Banstead, Carshalton And District Housing Society

Roseland

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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Roselands is a residential care home providing personal care for up to 39 older people some of whom were living with dementia. The home is a large purpose-built care home run by Banstead, Carshalton and District Housing Society which is a Not for Profit Charitable Society. At the time of the inspection there were 20 people living at the service.

People's experience of using this service and what we found

The leadership at the service was not robust and there was a lack of auditing to review the quality of care which impacted the care people received. There had been continuous breaches of regulations since 2019. Where shortfalls in care had been identified with staff around the recording on medicine records this had not been addressed. Staff did not always feel supported or valued. Risks associated with people's care was not always being managed in a safe way. Incidents and accidents were not always followed up on to avoid the risk of reoccurrence.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests.

People and relatives fed back there were enough staff at the service and we observed this during the inspection. Staff ensured that health care professionals were contacted when people became unwell. People received their medicines when they needed. Staff told us they felt the training they received had improved.

Rating at last inspection
The last rating for this service was Requires Improvement (published 17 August 2021) and there were three breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found there were some improvements however the provider remained in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We carried out an unannounced comprehensive inspection of this service on 8 July 2021. Breaches of legal requirements were found for safe care and treatment, need for consent and governance. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe, Effective and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified continued breaches in relation to safe care and treatment, consent and governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Roseland

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Our inspection was completed by three inspectors.

Service and service type
Roseland is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. This means the Provider is legally responsible for how the service is run and for the quality and safety of the care provided. The day to day management of the service was undertaken by an interim consultant manager and an external consultant.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to

send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection-
We spoke with four people who used the service about their experience of the care provided and two relatives. We also spoke with two visiting health care professionals. We also observed care and interaction between people and staff. We spoke with 13 members of staff including the interim consultant manager, the provider's consultant, care staff, the chef and housekeeping staff.

We reviewed a range of records including six care plans, multiple medication records, safeguarding records and incident and accidents. We reviewed a variety of records relating to the management of the service including staff recruitment files and training and supervision records.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection of the service, we found the provider had not ensured that people were protected from the risk of unsafe management of medicines. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that whilst there had been some improvements there were still concerns around the oversight of the management of medicines, the analysis of accidents and incidents and the management of risks associated with people's care. The provider remains in breach of regulation 12.

● Since the previous inspection steps had been taken by the provider to improve the management of medicines. There was closer monitoring of stocks to ensure people received their medicines where needed and people fed back they received their medicines. However, although monthly medicine audits were taking place this was not always used to make improvements. We noted from the June, July and August 2021 audits there were multiple gaps identified by the auditor on the medicine administration records (MAR). Although the manager told us retrospective checks were made by staff at the end of the shift (when the gaps were picked up) to ensure the medicine was given or refused by people there was no formal recording of this, or actions taken to prevent further occurrences of gaps on the MAR.
● Risks associated with people's care were not always managed in a safe way. The manager told us there were people at risk of dehydration who were placed on charts to monitor their fluid intake. The fluid charts did not always have targets and there was no evidence, where the person had not had sufficient fluids, this was being monitored with actions taken. Staff told us one person had frequent urine infections due to not having sufficient fluids. We also confirmed this from the medicine records.
● For example, on one occasion daily notes stated the person had, 'drank well', when we reviewed their fluid chart for that day, they had only had 310 millilitres of fluid. A member of staff told us, "The ones (people) that don't drink need more one to one. You need to keep encouraging." Another told us, "You don't know what happens here sometimes with the fluid charts." There were also no risk assessments in the person's care plan around the risk of dehydration.
● Another person had issues with their mobility and had weekly visits from a physiotherapist to assist them with this. However, there were missed opportunities for the person to have additional physiotherapy support funded by the person as the provider had not organised transport for them to attend a specialist centre. The person told us going to the centre meant a lot to them, "It's the only thing that is keeping me going." This had been identified at the previous inspection, yet the provider had still not taken sufficient action.

● A visiting health care professional told us, "I don't understand why this doesn't happen. I would strongly suggest (person) does go as they would benefit so much. They do exercises there; I really want to push for that to happen." They did feedback however that guidance they left for staff around supporting the person with exercised was followed. One member of staff told us the person used to be supported to attend the sessions and said, "(Person) used to go and come back really quite happy because he had been out and seen other people." They told us the person had been feeling low recently and said this could be attributed to not being able to go out to the centre.
● During the inspection a person fed back to us about an anxiety they had. We spoke to the manager about this who told us this anxiety was as a result of their mental health condition. They told us they had sought advice from a health care professional and detailed to us what actions staff needed to take to reassure the person. However, there was no risk assessment in the person's care plan or guidance for staff to what they needed to. This was a particular risk as there were frequent agency staff at the service who may not know the person or their needs.
● Accidents and incidents were not or analysed for trends and themes to reduce further occurrence. For example, we reviewed the accident folder for falls since the last inspection in July 2021. We identified there had been five falls recorded with five people between 30 July and 31 August 2021. However, the managers falls tracker only had three of these falls recorded. There was no information on the falls tracker relating to any investigation into this. The manager told us when asked if they do any analysis, "No I haven't, it's something I am working on."
● Where an incident had occurred people's risk assessments had not always been reviewed. According to an accident report on 21 September 2021 one person was found to have large bruises on their legs. There was no information on the incident form to show that an investigation had taken place. The managers 'skin integrity tracker' stated the person was known to bruise easily however there was no evidence that an investigation had taken place to determine the possible reasons for the recent bruising and their skin integrity risk assessment had not been updated to reflect this. This may have included more guidance on how they person needed to be supported with the hoist to avoid further bruising.

The failure to not always manage risks associated with people's care in a safe way was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● There were aspects to the risks around care that were managed appropriately. We also saw other risk assessments that related to moving and handling. From observations we saw staff hoisted people adhering to the guidance provided in their risk assessments. We noted where people were at risk of choking appropriate plans were in place to manage this.
● Environmental risk assessments for people were undertaken. This included risks associated with people using electrical items in the kitchen and that the building was safe for people. The service had spacious corridors which allowed people with walking aids to access areas independently and safely.
● There were Personal Emergency Evacuation Plans (PEEPS) in place for people with details around how they needed to be supported in the event of an emergency. There was a 'Business continuity plan' that detailed what staff needed to do in the event of an emergency such as a flood or a fire.

Using medicines safely
● At the last inspection we found occasions where people's medicines had run of out stock. There had been improvements around this. Most of the medicines were ordered in a four-weekly cycle. They were ordered at least two weeks in advance and they were delivered in enough time before the start of the cycle to be checked by the senior on shift. This ensured that all medicines were available to the people and any discrepancy dealt with.

● People's prescription information was recorded in all the MAR with a dated picture of the person and details of allergies, and other appropriate information for example if the person had swallowing difficulties.
● There were medicines prescribed on 'as required' (PRN) basis and these had protocols for their use. Where people were on time critical medicine, we saw this was given at the right time each day.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe with staff. One person said, "I am not worried about that at all. They (staff) are wonderful with people." A relative told us, "Mum is definitely safe here. I feel really reassured in terms of safety. She's very well looked after."
● Staff understood what they needed to do if they suspected abuse. One member of staff said, "It can even include bruising. I'd report to (manager) and to safeguarding."
● Staff received safeguarding training and there was a whistleblowing policy that staff could access. Staff told us that they would not hesitate to raise concerns. One told us, "I have not seen any concern. I would report it straight away. I would intervene if I thought it was bad. I would whistle-blow, it's about resident safety and you can't ignore that."
● We saw that where there were any concerns raised the manager would refer this to the Local Authority and undertake an investigation.

Preventing and controlling infections
● We were not fully assured that the provider was preventing visitors from catching and spreading infections. We found the sluice room at the service had been left unlocked and a bowl of urine had been left on top of the waste bin. The sluice machine was in use however we noted the sink was dry which meant staff were not washing their hands before they left the sluice.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using Personal Protective Equipment effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Staffing and recruitment
● People and relatives fed back that there were sufficient staff on duty. One relative told us, "There seems to be enough staff now. It's growing."
● There were sufficient staff to ensure that people's needs were being met. During the inspection we noted where people required a one to one from staff this was provided. Staff responded in a timely way to people when they needed them.
● The manager told us they frequently used agency staff and they tried to use the same staff to provide consistency for people. They also told us they were actively recruiting for permanent members of staff.
● Staff told us they felt there were sufficient staff at the service. One told us, "They're trying to get more staff. We have a lot of regular agency and they know the routine.
● Appropriate checks were made for all recently recruited staff included requesting and receiving references and checks with the disclosure and barring service (DBS). DBS checks are carried out to confirm whether prospective new staff had a criminal record or were barred from working with people.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question remains Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance

At our last inspection of the service, we found the provider had not met the requirement of the Mental Capacity Act (MCA) and consent to care and treatment was not followed. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that this had not improved and the provider remained in breach of regulation 11.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

● We observed people being asked for consent, and this being respected by staff, during the inspection. However, where decisions were being made for people there was no evidence that their capacity had been assessed. For example, one person, who was living with advanced dementia, was under constant supervision with a member of staff and had a sensor mat. The manager and consultant told us the person was a high risk of falls and but that the person had no recognition of this. There was no assessment of the person's capacity to agree to either of these restrictions to determine this was in the person's best interest or whether less restrictive measures had been considered. It was probable, given the advanced dementia of some people that lived at the service, they lacked capacity there was no formal assessment of this.
●. There was a lack of understanding from the manager and staff around the principles of MCA and we noted that staff had not received any training. One member of staff told us, "It's about being able to give them the quality of care and support for their mental health needs and making sure paperwork is up to date for those with mental health problems." The manager and visiting consultant told us they had a lack of understanding of MCA and had tried to get support from the local authority. There was conflicting feedback from the

manager, the consultant and staff around who they believed lacked capacity to make decisions.
● Where DoLS applications had been submitted to the local authority, a decision specific capacity assessment had not taken place. For example, in relation to the locked front door and people that had bed rails fitted. Although DoLS applications had been submitted for all these people there was no evidence of any capacity assessments specific to this.

As the requirement of MCA and consent to care and treatment was not followed this is a continued breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff support: induction, training, skills and experience
● Staff had not all received training in relation to their role which meant there was a risk that they may not be able to provide the most appropriate care when required. The provider gave us a list of staff and the training they had received. Out of 47 staff 12 had not received health and safety training and 14 had not received basic life support training.
● However, there was other training provided to all staff including moving and handling, safeguarding and infection control. Staff fed back the training they received was helpful to carry out their role. One told us, "We had an interesting person-centred care session by (external consultant) a couple of weeks ago." They told us it helped them to learn how to engage with people and reminded them that this is, "People's home which staff work in" and we saw this in practice on the day of the inspection. One relative told us, "I feel the training for staff has got better last few months."
● Agency staff received an induction when they worked at the service that included a tour of the building, a summary of people's needs and reminded how to use the equipment at the service including hoists. An agency staff member told us, "I like to work here, they are a nice team."
● Staff received one to one supervision with their line manager to assess their performance and to provide support. One member of staff told us, "It's a chance to ask for training and your opinions if you're fed up."

Adapting service, design, decoration to meet people's needs
● There were no sensory items or areas of interest for people living with dementia, particularly for those that walked with purpose. However, the consultant told us this was being considered as part of their improvement plans.
● Other areas of the service were suitable for the needs of people. There were various lounge areas for people to sit and enjoy more quiet areas if this was their preference. We observed one person sit in a separate lounge as they preferred to sit on their own.
● The garden was well maintained and had a ramp for wheelchair users. A relative fed back to us, "It's great for mum to use the gardens."
● There were signs on communal doors including the bathroom and toilets to help orientate people.

Supporting people to eat and drink enough to maintain a balanced diet
● People told us they liked the food at the service. One person said, "The food is alright, depends what you like. They ask you what you like." Another told us, "The kitchen are very obliging."
● Throughout the day people were offered snacks and drinks. During lunch the tables were well presented, and people were asked what drinks they wanted. There were choices of meals and if a person did not like what was on the menu an alternative was offered. Where people required support to eat their meal this was given.
● Staff were aware of people that were nutritionally at risk and took steps to address this. For example, higher calorie snacks were provided for people who had a food chart, and guidance was sought from health care professionals where needed. The chef told us people's dietary requirements were assessed at the very

earliest opportunity. This initial assessment was passed to the chef telling them about people's needs including whether they were diabetic, vegan, have any allergies or require their foods needed to be softened.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care; Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People fed back they had access to health care when needed. One told us, "If anything is wrong, they will look after you."

● There was a handover at the end of each shift where staff shared information to ensure changes in needs were highlighted, or to confirm care had been given as required. One member of staff told us, "At one point we were not getting information but now we have lunch handovers. Makes life a lot easier." Another told us, "The teamwork is better now."

● There had been no admissions to the service since our last inspection. We found where there had been a change in people's needs the care plans were reviewed and updated. For example, one person developed difficulties with swallowing. Staff had consulted the speech and language therapist and updated guidance had been included in their care plan.

● Information recorded in care plans showed staff contacted healthcare professionals if a person became unwell. This included the GP, dentist, opticians and hospital appointments. One member of staff told us, "If I see someone struggling [to swallow food or drink], I would report to the senior. I'm confident they would call the Doctor." A health care professional told us, "They know the residents very well and they're all lovely. They're very good here."

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection of the service, we found the provider had not ensured there was ongoing and robust management oversight to ensure changes and standards were maintained. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There had not been sufficient improvements around this, and the provider remained in breach of regulation 17.

● At this inspection there were continued breaches related to consent to care and governance, these have been in breach since November 2019. Since November 2020 there has also been a continued breach of regulation relating to safe care and treatment. The previous concerns and new areas of poor practice had not been proactively identified through the operation of a robust and continuous quality monitoring system. The provider has continuously failed to establish and operate effective systems and processes to assess, monitor and improve the quality and safety of the services

● There remained a lack of robust management oversight at the service which was impacting on the delivery of safe care. Although some audits were taking place, there was not sufficient action taken to make improvements. For example, where audits of medicines found shortfalls, sufficient action was not being taken to make the required improvements. The service medicine policy stated, "Auditing of all medication documentation, including MAR sheets, is performed each calendar month and corrections implemented with immediate effect where any shortfalls are identified." However, this was not always the case.

● There was a lack of effective oversight with the monitoring of people's fluid intake where people were at risk of dehydration and urine infections.

● Other audits including health and safety, care plan audits and infection control audits were not consistently taking place. For example, infection control audits had not taken place since our last inspection in July 2021. The manager told us of care plan audits, "(External consultant) has been dealing with that. I would have to ask her. We are just beginning to see the light at the end of the tunnel." To date no additional audits have been provided to us. It was evident that routine audits to assess, evaluate and improve care of people in a systematic way was not taking place.

● The records relating to people's care were not always up to date or accurate. For example, according to their MAR, one person had been prescribed antibiotics by the GP. However, there was no record of when the GP was contacted about this or the reasons why they had been prescribed. The manager told us visits from any health care professional needed to be recorded on forms in people's care plans however this was not always being done. We found there were no MAR for peoples prescribed topical creams. Although we found

no evidence creams were not being applied the lack of recording meant there was a risk people's creams may be missed.
● Systems for identifying, capturing and managing organisational risks and issues were ineffective. For example, the manager told us gaps in the MAR were mainly down to staff that no longer worked at the service. However, we noted from the September 2021 MAR that gaps were still being identified by the manager including on the day of the inspection. The service policy stated that where, "There is an error or omission in the recording" an investigation needed to take place and, "Depending on the investigation, the member of staff may require further training, shadowing, or competency assessments." We found this was not happening. The manager was unable to describe the process to take when a gap was found on the MAR.
● The manager told us that in June 2021 they had identified historic concerns around the recruitment of staff. The manager told us that staff that had worked at the service for a number of years had not all had the appropriate recruitment checks including missing employment histories and references. The manager told us all of the recruitment files for staff that had been there for a number of years was currently being reviewed by their HR department. There was no information on these staff files around what risk mitigation they have taken around this.
● Some people and relatives felt there had been improvements with the management of the service. One relative said, "The change in leadership has been for the better. Staff have uniforms now and there is a customer care approach."
● Despite this there was a mixed response from staff about the leadership. One member of staff told us, "It's much better organised, there is better equipment. The management has improved leaps and bounds." Another member of staff told us, "Managers can be rude to staff, makes me feel about that big and in front of other people. Some days I really don't want to come to come in." A third told us, "There have been lots of changes, the house has been improved. Things are getting better." They said however, "The manager can be abrupt and rude." Staff told us that although the atmosphere at the service was better there were still improvements that could be made around the culture.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● There was an inconsistent approach to gathering feedback from people and their families to improve the quality of care. People and relatives told us they were not formerly asked for feedback about care and we noted that residents and relatives' meetings had not taken place since the last inspection. One person told us, "I have only been invited to one." However, relatives told us they felt communicated with and one told us, "Any changes with mum and they ring me and inform me. The communication is great with any issues."
● Staff did not always feel involved or valued in their role. There were mixed views from staff about whether they felt supported at the service. One member of staff told us, "(Manager) doesn't explain herself. You don't get an answer and feel disregarded." Another told us, "(Managers) very unapproachable." However, another member of staff told us, "I feel I have more of a voice now. My ideas are taken on board, I feel more valued." Another said, "I do feel supported. I think they value what we do."

Systems or processes were not established and operated effectively to ensure compliance with the requirements. This is a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Working in partnership with others
● Other health care professionals were complimentary about the joint working they undertook with the service. A health care professional told us, "Action is taken where needed. They also let me know when there are any problems."

● We saw from the records that relatives had been contacted where there had been an incident with their family member.
● Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The provider had informed the CQC of significant events including incidents and safeguarding concerns.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure the requirement of MCA and consent to care and treatment was being followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that safe care and treatment was provided to people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure there was robust oversight of the service to ensure quality of care.