us such as, ' No you can't go to the toilet now cos its lunchtime.' Or 'No you can't have any more tea."

We witnessed some caring interactions between staff and the people they were supporting and it was clear that there was warmth there and people were comfortable with some staff. We observed a member of staff making efforts to find a private space to enable an individual to spend time with their visitor. Some staff maintained good eye contact and spoke gently to people. However, a lack of staff at key points of the day impacted on the care provided. We observed that staff were busy and task orientated in approach. For example, we observed staff assisting people with meals standing behind their wheelchairs, rather than facing them and taking time to talk to them whilst assisting them. We observed staff moving people in wheelchairs without asking them or informing them about what they were doing or where they were going. We observed that two people required assistance with eating their meal in the dining room and they received their meal before other individuals. They were then left in their wheelchairs for an hour whilst other individuals ate. One of the individuals was facing the wall and during this time we observed no interaction between them and staff.

One member of staff told us, "There isn't time to give quality care and give them the individual time they need." Another member of staff told us, "The carers are lovely and caring. More staff would make it a much better home. I don't feel able to do the job I want to do to the standard I want to do it." A third member of staff said, "We don't talk to residents enough."

Staff considered that people in the home were becoming more dependent, with more of them needing to be moved with a hoist and assisted to eat. However, they told us that they were not able to promote people's independence. One member of staff said, "Time constraints impact on our ability to help them to be independent." The inability of staff to give people time to do things for themselves meant that people were likely to become more dependent when admitted to the home.

Staff were observed to not consistently respect people's privacy and dignity. There was information on promoting dignity in the entrance hall of the home. Staff told us that they always knocked before they entered a person's room and kept the door closed when providing personal care. One member of staff told us, "I always tell people what I'm going to do. I talk them through the care and support as I give it." However, the issue was not well understood by all staff and we observed audible conversations taking place about personal care, such as one person asking to use the toilet and a member of staff discussing this with them across the dining room whilst serving lunch to other people. We heard a member of staff tell one individual who had requested to use the toilet, "You know that we don't do that during lunch…I'm sure that you went before hand. You need to wait." Another member of staff subsequently took the individual to the toilet. People's particular likes and dislikes were recorded in their care plans and we saw that as part of their preparation people were asked about their care preferences such as how many pillows they liked, what time they liked to retire and what whether they wanted the lights on or off.

We saw that a number of customer surveys were untaken to ascertain people views. The most recent was a catering survey which asked people for feedback on the meals. Where issues were identified an action plan was developed to address the shortfalls. Resident meetings were held regularly.

Information on advocacy services was displayed in the entrance hall. Advocates are people who are independent of the service and who support people to decide what they want and communicate their wishes

Requires improvement

Is the service responsive?

Our findings

We saw that people's needs had been assessed before they moved into the service. However, the quality of the care plans varied significantly. Some care plans were informative and included details of people's backgrounds and interests but others did not. Other sections of some individual's plans were blank and did not give any guidance to staff.

One individual was on oxygen but the plan was not detailed and the staff member told us one setting but the individual another and it was not clear who was correct. Staff did not always know people's needs, for example we asked a permanent member of staff whether an individual had a catheter in situ but they were unclear and had to go and check. There were systems in place to handover information but we did not see that these communication systems worked effectively. In one individuals records it was recorded that that the catheter bag did not contain urine and that the senior was informed but there was no entry to show that this had been followed up, although there were other entries which may indicate that the individual may have had an infection.

We also observed that at lunchtime two people did not eat the meal provided; staff did not document this nor was this information handed over at the handover meeting to enable the staff coming on shift to monitor and offer additional snacks. One of the individuals was receiving treatment for a urinary tract infection and had a food and fluid chart in place but this was not being regularly completed and some days were blank. Where records had been competed fluid intake was well below recommended levels and we could not see that action had been taken to address this. We spoke with the manager about our concerns and it was agreed that they would immediately review this individual's care.

People did not always receive care and support when they needed it. We found that people did not always receive support to access regular baths and showers, One person told us that they had not had a bath for four weeks. A visitor told us that their relative, "Does not get a bath every week. If [my relative] asks they say, 'We will see if we can fit you in.' They won't though, three to four weeks is not unusual." We looked at some of the individual records to check whether this was a recording issue and saw very little was recorded about bathing. One individual's records that we looked at said that they liked frequent showers but we could not see that this was being provided. We saw that in the previous month they had been supported with one bath. We observed one person walking along the corridor without any socks and shoes and noted that their feet were not cared for and their nails were very long.

This is a breach of Regulation 9 the Health and Social Care Act 2008 (regulated activities) regulations 2014

Activities were provided but they did not meet the needs of all the people in the service. There were regular structured activities and on the day of the visit bingo took place in the morning and there was a carol service in the afternoon. Both sessions were well attended and people smiled and sang along to the carols. The bingo session however was not well suited to people living with dementia as it was fast paced with the numbers changing every 20 seconds which meant that some people could not keep up. We did not see that any activities were provided to those individuals who were either confined to bed or those who chose to remain in their rooms. The manager told us that there were activities held five days each week for a total of 25 hours. Given the size of the service and the differing needs of people in the home it was unclear how activity staff would have sufficient time to provide activities and stimulation for all.

Consideration had been given to best practice for people living with dementia and there were a number of areas of interest around the home which people could touch and look at. For example, a small room decorated as a café, an area that looked like a bar and an old fashioned sweet shop that contained jars of sweets for people in the home. There were also piles of jewellery, hats and handbags that could be used to aid reminiscence.

The complaints procedure was on display in the entrance hall of the home. People told us they knew how to make a complaint if they needed to. One relative told us that they had raised a complaint and said, "When we did that it got sorted." Records showed that all formal complaints had been appropriately logged, investigated and responded to in line with the provider's policy.

Requires improvement

Is the service well-led?

Our findings

People and relatives we spoke with were positive about the new manager and told us that they were approachable. One person said, "We know the new manager and she's easy to talk to." Another person said, "I'm happy with this home and (the manager) knows it because she has asked me what I think and I have told her." However people also expressed concerns about the quality of care and leadership at the service. One person said, "The weekends are a time when the place drifts-no one seems to be in charge." Another person said, "The staff need to be more aware of the needs of residents who need more care than others."

The manager acknowledged that there had been challenges at the service but said that they had a plan to address the concerns which included the appointment of new staff and the building of a new team. They told us that a number of new staff appointments had been made and that a new deputy manager had had commenced employment. In the interim they were using agency staff who were known to the people in the service. Regular meetings had been set up with key staff such as head of departments to drive improvement and there were plans to develop staff skills by giving them leads in clinical areas.

The manager told us that they had recently become involved in the Prosper scheme, this is a scheme organised by the local authority and partner agencies and looks to support care services to improve safety and reduce hospital admissions. The manager had started to collect and analyse the data on falls and pressure ulcers. They told us that they were planning to look at infections as the programme developed.

Observations of how the registered manager interacted with staff were positive; the manager was visible and accessible to staff encouraging staff to report issues and create an open culture. Staff said that they felt well supported by the senior team. One member of staff told us, "The new manager seems to address issues you raise with them. It's a friendly home. Morale was low at the time of the change of manager but it's now moving forward." Staff also described the new manager as "approachable" and "supportive."

The manager told us the area manager visited the service on a regular basis and provided support when required. They were aware of the requirements to make notification to the Care Quality Commission, (CQC) and we saw evidence that they had appropriately raised matters of concern to the local authority safeguarding team.

We asked the manager how they and the provider assessed the quality and safety of the service. The manager told us that they were visible around the service and that they undertook a series of audits which included a weekly floor audit where areas were examined in detail. Records showed that the manager and area manager carried out a range of audits and where shortfalls were identified an action plan was developed. The audits included medication and care planning. However we were concerned that the audits did not always identify issues and address the shortfalls efficiently, for example the audits had not picked up the shortfalls in staffing and how this impacted on people using the service. The infection control audit had not picked up that they had a low number of some moving and handling slings which did not allow for regular washing.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were not sufficient staff to consistently meet the needs of the people living in the service

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Medication practice did not safeguard people and ensure that they received their medication as prescribed

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Care did not consistently meet people's needs and preferences