Astoria Healthcare Limited

Vicarage Farm Nursing Home

Inspection report

139 Vicarage Farm Road
Hounslow
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Date of inspection visit: 27 and 28 July 2015
Date of publication: 26/08/2015

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

The inspection took place on 27 and 28 July 2015 and was unannounced. The last inspection of the service was on 23 September 2014 where no breaches of Regulation were identified.

Vicarage Farm Nursing Home is a residential and nursing home registered for up to 59 older people. Some of the people are living with the experience of dementia and some people have health needs which require nursing care. At the time of our inspection 58 people were living at the home. The home is managed and run by Astoria Healthcare Limited, a private organisation. The organisation does not have any other services.

There was a registered manager in post. 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 and associated Regulations about how the service is run.

There was a malodour throughout the environment and cleaning had not eliminated this or the risks of spread of infections

Summary of findings

The staff had not received training in some areas and some staff did not understand the training they had undertaken.

Some staff did not treat people with dignity and respect. However, other staff did treat people in a positive way.

Although there were some organised activities, people living at the home were not engaged in stimulating activities which reflected their individual needs and preferences.

There were appropriate procedures for safeguarding vulnerable people.

The risks to people had been assessed.

There were enough staff to keep people safe and meet their needs.

People living at the home and their relatives had positive relationships with staff and thought they were kind and caring. Their privacy was respected

People's needs were assessed and care had been planned to meet these needs.

There was a complaints procedure and people knew how to make a complaint. They felt confident these would be acted upon.

The provider had systems for monitoring the quality of the service and these were detailed and responsive. However, we identified areas for improvement which the provider's systems had not identified or acted upon.

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 always safe.

There was a malodour throughout the environment and cleaning had not eliminated this or the risks of spread of infections.

There were appropriate procedures for safeguarding vulnerable people.

The risks to people had been assessed.

There were enough staff to keep people safe and meet their needs.

Is the service effective?

Requires improvement

The service was not always effective.

The staff had not received training in some areas and some staff did not understand the training they had undertaken.

The environment had not been modified to support orientation or help positive stimulation for people who had dementia.

People's capacity to consent had been assessed and the provider had acted in accordance with the legal responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People's health care and nutritional needs had been assessed and were met.

Is the service caring?

Requires improvement

The service was not always caring.

Some staff did not treat people with dignity and respect. However, other staff did treat people in a positive way.

People living at the home and their relatives had positive relationships with staff and thought they were kind and caring. Their privacy was respected.

Is the service responsive?

Requires improvement

The service was not always responsive.

Although there were some organised activities, people living at the home were not engaged in stimulating activities which reflected their individual needs and preferences.

People's needs were assessed and care had been planned to meet these needs.

There was an appropriate complaints procedure and people knew how to make a complaint. They felt confident these would be acted upon.

Summary of findings

Is the service well-led?

The service was not always well-led.

The provider had systems for monitoring the quality of the service and these were detailed and responsive. However, we identified areas for improvement which the provider's systems had not identified and acted upon.

Requires improvement

Vicarage Farm Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on 27 and 28 July 2015 and was unannounced.

The inspection team on 27 July 2015 consisted of two inspectors, a specialist advisor and an expert by experience. The specialist advisor on this inspection was a senior lecturer in clinical human factors focussing on patient safety and quality improvement, leadership, mental health and non-medical prescribing. He also had a background working with people who had dementia and mental health needs. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience on this inspection had personal experience of caring for someone who had dementia. The inspection team on 28 July 2015 consisted of a pharmacy inspector who looked at the way in which medicines were being managed at the home.

Before the inspection visit we looked at all the information we held on the provider including notifications of significant events and safeguarding alerts. During the inspection visit we spoke with eight people who used the service, ten visitors, the registered manager, the provider and staff on duty including three nurses, eight health care assistants, the activity coordinator, domestic staff and the chef.

As some people were not able to contribute their views to this inspection, we carried out a Short Observational Framework Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We looked at the environment, observed how people were being cared for and looked at records, including the care records for nine people, staff recruitment records for four members of staff, staffing training and supervision records, records of accidents and other records used by the provider for monitoring the quality of the service. We looked at medicines storage, medicines records, and the medicines care plans for people who were being administered insulin, warfarin, and sedating medicines. We also looked at the records for people were being administered their medicines covertly (without their knowledge).

Requires improvement

Is the service safe?

Our findings

People who were able to tell us about their experiences told us they felt safe at the home. Their relatives and visitors also told us they felt the home was safe. They told us they trusted the staff. People told us that call bells were answered promptly and that the staff were available whenever they needed them.

The environment had a malodour throughout on both days of our inspection. The ground floor lounge, some ground floor corridors and the first floor lounges, corridors and some bedrooms strongly smelt of urine throughout the morning and afternoon on both days of the visit. The manager and provider told us they had noted malodour on the first floor and had plans to replace some chairs, carpets and flooring on this floor. They told us that carpet cleaning took place regularly but this had been ineffective at removing the smell. We saw evidence that orders for new furniture and carpets had been made. The carpets on the first floor were due to be replaced during August 2015. Although cleaning was taking place, this was not sufficient to eliminate risks and decontaminate the environment and therefore people were at risk of the spread of infection.

This was a breach of Regulation 15(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people had been prescribed medicines which had a sedating effect. They had been prescribed these by a local mental health team and the use of these medicines was reviewed on a regular basis. People's care plans about the use of sedative medicines were not detailed enough and did not always take into account the risk of falls or other risks associated with the use of this type of medicine.

The staff had not recorded individual protocols for when they should administer as required (PRN) medicines. They did not always record why these medicines had been administered. We saw evidence that, in general, they were following recognised good practice guidelines for the administration of these medicines. However, people could be at risk of receiving inappropriate or wrongly administered medicines because individual care plans were not in place. Since the inspection visit the manager has confirmed they had updated medicines care plans to include this information.

The staff used a pill crushing devise to crush tablets where this was required. However, they used the same piece of equipment for different people. This could result in cross contamination. The provider agreed to purchase additional pill crushers and change the practice immediately following our inspection. The manager confirmed this had been purchased shortly after the inspection visit.

We noted that two people were being administered medicines in a way which differed from recognised practice. For example, one person was being administered insulin before they went to bed each night instead of before their evening meal. The pharmacy direction for another person's medicine was to crush their tablets; however the staff told us these dissolved in water. The staff agreed to contact the GP and pharmacy to discuss these people and make sure their medicines were being administered appropriately. The manager confirmed that this had happened shortly after the inspection visit and that information had been updated. The manager told us that the GP and pharmacist were satisfied with the way in which these medicines were being administered.

Medicines were stored securely and appropriately, with the exception of medicated food supplements which were stored in communal lounges. We alerted the staff to this and they were removed and stored securely by the end of the inspection visit. There were enough of each person's prescribed medicines to meet their needs for the month. Controlled drugs were stored appropriately and the staff maintained a controlled drugs register. Medicine administration records were completed accurately with the exception of the record to show that prescribed topical creams had been administered. We discussed this with the manager who agreed to remind staff of the importance to record the administration of all medicines.

There was a supply of non-prescribed pain killers at the home. There were accurate records to show how many of these had been used and who they had been administered to. The GP had authorised the use of these for certain people and this was recorded.

The Clinical Commissioning Group (CCG) pharmacist had carried out an audit of medicines management at the home on 19 June 2015. They had made some recommendations for the provider and these had been actioned. The staff carried out their own audits of medicines each month.

Requires improvement

Is the service safe?

We observed the staff administering medicines and saw that they did this appropriately, following the medicines procedures. The staff explained what they were doing and offered people the opportunity to refuse medicines. They provided drinks and made sure the person had taken their medicines before they left them.

The provider had procedures for safeguarding people. These included reference to the local authority safeguarding procedures. The staff had received training in this area. However, some of the staff we spoke with did not demonstrate a good understanding of what constituted abuse or what they would do if they suspected someone was at risk of or being abused. Other staff were able to tell us what they would do. Since the last inspection the provider had worked with the local authority safeguarding team to investigate allegations of abuse and to make sure people were protected. The manager contacted us following the inspection visit to tell us that they had planned more training for staff about abuse and had also discussed this with all staff.

We observed that some of the wheelchairs people were using were not equipped with footplates when the staff started to support people to move. The staff rectified this and found footplates which they then attached to the wheelchairs. However, the practice of moving people without ensuring wheelchairs are equipped with footplates puts people at risk of injury. We spoke with the provider about this. They told us there were enough footplates for each wheelchair and did not know why this had happened. They agreed to speak with staff about this and put in place measures to ensure staff always checked that footplates were in place before they started to support people to move. The contacted us following the inspection to confirm they had discussed this with all of the staff.

The provider had carried out risk assessments on the environment, including a fire risk assessment. They had taken action to reduce risks in the environment, by following guidance and recommendations from external organisations who serviced equipment and checked the environment. There was evidence that checks on electrical, water and gas safety had taken place regularly. Equipment, including hoists and lifts had been serviced. The manager told us that they had used edible and non-poisonous plants in the garden so people were not at risk from these. The majority of cleaning products and other hazardous materials were stored securely. However, we found a bottle containing ant killer in the garden. The manager immediately removed this and stored this in a secure place.

The staff assessed the risks to people's safety and well-being. Risk assessments were completed within 24 hours of someone moving to the home. They included risks of falling, risks associated with their physical and mental health and nutritional risks. Records of these were clear and included strategies for reducing risk and helping to keep people safe. They were reviewed and updated monthly.

The provider had appropriate procedures for recruiting staff who were suitable. These included a formal interview, checks on criminal records and references from previous employers. We looked at the recruitment files for four members of staff. There was evidence that appropriate checks had been carried out. The provider employed enough staff to keep people safe and to meet their needs. We saw that both nursing staff and healthcare assistants were employed throughout the day and night. Where people's assessed needs indicated they required additional support and observation, this had been incorporated into the staffing levels at the home.

We recommend the provider follows appropriate guidance to make sure all persons employed have a good understanding of what constitutes abuse and how they should respond if they suspect someone is being abused or at risk of abuse.

Requires improvement

Is the service effective?

Our findings

Not all the staff had received training about the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. The majority of staff we spoke with were not able to tell us about this legislation or their responsibilities. The staff told us the majority of their training had been provided by watching DVDs and some staff were not able to tell us about the training they had received or how this enabled them to safely carry out their responsibilities. For example, how to safeguard vulnerable people from abuse. Some of the staff were unable to tell us about the content of any of their training and did not demonstrate a good understanding of the areas which records showed they had been trained in. This may have been because English was not their first language and they had not fully understood the content of their training. The manager told us that DVD training was only used to refresh staff knowledge after face to face training. There was no assessment or test of learning following some of the staff training, therefore the registered persons could not judge whether staff had understood all the training they had undertaken. This meant that people could be at risk from receiving inappropriate care and treatment.

This is a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The environment was not designed to support or orientate people who were living with the experience of dementia. There were no signs or pictures to help people find their way to their bedrooms, bathrooms and other communal areas. All the corridors on the first floor looked similar and it may have been difficult for people to orientate themselves. There was nothing to help stimulate people's senses. There was some equipment, such as games and toys, but these were not readily accessible to people, for example the games were stored in a closed cabinet behind a footstall and chairs. They were also located solely in the lounges rather than in different parts of the environment. The National Institute of Care Excellence (NICE) guidance about environments for people with dementia states, '' Good practice regarding the design of environments for people with dementia includes incorporating features that support special orientation and minimise confusion, frustration and anxiety.'' The guidance also refers to the use of ''tactile way finding cues.'' The government guidance on creating ''Dementia friendly health and social care environments'' recommends providers ''enhance positive stimulation to enable people living with dementia to see, touch, hear and smell things (such as sensory and tactile surfaces and walls, attractive artwork, soothing music, and planting) that give them cues about where they are and what they can do.''

The staff said that they felt supported and had opportunities to meet with their manager individually and as a team. There were records of staff meetings, supervisions and appraisals. The staff told us they were able to discuss their work and any questions they had. One of the nurses had undertaken external training in dementia care and had provided additional training and support for the other staff to help them understand this better. The nurses told us they had the support they needed to maintain their professional qualifications and undertake additional training where needed.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLs). DoLS provides a process to make sure that providers only deprive people of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them. The manager demonstrated a good understanding of their responsibilities in respect of this. There was evidence that where people were unable to consent to certain decisions this had been assessed. Where people's liberty was being restricted the provider had applied to the local authority for this restriction to be authorised. For example some internal doors were secured with keypads to prevent people opening them and some people's beds were equipped with bedrails to prevent them falling out. The provider had made an application under DoLS where people were unable to consent to the use of these.

Some people were administered medicines covertly (without their knowledge). This was because they refused to take their medicines. We saw evidence that a multidisciplinary team including the doctor, person's next of kin and pharmacist had met to discuss what was in the person's best interest. The provider had carried out an assessment of the person's capacity to see if they were able make this decision and this had been recorded. The provider had also applied to the local authority for authorisation for this practice.

Requires improvement

Is the service effective?

People's capacity to consent had been assessed and this was recorded. We saw the staff offered people choices about their care and treatment where this was possible. For example, when one person wanted to change their outfit and when people wanted to move to a different room.

People told us they had the support they needed to stay healthy. Visitors said that people's health was monitored. They told us they were immediately informed about any changes in people's health. People's healthcare needs had been assessed and care plans were in place for individual healthcare needs. Nursing staff were employed at the service to meet people's nursing needs. There was evidence they saw a range of other professionals as needed and consultations with professionals were recorded. The GP visited the home weekly and there were records of clear communication between the staff and GP. We saw evidence of other healthcare professional involvement, such as dietitians and speech and language therapists. Care plans gave clear information about how the staff could meet people's individual needs. These were reviewed and updated monthly. We saw people's changes in need had been recorded.

People told us they liked the food and they felt there was enough variety and choice.

People's nutritional needs had been assessed and the staff had created care plans where there was an identified risk or need. Individual food preferences and dietary needs were recorded. The staff kept up to date records where people needed their food and fluid intake monitored. We saw they had responded appropriately when people's weight changed and if their food and fluid intake changed.

The catering staff had clear information about individual dietary needs and preferences. They met with people when they moved to the home to discuss their needs. They provided three different meal choices for all main meals, including an Asian and a vegetarian meal. They made appropriate checks on the kitchen and the food served, including temperature of the food. All meals were freshly prepared.

People were served food which looked and smelt appetising. The staff made sure everyone had enough to eat at meal times. Hot and cold drinks were offered throughout the day. The provider told us fruit and snacks were available during the day but we did not see people being offered these and these were not located in an obvious place for people to help themselves.

Menus were on display on the ground floor but these were not always visible and accessible for people who lived there and there were no menus displayed for people living on the first floor. The manager told us that people on the first floor were usually offered a choice at the point of service because they did not find written menus helpful.

We Recommend the provider consult recognised good practice guidance for improving the environment to help orientate and support people living with the experience of dementia.

Requires improvement

Is the service caring?

Our findings

People told us they had good relationships with the staff. Visitors said the staff were kind and caring. One visitor said, 'They are marvellous.'' People told us there was a positive atmosphere and we observed the home was calm. In general people were supported in an unhurried and gentle way. Some of the things visitors told us were, ''The staff are brilliant'', ''I would recommend this home to anyone'' and ''we are welcome with open arms.''

However, some of the support people received did not respect their privacy and dignity. For example, a person spilled a drink on their lap. Whilst the staff attended to this and took the person to another room to change their clothes, the person waited over ten minutes for the staff to get the equipment they needed to move the person. During this time the staff did not reassure the person and spoke to each other rather than the person. When the person was taken to the bathroom they were heard shouting and calling out. The staff member supporting them responded by telling them to be quiet. In another incident a person told the staff they wished to use the bathroom, they were made to wait whilst the staff member was looking for their colleague and bring the person's wheelchair. During this time they did not reassure the person or make it clear what was happening.

One staff member was supporting a person to eat their lunch. The person had their eyes closed and at times appeared to fall asleep. The staff member did not tell them when to expect food and at times woke them by putting a spoon to the person's mouth. The person woke with visible surprise on a number of occasions during the meal. The staff member also left them to attend to other people and returned to continue supporting them without explaining what they were doing. They did not tell the person when the meal was complete or when they moved on to serving dessert.

During lunch time a staff member assisted two people who did not require support. In both cases the staff member did not ask the people if they wanted support or tell them what they were about to do. Both people were eating their meal unsupported with no apparent problem. The staff member who had finished supporting others sat next to them, took cutlery out of their hands and proceeded to give them the rest of their food. On several occasions food fell on the person's protective tabard, the staff member picked this up and gave it to the person to eat. We looked at the care plan for one of these people and it stated, ''allow to eat independently and provide gentle encouragement.'' The other person attempted to continue to hold their own fork. The staff member held their hand to prevent them from doing this.

We heard some of the staff calling people names which they considered terms of endearment but which others may have found offensive. For example the staff called people, ''granddad'' and ''good boy.'' We heard one member of staff calling a person ''darling'', the person challenged this but the staff continued to use this term.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager contacted us following our inspection visit to tell us that training and meetings to support staff to have a better understanding about privacy and dignity had taken place and that the staff had been reminded to address people by their preferred names.

We witnessed other examples where people were being treated respectfully. The staff made eye contact with people and allowed them time to make choices. In some cases the staff explained what they were doing, and listened to the person's views and opinions.

People were well presented, clean, in clean clothes and with clean hair and nails. There were records to show people had received regular baths or showers. The staff attended to people's personal care needs in private and behind closed doors. Where people had expressed a preference for same gender carers this was recorded and their wishes were acted upon.

People's religious and cultural needs were respected. Care plans included details of this. Religious leaders and volunteers visited the home to help people pray and celebrate their religion. Different cultural diets were catered for.

Requires improvement

Is the service responsive?

Our findings

The home employed an activities coordinator to organise and facilitate activities. They had a programme of planned activities. However, outside of these organised group activities there was limited stimulation or entertainment for people. For example, on the first floor the majority of people were seated in two lounges from 10am until 2.30pm without anything to do, with the exception of lunch time. We observed that from 10am until 12pm and again from 1.40pm until 2.30pm the majority of people were either asleep or had their eyes closed. Some people had no interactions with anyone else. During the morning the TV was on and we noted that two people were watching this. However, a large information message about updating the channels dominated the screen making it difficult to view. None of the staff noticed this or acted upon it until the clinical lead entered the room and removed the message. Although there were games, soft toys and books available, people were not supported to access these or offered them with the exception of one person who was holding a soft toy. In the ground floor lounge we observed people were also seated without any activity or entertainment apart from the television. There were staff present in these rooms but they only spoke with people for brief interactions and these were mostly to do with a task, for example giving someone a cup of tea or removing a drink from a sleeping person's hand.

Some people were unable to get out of bed due to their health conditions, and others preferred to spend time in their rooms or in bed. Throughout the day the staff did not spend much time with these people and, although their health and personal care needs were met, they were at risk of social isolation.

The National Institute of Care Excellence (NICE) guidelines on Mental wellbeing of older people in care homes states that ''it is important that older people in care homes have the opportunity to participate in activities which promote their mental health and wellbeing.'' The guidance defines meaningful activities as including physical, social and leisure activities that are tailored to the person's needs and preferences.

During our inspection the majority of people did not receive support to take part in meaningful activities. Their interactions with staff were mostly functional and related to a task the staff were performing. For example, supporting them to eat or to move around. The staff did not ask people about their enjoyment or feelings around these tasks, for example whether they enjoyed their meal or if they felt comfortable or needed anything. Although some people lacked the ability to express their needs verbally and therefore verbal communication was largely one way, the staff did not use positive touch, objects of reference or other methods of communication.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection visit the manager contacted us to tell us that all staff had received training about ''responding to people's needs'' to help them better understand how to deliver person centred care.

People's needs had been assessed and the staff had created detailed care plans. These were regularly updated and included information on people's preferences, likes and dislikes. Care plans covered social, emotional, health and personal care needs. The staff recorded daily logs to show how people had been cared for and how they had met their needs. Changes in people's needs were recorded. Some of the staff had worked at the home for a few years and they told us they knew people's likes and preferences well. Relatives told us they had been consulted about care plans and had agreed to these. They told us they were well informed by the staff about the care their relative received.

There was an appropriate complaints procedure and people knew how to make a complaint. There was evidence that complaints had been investigated and acted upon. The provider responded to people's feedback and people felt able to raise concerns or comment about the service.

Some of the things people told us were, "I can raise any issues with anyone here and they always respond straight away. The manager is always available when I need to talk to her", "They're very efficient here – if there's ever any problems they're in touch immediately – they're always 'on it'' and "Information flows very well here – if there's ever a change to what (my relative) needs or what she wants it always seems to happen quickly and effectively."

Requires improvement

Is the service well-led?

Our findings

People told us the manager was open, approachable and available. They also told us the provider was available at the service. People felt their concerns were acted upon and responded to quickly. They felt there was a positive and inclusive atmosphere at the home. The staff confirmed this, telling us they were well supported and the manager was always ''visible''.

The manager was an experienced nurse who had worked in other nursing homes. She had worked at the service for three years. She had a good knowledge of the service, each person's needs and the areas of improvement needed. The home is run by a small private organisation. The nominated individual (provider) made regular visits to the service and worked closely with the manager.

We found areas requiring improvement at this inspection. We discussed these with the manager and provider. In some cases they put things right during our inspection visit. They had identified some areas requiring improvement, for example the need to replace malodourous carpets.

However, systems did not always identify, monitor or improve the quality of the service to ensure that the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were being met. For example, the staff did not always have the skills and knowledge to meet people's needs, in particular their social and emotional needs.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider and manager had a range of methods for monitoring the quality of the service. These included checks on record keeping, health and safety and the care people received. They audited all accidents and incidents and planned ways to reduce these. The provider had also asked people who lived at the home, their relatives and staff to complete satisfaction surveys. They had analysed the responses to these. The majority of respondents were happy with most aspects of the service. Where people had expressed a concern the provider had responded to this, by talking with the person and putting in place action plans.

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 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **The premises were not always clean.** **Regulation 15(1)(a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered person had not ensured that staff received appropriate training to enable them to carry out the duties they were employed to perform.** **Regulation 18(2)(a)**

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 (RA) Regulations 2014 Dignity and respect **Service users were not always treated with dignity and respect.**

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 (RA) Regulations 2014 Person-centred care **The care of service users did not always meet their needs and reflect their preferences.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

Treatment of disease, disorder or injury	The registered person's systems and processes did not always assess, monitor and mitigate the risks relating to health, safety and welfare of service users. Regulation 17(2)(b)