The Sisters Hospitallers Of The Sacred Heart Of Jesus

St Augustine's Care Home

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

St Augustine's Care Home provides residential care for up to 52 elderly people, some of whom have care needs associated with dementia. The home is divided into four units. Units A, B, C and D.

The inspection took place on 18 June 2015 and was unannounced.

The home had 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 2008 and associated Regulations about how the service is run.

Staff did not understand their responsibilities in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). People could not be confident that decisions made on their behalf fully respected their legal rights.

Summary of findings

There were not always enough staff deployed in the home to meet the needs of the people who were living with dementia. This was particularly noticeable in Unit B in which eight of the ten residents were living with dementia.

People were not always protected from the potential risk of harm because steps to mitigate identifiable risks had not been taken.

There were limited activities available in the home for people living with dementia. The home had good signposting throughout, however for people living with dementia there were no sensory items which may keep people engaged.

People reported staff were kind and caring however we found this was not always the case for those living with dementia.

Care plans were not person centred which meant people may not always receive responsive care. Care plans did not always contain sufficient information about the person as an individual to help staff get to know people.

People received adequate food and drinks and were involved in making decisions about the food they ate.

People received their medicines in a safe way. Care was provided to people by staff who were trained and received regular supervision. Staff understood their responsibilities in relation to safeguarding. Appropriate checks were carried out in the recruitment of new staff to help ensure only suitable staff worked in the home.

Staff supported people to access health care professionals, such as doctors, dietician, district nurse and optician.

People were encouraged to voice their opinions as there was a complaints policy available. Residents meetings took place as well as satisfaction surveys to ensure everyone was involved in the running of the home. Relatives were made to feel welcome.

Staff carried out regular audits to check the quality of the service they were providing. However, the registered manager had not effectively monitored and acted on feedback from relatives, or lack of staff in Unit B.

During the inspection we found some 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?

Requires improvement

The service was not always safe.

There was an insufficient number of staff to care for people living with dementia.

Risks to people were not always assessed.

Staff were trained in safeguarding adults and knew how to appropriately report concerns.

Staff managed people's medicines safely.

The provider undertook appropriate checks when new staff were employed.

Is the service effective?

Requires improvement

The service was not effective.

Staff did not have a good understanding of the Deprivation of Liberty Safeguards and the Mental Capacity Act. People's movements were being restricted without the proper assessment and consent.

Staff had access to training as well as supervision and appraisal.

People were provided with food and drink which supported them to maintain a healthy diet.

Staff ensured people had access to external health care professionals.

Is the service caring?

Requires improvement

The service was not consistently caring.

People did not always have choice and control over their daily routines.

Care did not always promote people's privacy or treat them as individuals.

People felt that staff treated them with kindness and respect.

Relatives were made to feel welcome in the home.

Is the service responsive?

Requires improvement

The service was not responsive.

People who were living with dementia did not have sufficient opportunities to take part in activities that meant something to them.

Care plans did not provide sufficient information to help staff get to know people or to provide responsive care.

People were given information about how to make a complaint.

Summary of findings

Is the service well-led?

The service was not always well-led.

Quality assurance audits were carried out to check the quality and safe running of the home. However, the quality of care was not effectively monitored by the registered manager.

The home had a positive ethos where people were encouraged to express their ideas and thoughts.

The registered manager was aware of their responsibilities in relation to their registration with CQC.

Requires improvement

St Augustine's Care 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 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 18 June 2015 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of service. Our expert by experience had personal experience of care homes that supported people living with dementia.

As part of our inspection we spoke with 13 people, seven staff, eight relatives, the registered manager and two healthcare professionals. We observed staff carrying out their duties, such as assisting people to move around the home and helping people with food and drink. We also observed the staff administer lunchtime medicines.

We reviewed a variety of documents which included four people's care plans, four staff files, and records, policies and procedures in relation to the running of the home.

In addition, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the registered person is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

On this occasion we had not asked the provider to complete 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. This was because we were responding to some concerns we had received.

The home was last inspected in October 2013 when we had no concerns.

Requires improvement

Is the service safe?

Our findings

There was not always a sufficient number staff on duty to meet everyone's needs. The registered manager explained care staff were employed to work in the home and they were supported by Catholic Sisters who were trained volunteers. We observed on the ground floor of the home there were plenty of staff and Sisters available to support people in a timely, unhurried and individualised way. However, in Unit B, where people living with dementia resided, we observed a lack of staff. The staff on duty were rushed and carrying out the care in a very task orientated way. We observed nine people being attended to by two members of staff for a period of two hours, however later in the day this reduced to one member of staff. In a care plan one person required one to one, however we did not always see staff provide this on the day. At lunch time two care staff were supporting people to eat, but were repeatedly distracted to support the person who required one to one support. People were becoming distressed and agitated because staff were unable to give them sufficient time or attention. Staff told us people needed one to one support in the garden and it was therefore not possible to take people out whenever they wanted to go.

The registered manager told us staffing levels were flexible according to the needs of the people and they used a dependency tool to calculate the number of staff required. She told us there would be 11 staff on duty throughout the morning and eight or nine in the afternoon. At night, this reduced to four care staff. We looked at some previous rotas and saw that staffing levels were mostly as described. However staff were not deployed around the home appropriately to ensure everyone received unhurried, individualised care in a timely manner.

Staff told us they felt pressurised. One member of staff said, "Sometimes there is not enough staff." Another said, "It's difficult here on my own. I have to wait until 4 pm until someone comes to help me. The (registered) manager must know – she does. She tells us to get someone from downstairs, but they're busy." And a further member of staff said there had been some, "Near misses with people becoming aggressive due to a lack of staff."

People did not always feel there was enough staff. One person told us, "Sometimes there is a shortage of staff." Another said, "On occasions there have been shortages, when people are sick. At night they are a bit thin on the ground." However other people (who were not in Unit B) said they felt there was ample staff. One person told us, "When I ring my bell, mostly they come within five minutes," and, "When I use my call bell at night, they do usually respond quickly."

The lack of appropriately deployed staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe. They said, "Yes, I definitely have felt safe here. It's lovely here," "I'm looked after very well, very safely" and, "There are definitely no harmful things happening here." A relative said they felt confident their mother was safe and had never had cause to doubt their safety in the home at all.

Despite these comments, people were not always protected from risks. We noted the lock to one sluice room was broken which meant the room was accessible to all. A bottle of cleaning detergent was stored in an unlocked cupboard in this room. Following our intervention, staff made this area safe during the inspection and the registered manager had the lock repaired following our inspection. We read in one person's care plan following their deterioration, 'mobility deteriorated and needs two carers to mobilise'. However we saw three occasions when this person was assisted by only one member of staff. On another occasion, they moved independently because they told the staff member to go away. We read in people's care plans risk assessments had been carried out in relation to people's mobility and nutrition, for example. We saw people were encouraged to be independent but within a supportive environment. For example, everyone was encouraged to walk as much as possible, but staff were not always at hand to ensure people were safe. Staff provided this support in a sensitive manner. One person told us, "I need help to move about, the staff are good at that."

The lack of safe treatment for people was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were trained in safeguarding adults and demonstrated a good understanding of their responsibilities in relation to this and how to appropriately report concerns. There were clear policies and procedures on how to safeguard people and these were displayed in staff rooms on each floor. There was also safeguarding

Requires improvement

Is the service safe?

information available for people in the lobby area of the home. However, we reported to the registered manager that not all staff were not aware that the local authority was the lead agency for safeguarding.

People's care and support would not be interrupted or compromised in the event of an emergency. Guidelines were in place for staff in the event of an unforeseen emergency and there was a contingency plan in place in the event the home had to close for a period of time.

Medicines were handled safely and securely and people received their medicines on time. We observed one of the staff administer lunchtime medicines to one person. We saw this was undertaken in a person-centred way, with the person being asked if they were ready for their medicines and talking to them about the medicines. The person was given a drink to assist the swallowing of their tablets and we saw the member of staff took time with this person to ensure they were not hurried. We saw the member of staff wore a 'do not disturb' tabard, which allowed them to complete the medicines round without being interrupted to ensure people got their medicines when they required them. One person told us, "I always get my medication on time."

Medicines records were completed appropriately. Each record contained a photograph of the person it related to, to ensure the medicine was given to the right person. There was a list of specimen staff signatures so it was possible to track who had administered which medicine. People who had 'as required' (PRN) medicines had an explanation of when they may require this included in their MAR. The member of staff explained how they would complete the MAR if someone refused their medicines to ensure it was clearly recorded. One person told us, "I can have a pain killer when I need it." Medicines were audited and accounted for regularly which helped to ensure that any discrepancies were identified and rectified quickly.

The provider carried out appropriate checks to help ensure they employed suitable people to work at the home. Staff files included the required information, such as a recent photograph, written references and a disclosure and barring system (DBS) check. DBS checks identify if prospective staff had a criminal record or were barred from working with people who use care and support services.

Requires improvement

Is the service effective?

Our findings

Staff did not have a good understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff were unable to describe to us when they would need to submit an application. The DoLS protect the rights of people who lack capacity. This is done by ensuring that any restrictions to people's freedom and liberty have been authorised by the local authority as being required in their best interests to protect them from harm. Mental capacity assessments had not been carried out for people and best interest meetings had not been held when decisions had been made on behalf of people. For example, in the case of people who had bed rails. We read two DoLS application which had been submitted and saw these included generic statements about people's capacity, rather than the reason the registered manager felt a person's liberty was being restricted.

People were not always provided with care in the least restrictive way. For example, those living in Unit B had a locked door into the Unit. One person was unable to access the garden unaccompanied (an activity they liked doing) because of the locked door.

People's valid consent not always being sought was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had a programme of training for staff which covered a range of essential courses. Staff told us there was good access to training and we saw a training course was held on the day of the inspection. We observed staff exercised best practice, such as moving and handling people safely. Staff were competent in their role and carried out their tasks in a professional and efficient manner. People told us, "The Sisters and seniors are well trained. The experienced carers supervise the new one's."

With some people with more specialist needs however, staff were not always clear about how to support people effectively. For example, one person presented with complex emotional needs and it was evident that staff lacked the skill or confidence to meet these individual needs.

We recommend the provider finds out more about training for staff based on current best practice, in relation to the specialist needs of people living with dementia.

Staff told us they had supervision, which meant management checked training was being put into practice. We heard both group and one to one supervisions took place. Staff received annual appraisals which gave them an opportunity to meet their line manager on a one to one basis to discuss progress in their role, any training requirements or to discuss any concerns they may have.

People were provided with food and drink which supported them to maintain a healthy diet. People were complimentary about the food and made comments such as, "The meals are varied and are very nice," "We choose our meals beforehand," "The meals are superb" and, "When I don't fancy the menu I ask for an omelette." Relatives reiterated this. One told us, "She (family member) thinks the food is excellent."

People could choose where to eat their meals. We saw people eating in the dining room, the lounge or their rooms. One person was not a good eater and staff had found by sitting them in a more private area they enjoyed their meals more. There was a choice of two main courses. Squash was served with the meal and tea/coffee afterwards. The food was observed to be appetising and served hot. In addition to the main meal, refreshments were served to people in the morning and afternoon. Water and juice was available in the lounge and bedrooms during the day. We saw people were able to help themselves to drinks whenever they wanted them.

People who required support were assisted to eat their meals in an unhurried way. Staff spoke with people throughout and encouraged and prompted them to eat.

People were involved in decisions about what they ate. Meal choices were offered on the day from a rotating menu based on the likes, dislikes and feedback of people who lived in the home. The menu was displayed in the lobby area of the home as well as on tables in the dining room. One person said, "There is a choice of food." We heard another comment when they finished their meal, "Lovely, beautiful pudding."

Staff ensured the chef was aware of people's dietary requirements. The chef had a list which was updated each day from staff of those who required a pureed or soft diet or had any other dietary requirements, such as diabetes.

People received effective care by staff who knew them. People told us, "Staff always acknowledge you" and, "The staff do talk to me about my care, but I usually look after

Requires improvement

Is the service effective?

myself." We were told one person would not eat, but staff had encouraged them to eat and slowly they were getting better and putting on weight. A relative said, "They (staff) are good at interacting and know all their names." Another told us, "They are lovely with both mum and dad. They talk to him (dad) about football."

Staff ensured people had access to external healthcare professionals including the doctor, dentist, optician and dietician. We were told by health care professionals that staff made referrals in a timely manner and referrals were appropriate. One health care professional told us staff sat in on assessments which helped them understand the diagnosis and treatment required, this enabled them to follow any guidance for continuing the care in a competent manner. People told us, "We can see the doctor if you need to" and, "They organise transport to the hospital and someone always goes with you."

A relative told us, "They call health care professionals when needed and for the occasional hospital check-ups staff will take my wife."

Requires improvement

Is the service caring?

Our findings

People told us the quality of care delivered was good. They said, “I like it here. Staff look after me,” “Their (staff) heart is in the right place,” “The Sisters are lovely” and, “The staff are marvellous, they have a sense of humour.” A healthcare professional told us if they had to move into a home, they’d like to be at St Augustine’s. Relatives said, “I’ve never regretted moving my wife in. I am extremely pleased with the place and couldn’t ask for anything better” and, “The carers are lovely.”

Despite these comments however, we did not find all staff always demonstrated good care. We found people living on the ground floor of the home had a very different experience to those living in Unit B. Staff on the ground floor were attentive and reactive to people’s needs. However in Unit B, we found staff unable to manage the needs of people. Staff were short when they spoke with people and did not know how to handle some situations, for example when one person displayed behaviour which was disruptive to other people. Most people were asleep from lack of stimulation, or wandering around because staff did not spend time with them.

People’s privacy was not always respected. We found several rooms in Unit B were locked. Staff told us this was because people went into each others rooms and took their belongings. As a consequence should people require privacy, they were unable to return to their rooms without asking a member of staff to unlock the door. We read in one person’s care plan this person was, ‘not capable of holding their room key’ however we had seen them move around the unit throughout the inspection with their handbag with them at all times.

People in Unit B were not always provided with the dignity or attention they should expect. We heard one person ask a member of staff to take them to the toilet. We heard the member of staff tell a Sister, “I’m going to leave her as I’ve just taken her.” We observed a Sister sit beside someone for at least 20 minutes but they did not speak to them once during this time.

The lack of respecting people was a lack of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People in other areas of the home were provided with privacy and dignity. One person told us, “The staff respect me and give me privacy when I’m in my room.” Another said, “Most of the time they make sure I’m private. They knock before coming in.” Relatives told us they believed staff provided their family member with dignity.

People on the ground floor had choice and control as to where they spent their time throughout the day. We saw many people moving freely around the home. One person told us, “You have the freedom to go around. You can be upstairs or downstairs in here (the lounge).”

Staff were empathetic with people. We saw one person become upset and heard and saw a member of staff comfort them in a compassionate way. One person told us, “The care staff are very kind. They’ve got compassion here.”

We saw some good examples of care from staff. We heard one member of staff speak kindly and in a caring manner to people throughout the day. Another member of staff checked the temperature of a cup of tea before assisting someone to drink it. A member of staff was seen to adjust someone’s scarf as they sat down and touch and comfort people as they spoke with them. We saw a member of staff hold one person’s hand as they supported the person to eat. One person told us, “The staff are all lovely, they are kind to all of us.”

People were involved in the running of the home and had their views were sought. We read people were consulted with how the home could be improved through residents meetings. We read various topics were discussed such as the food, cleanliness or standard of care. There was a suggestion box available for people to post their feedback or comments and a ‘life good tree’ with stick-it notes available for people to write comments, their thoughts, suggestions and prayers. These were stuck to the branches of the tree for all to read.

Visitors were made to feel welcome and could visit at any time. One person told us, “I have visitors, they have permission to come at any time.” And a relative said, “We can visit at any reasonable time.”

Requires improvement

Is the service responsive?

Our findings

Care plans contained sufficient information for staff to know what care was needed for a person, however we found they contained general statements which may not always have meant they were as individualised or person-centred as they could be. For example, one person suffered with depression and guidance to staff read, 'if (the person) showed signs of deteriorating staff should report to the manager'. There was no guidance to staff on ways in which they could support this person. We read care plans contained information around people's risk of falls, nutritional needs and manual handling requirements. However, we noted people's life histories had not been completed which meant staff did not know information which could be used to personalise people's support. For example, one care plan read, 'retired' as the person's occupation and another person was recorded as being, 'difficult due their emotional needs associated with dementia'.

Staff did not always provide responsive care. For example one person experienced a lot of leg pain. Although this person was on medication for the pain, there was no written guidance or pain care plan to steer staff on a consistent approach how this should be managed. This person got disorientated and distressed, but again there was no further guidance other than, 'one to one support in a calm and patient manner'. We heard this person call out repeatedly throughout the day. Staff told us, "They're like this every day." It was evident staff had stopped responding to their distress because they did not know what to do. This same person required prompting to eat and drink, however we did not see staff provide this during the lunch time and as a consequence they ate very little.

The lack of person-centred care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us they liked to go out in the garden and tried to join in the activities whenever they could. Another said people mixed well with each other. A further commented, "There are many things to do in here. There are a lot of activities." Relatives said they felt there was a good programme of activities and there was plenty to entertain their family member.

However, we found people were not always provided with individualised activities that mattered to them. Although people said they were encouraged to be independent and could attend Mass or Holy Communion, one person told us they liked embroidery but we saw no evidence that staff had given them the opportunity to do this.

Whilst there were activities for people to get involved in, we found these mainly occurred on the ground floor. We did not see any activities for people living in Unit B. We saw one person sit in the same chair for four hours. They had a visit from relatives in the morning, but received no activity or interaction from staff for the rest of the time. This had been highlighted in the last feedback survey, with comments such as, "More stimulation, not enough activities," "More music and activities, especially on Unit B" and, "Residents from section B need to be more involved with others."

We saw bedrooms had been personalised and people had brought their personal furnishings to make their rooms their own. Signage around the home was appropriate for those people living with dementia in order to orientate them. We saw all communal areas and people's room were easily identifiable and one person living in Unit B clearly knew how to locate the bathrooms, toilets and their room aided by the pictures and photos. However, we did not find any sensory items which would be suitable or appropriate for people living with dementia.

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

People were enabled by staff to be involved in and maintain good links with the community. Each month there was an open invitation to neighbours to join people and staff for refreshments. The registered manager told us this had been extremely successful and as many as 20 people regularly attended. We saw students from a local college arrive during our inspection to provide a musical session for people. This took place each week. The corridors on the ground floor were filled with pictures of people enjoying various activities organised by staff.

People were enabled to make complaints should they need to. We saw a copy of the complaints procedure was available for people in the main lobby of the home. Relatives told us, "We've never complained but we feel we would if necessary" and, "There's no reason to complain. I'm not intimidated, I would say something."

Requires improvement

Is the service responsive?

People were aware of their care plans and involved in developing their package of care. One person told us, “They drew up my care plan with me and my daughter.” A relative told us they were involved in their family member’s care. They said staff involved them in the reviews of the care plan. Other relatives told us they were party to the care plan and were given a copy.

Requires improvement

Is the service well-led?

Our findings

People were positive about the leadership and the atmosphere of the home. One person told us, "It is extremely well run." Another said, "The (registered) manager is very nice." A further person added, "This is my home. It's like my home." Relatives told us, "The (registered) manager is extraordinarily good. There is nothing she can't do," "Sister has an open-door policy. We think she makes sure everything is done. The home is run very well" and, "I don't have any problem with the (registered) manager. She keeps standards high. She is good at her job and she is caring."

However, despite these comments, the registered manager had not effectively monitored the care being provided to ensure it was of a good quality. For example, feedback from relatives regarding activities and changes they'd like to see for people living in Unit B had not been picked up. In addition, although the registered manager told us they were aware staffing levels in Unit B were not ideal, they had failed to act on this.

The management team carried out a number of checks and audits, which quality assured areas such as fire, housekeeping, equipment and medicines. Actions were set on areas that required improvements and there was evidence to show actions had been completed. For example, ensuring MAR records were up to date and completed appropriately.

Staff felt supported. One member of staff told us, "I feel supported by the registered manager. She is always around." They said they felt the registered manager knew people as she, "Talks to them and has tea with them." Another said, "We need team work which we have."

There was a good ethos within the home. Throughout the inspection there was a calm atmosphere. One relative told us, "Since mum's been here, I have come to love the home. The ethos is wonderful." Another said, "I am extremely pleased with the place. The place is very welcoming."

Resources and support were available to drive improvement. The registered manager told us of building work which was to commence shortly which meant everyone moving to new premises within the grounds. This would allow both people and Sisters to live together in purpose built units with en-suites and balconies and a communal patio area.

Staff were involved in the running of the home. We read regular meetings were held and different topics were discussed such as the values and ethos, policies, medicines and safeguarding. Some meetings included a short training session.

The registered manager had a good understanding of their legal responsibilities as a registered person, for example sending in notifications to the CQC when certain accidents or incidents took place and making safeguarding referrals. The registered manager accepted they had to focus more on the care provided to people living in Unit B and assured us they would make it their priority.

Policies and procedures were in place to support staff. The registered manager held a file which contained policies useful for staff. For example, this included the provider's whistleblowing policy, safeguarding information, the fire procedure, infection control and health and safety.

People, relatives and staff were encouraged to give feedback about their experiences. The results of the most recent satisfaction survey's were provided to us. We read people were happy with the staff, the care they provided and the food. Staff were encouraged to complete surveys and we read positive feedback. Relative's told us, "A friend came to the summer fair and has decided to find a place for their relative here," "I would recommend this place to anybody" and, "I would recommend this home to someone else. They do listen when you say things."

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 was not a sufficient number of staff deployed around the home**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **There was a lack of proper or safe treatment provided to people.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The registered person had not obtained people's consent to their care.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The provider had not ensured staff always showed people respect.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **There was a lack of person-centred care provided to people.**

This section is primarily information for the provider

Action we have told the provider to take

Staff did not involve people in activities in an individualised appropriate way.