Premier Nursing Homes Limited

Sycamore Hall

Inspection report

Kearsley Road
Ripon
North Yorkshire
HG4 2SG

Tel: 01765606025
Website: www.newcenturycare.co.uk

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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**

Summary of findings

Overall summary

This was an unannounced inspection which took place on the 18 August 2016. The service was last inspected in December 2013 and was meeting the regulations in force at that time.

Sycamore Hall is a care home providing nursing and personal care for up to 62 people who are living with dementia. Sycamore Hall has a ground and first floor, with the first floor providing support for people who require nursing care. There were 56 people living there at time of inspection.

The service did not have a registered manager in post; the service had a registered manager who was no longer working at the service. A new manager had recently started working at the service and intended to register. 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. The service also had a home manager who had day to day responsibility for running the service and staff supervision.

Staff had not identified and reported possible safeguarding alerts to the local authority and to us. We write to the provider to remind them of the need to notify us promptly of these events.

We found there were a number of potential hazards around the service which had not been identified or acted upon by staff. For example doors to chemical storage areas were unlocked and potential hazards had not been identified by staff and action taken to remove these.

Staff told us that at times they had little time to spend with people and were observed to be task focused. People were not always observed consistently throughout the service and staff seemed rushed at times.

Staff were recruited correctly and had been subject to checks before starting work with vulnerable people. People's medicines were managed well by the service and we saw that staff had been trained and supported to maintain competency.

Staff had not consistently received supervision over the previous year due to changes in management. Staff told us they could not always access the training needed to meet their developmental needs and the requirements of people using the service. For example staff felt their understanding of the needs of people with a dementia related condition was limited. Some people's needs for behaviour support were not responded to effectively by the service, staff told us they had limited training on supporting dementia related conditions. We saw the provider had drafted a proposal for the development of staff training and more personalised care for people using the service. Peoples care records were not always kept securely.

The service was not adhering to the principles of the Mental Capacity Act; records and assessments of capacity could not always evidence best practice in supporting people who lacked capacity. Consent was

not always clearly gained from the person, or their representative, before care or treatment commenced.

The service had been recently re-decorated but it was not always suitable for the needs of people who had a dementia related condition and had made parts of the service stark and lacking in stimulation for people.

Staff did not always have sufficient time to interact with people except when receiving care. Some staff were task focused at times rather than focused on the person they were supporting. We observed some positive and negative interactions between people and staff. Staff told us they did not always get the support they needed to meet people's needs. They told us the team felt stretched at times to meet people's complex needs and they struggled to attend essential training.

Relatives and external professionals told us they found the staff to be caring towards people and told us the home was good at communicating with them as people's needs changed.

Care plans were task focused and lacked personalised details about how best to support people as individuals. There was not always evidence of effective review and improvement to care plans. Some personalised details gained over time were not incorporated into people's care plans.

We saw that activities for people were limited and care staff did not always feel able to support meaningful activity in the service. Activities for people on a one to one basis were limited by staff availability and resources in the service.

The service had not always had consistent management support, as well as support from the provider. Some regular checks and audits were not completed or actions not always followed through. The newly appointed manager had already taken steps to improve the service. The most recent audit of the service by the provider had been more comprehensive and identified areas for improvement. Staff we met were open and transparent with us about issues and showed commitment to improving the service.

We found breaches of regulation relating to person centred care, dignity and respect, seeking consent, safe care and treatment, governance of the service and staffing. You can see what action we told the provider to take at the back of the full version of the report.

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 were a number of potential hazards around the service which had not been identified or acted upon.

Staff told us and were observed to be task focused. Supervision of people was not effective in all areas of the service at all times.

Staff were recruited correctly and people's medicines were managed well by the service.

Is the service effective?

Requires Improvement

The service was not always effective at meeting people's needs.

Staff did not consistently receive supervision and training needed to meet their developmental needs and the requirements of people using the service.

The service was not adhering to the principles of the Mental Capacity Act, records could not always evidence best practice in supporting people who lacked capacity.

The service had been recently re-decorated but it was not always suitable for the needs of people using the service and had made parts of the service stark.

Is the service caring?

Requires Improvement

The service was not always caring.

Peoples care records were not always secured when they were not in use.

Staff did not always have sufficient time to interact with people except when receiving care. Some staff were task focused.

Relatives and external professionals told us they found the staff to be caring towards people and we observed positive interactions with some staff.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

Care plans were task focused and lacked personalised details about how best to support people as individuals.

We saw that activities for people were limited and care staff did not always feel able to support meaningful activity in the service.

Some people's needs for behaviour support were not responded to effectively by the service and staff told us they had received limited training on supporting people with dementia related conditions.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service had not always had consistent management support, as well as support from the provider.

Staff told us they did not always get the support they needed to meet people's needs.

The newly appointed manager had already taken steps to improve the service. The most recent audit of the service by the provider had been more comprehensive and identified areas for improvement.

Sycamore Hall

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 August and the 16 September 2016 and day one was unannounced. We visited the service on 18 August and spoke with relatives and professionals via phone on 16 September 2016.

The inspection team was made up of two adult social care inspectors.

Before the inspection we reviewed information we held about the service such as notifications we received from them. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We also contacted commissioners of the service for any feedback.

During the inspection we spoke with 12 staff including the deputy manager, as well as five people who used the service and three relatives. We also spoke with four external professionals who had regular contact with the service.

Six people's care records were reviewed as were the staff training records. Other records reviewed included: policies and procedures and accidents/ incidents. We also reviewed complaints records, four staff recruitment/induction/supervision and training files, and staff meeting minutes. During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

The internal and external communal areas were viewed as were the kitchen, lounges and dining areas, bathrooms and, when invited, some people's bedrooms. We undertook general observations of people and staff interactions in communal areas and during mealtimes.

Requires Improvement

Is the service safe?

Our findings

We looked at records relating to safeguarding alerts that had been raised by the service and saw that actions had been taken by the service in response to these, but record keeping sometimes lacked clear evaluations of the outcome for the person affected. Senior staff from the provider noted they had raised a number of alerts following a recent review visit of the service. They told us these had not been identified at the time as possible alerts by staff, and that they had not been raised as alerts with the local authority or the Care Quality Commission. We have written to the provider to remind them of the requirement to notify us in prompt manner.

This was a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009 (Part 4).

As part of our checks around the service we saw that there were several 'gates' across peoples doorways, these were to stop people accessing other people's rooms uninvited and removing items. Several staff and relatives we spoke with told us this was a reoccurring issue. These gates posed a trip hazard to people, as well a potentially unlawful restriction. We discussed this with the new manager and they advised us they had plans to fit door sensors in order to better manage these issues.

Whilst checking around the service we found that doors to areas that contained risks to people were not secured. For example the doors to the cleaning chemical storage area and utility cupboards were left unlocked. Both doors were marked as requiring to be locked at all times. We brought this to staff attention who took immediate action.

In communal areas we found possible risks to people's safety and wellbeing as cleaning products, perfume and deodorant aerosols had been left where people could access them. We found that two fire extinguishers had been removed from their appropriate place by a person. Staff told us this happened often, but this meant firefighting equipment was not always in place when required.

We checked in bathrooms and toilets, we found that some lacked waste bins, we found areas of damaged woodwork where cleaning would have been impossible. In other areas we found a bin in a kitchenette area covered in old food debris, a microwave being used which was rusty, as well as sealant around worktops engrained with dirt. Window ledges had obvious dust and dead flies. We brought this to the staff's attention and they took immediate action.

We reviewed the services contingency planning and looked at the service 'grab bag' in reception. The services contingency planning lacked clear guidance for staff on what procedure to follow if an emergency, such as a fire, was to occur. The grab bag lacked essential items. Telephone numbers to contact for support such as the local authority, as well as information about peoples care and support needs which may have been needed in an emergency were not in place. We advised the deputy manager to review this urgently and they agreed to do so.

Peoples care needs were assessed for potential risks they may have faced due to their needs or through

receipt of care, such as moving and handling. Some had been completed and were subject to regular review, others lacked details or evidence that reviews were effective. For example one person was to be weighed weekly, but records showed they were still being weighed monthly.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with staff and relatives about the services staffing numbers and how well the staff were able to respond to people's needs. Staff and relatives told us that sometimes staff were task focussed and did not have much time to interact with people except when providing care. All the relatives we spoke with told us that staff were caring and we observed numerous positive interactions, however we also observed some staff avoiding interacting with a person with challenging behaviours and we had to ask staff to support another person after they failed to respond. We observed a marked difference between the two floors of the service, with staff downstairs responding more quickly to peoples request for support, but that on both floors interaction was minimal.

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

Staff we spoke with and records we reviewed showed that new staff attended safeguarding training as part of their induction and as part of refresher training for all staff. Staff we spoke with told us they would raise a safeguarding alert if they had concerns, and felt the new manager would act on their concerns. They were able to tell us the vulnerabilities the people they supported may have due to the nature of their disability or dementia related condition. One staff member told us "I have done my safeguarding training; I know what to do and would report to the person in charge."

We spoke with members of staff and looked at four personnel files to make sure staff had been appropriately recruited. We saw relevant references and a result from the Disclosure and Barring Service (DBS) which checks if staff have any criminal convictions, had been obtained before applicants were offered their job. Records of checks with the Nursing and Midwifery Council to check nurses' registration status were also available and up to date. Application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people.

Medicines were given as prescribed. We observed a medicines round. We saw staff who were responsible for administering medicines checked people's medicines on the medicine administration records (MAR) and medicine labels to ensure people were receiving the correct medicine. Staff who administered the medicines explained to people what medicine they were taking and why. People were offered a drink to take with their medicines and the staff remained with the person to ensure they had swallowed their medicines. Medicines records were accurate and supported the safe administration of medicines. There were no gaps in signatures and all medicines were signed for after administration.

Staff were trained in handling medicines and a process was in place to make sure each worker's competency was assessed. Staff told us they were provided with the necessary training and felt they were sufficiently skilled to help people safely with their medicines.

Audit systems were in place to ensure that all medicines had been ordered and administered safely. Medicines were stored securely within the medicines trollies and treatment room. Medicines which required cool storage were kept in a fridge within the locked treatment room. Records showed current temperatures

relating to refrigeration were recorded daily and were within the required range for the storage of refrigerated medicines. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines which may be at risk of misuse.

Requires Improvement

Is the service effective?

Our findings

We observed staff throughout the inspection as well as speaking with them and relatives about how well they thought the service was staffed. We saw the provider had a tool to assess staffing numbers based on numbers of people and levels of dependency. However we noted on numerous occasions, particularly at mealtimes, staff were task focused and did not have much time to interact with people except when carrying out a task. Staff we spoke with also told us that they were busy and did not have time for anything except essential care and nursing activity. We observed that the downstairs mealtime was a more relaxed atmosphere and that people were supported more quickly than upstairs.

Staff we spoke with told us they had attended training as part of induction, or on-going updates. But the majority of staff we spoke with told us they would like to have more training on supporting people with dementia, or related conditions. Staff we spoke with sometimes lacked skills or knowledge on how best to support people with behaviour which was challenging and lacked skills in recording and learning from such incidents. We observed incidents where people were demonstrating verbal behaviour and staff avoided interacting until the person became more agitated. Staff we spoke with told us they did not have a clear care plan in place on how best to support this behaviour.

We looked at supervision and appraisal records for staff. Records could not confirm that supervisions were taking place as regularly as the providers policy stated, or that annual appraisals were taking place. Staff we spoke with told us that due to changes in management that they had not received regular supervision for some time. The new manager was aware that supervision had not taken place and was taking steps to address this.

These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. 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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be the least restrictive possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

In care records we saw that people's capacity to make decisions about their care or treatment was assessed. However some forms lacked details to demonstrate how people's capacity had been assessed, or lacked details to confirm if people had been supported to be involved or encouraged to participate in the assessment process. On some forms we saw that multiple decisions had been assessed at the same time

and then had not been subject to further review. An external professional we spoke with confirmed that staff did not understand the principles of the MCA, and that whilst assessments of capacity were being carried out, these were not in line with best practice. Staff we spoke with had variable knowledge of the MCA.

Records could not always demonstrate that consent had been gained from people, or their representative before care had commenced or at review.

These were breaches of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff records and staff feedback showed that staff underwent a common induction process; this largely consisted of e-learning. Staff described the training they received as "Good", or "Gets the key skills in place". However most of the staff we spoke with told us they had little time to take on any additional training due to work pressures, they told us that making time for refresher training was also hard.

We saw minutes of meetings between staff and the new manager, these had been shared with staff and we could see the new manager had taken steps to ensure that these notes reflected the issues they had raised with staff, as well as what actions they wished staff to take. For example the new manager had identified staff using out of date moving and handling techniques and reminded staff this was not acceptable and that re-training would be provided.

We observed the mid-day meal on both floors of the service. It was noted that the experience was different on both floors, with the upstairs being more rushed, and less personalised. Upstairs there were no picture menus and staff didn't always show people example plates for choice. We observed two staff assisting two people at once to eat, whilst talking to each other across the room. We observed one member of staff engage positively with one person, giving good eye contact and lots of time for the person to eat between spoonful's. They asked the person if they were enjoying it and if they were ready for more. We saw that one person finished their breakfast at 11.50 and then had their lunch at 1pm. People waited for more than thirty minutes to have their dessert. We discussed this with the new manager and staff at feedback and they agreed to take action to improve the consistency between the two floors dining experience.

The service had recently undertaken a re-decoration of communal areas. The décor had been highlighted in surveys of people and relatives. However the decoration had left much of the service quite stark and lacking details or signage to support people with a dementia related condition in their orientation. There was little or no activity or sensory equipment. We saw that people often moved about the service without purpose and staff did not have time to interact with them. Staff and relatives told us that during the refurbishment many seating areas had been moved and would be replaced. When we discussed this with staff they told us they would take steps to improve access to informal activities which had been removed during the refurbishment.

Requires Improvement

Is the service caring?

Our findings

During the inspection we noted that staff did not always keep records relating to people secure. We saw that an office with peoples care records was left unsupervised and with the door unlocked, and that care records were left by staff in communal areas. We brought this to the deputy manager's attention during the inspection who agreed to ensure records were secured.

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

People and relatives we spoke with told us that staff were caring towards people. One relative told us "The staff here keep in touch with me about how [Relative] is. I was worried about moving [Relative] into a home, but so far they have been caring towards us both". Another relative told us they had seen how staff spoke gently with their relative to get them to eat more at mealtimes. They told us "I was getting frustrated at their refusing me; the staff took over and managed to get [Relative] to eat the whole bowl".

However we also observed that staff sometimes did not have time to talk with people unless they were carrying out some task or activity. For example we heard staff say to people "Are you alright" and "How are you" but they didn't stop and engage with people after this. We observed that one person received an abrupt response from one member of staff but a very warm, genuine response from another. Staff told us they did not always have time to talk to people.

Some staff showed genuine warmth towards people and spoke with people at a pace which was comfortable for them. Staff knelt to be at eye level and used touch to reassure. Three staff we spoke with talked fondly about people and were able to talk knowledgably about people's likes and dislikes. One member of staff told us they had not worked in care before but that they "Loved it". They said "I really hope I make a difference to people, it's what I'm here to for and I hope I do."

People's privacy was respected. Staff knocked on people's doors before entering their rooms, including those who had open doors. Most people sat in communal areas but some preferred to stay in their own rooms. Staff treated people with dignity and respect. We observed that when people were moved using a hoist; a blanket was used to maintain their dignity as they were transferred. Staff meeting minutes also showed people's dignity was promoted. Meeting minutes recorded that male and female staff would be available on night duty to respect the wishes of people and their choice of gender of carer to assist with their care and support.

Staff we spoke with had a good knowledge of the people they supported. They were able to give us information about people's needs and preferences which showed they knew people. Staff described how they supported people who did not express their views verbally. They gave examples of asking relatives for information, showing people options to help them make a choice such as showing two items of clothing. This encouraged the person to maintain some involvement and control in their care.

We were told the service used advocates as required and people were supported by Independent Mental Capacity Advocates (IMCA) if they lacked the mental capacity to make decisions with regard to their well-being. Advocates can represent the views of people who are not able to express their wishes. An external professional we spoke with told us that staff could improve their understanding of how best to support people with limited capacity, but that staff were generally caring, but seemed task focused.

Records showed the relevant people were involved in decisions about a person's end of life care choices when they could no longer make the decision themselves. The care plan detailed the "do not attempt resuscitation" (DNAR) order that was in place for the person. This meant up to date healthcare information was available to inform staff of the person's wishes at this important time to ensure their final wishes could be met.

Requires Improvement

Is the service responsive?

Our findings

We looked at the services care records, we saw that these were often task focused and lacked personalised details about how people liked to be supported. Most of the care plans gave minimal information about a person's background, likes and dislikes, focusing mainly on care or nursing tasks that needed to be carried out throughout the day. For example one care plan described what equipment and staffing was required to perform moving and handling during personal care, but told us nothing about how the person preferred this task to be completed. We noted this person could at times be resistive to personal care and that a more detailed plan based on learning from staff may have improved the experience for the person.

Reviews of care were also at times limited in scope. For example one person had periods of distressed behaviour, but no action had been taken to gauge which staff responses had been more effective in managing this behaviour or to draft a specific care plan to support this behaviour. There was information gathered over time in another person's records about their background and important events in this person's life, but this had not been used to develop a more personalised care plan.

The service had activity staff, and offered communal activity during the day. We saw there was a timetable of events, but it was unclear if people understood this. We observed staff supporting people in an activity. The staff member was at times left alone with several people to support and the activity was at times chaotic. Care staff became involved, but were constantly distracted by other people's immediate care needs. Staff we spoke with told us that they would like to have more time to support activities in the home, but had to focus on essential care tasks. Staff told us that one to one activity did sometimes occur, particularly where people were supported in their bedrooms, but this was again limited. During the day we saw people that remained seated in the same place for up to four hours and during this time people were disengaged and either staring into space, asleep or watching the TV screen. The TV was on but silenced with music playing over it.

These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Initial assessments were carried out to identify people's support needs and they included information about their medical conditions and dietary requirements. Care plans were developed from these assessments that outlined how these needs were to be met. Records showed that monthly assessments of peoples' needs took place with evidence of evaluation that reflected any changes that had taken place. These remained task focused and contained little or no personal detail.

The service consulted with external healthcare professionals about any changes in peoples' needs. For example, the behavioural team were asked for advice with regard to people's distressed behaviour as required. External professionals we spoke with told us they had a good relationship with the service. One told us, "They seek out my advice and take ideas on board quickly", another said "I think the staff here are good overall, they follow my guidance and keep on top of things". However we did not always find that professional advice not always incorporated into effective care plans quickly.

The service carried out annual surveys to gauge feedback on possible areas of improvement. The latest survey was underway at time of inspection.

Charts were also completed to record any staff support with a person. For example, when staff turned a person in bed, where it was identified a person was at risk of developing pressure areas, when personal hygiene was attended to and other interventions to ensure peoples' daily routines were met. These records were used to make sure staff had information that was accurate so people could be supported in line with their needs. Care plans alerted support staff when a person may be at risk of developing pressure areas on their body.

We looked at the services complaints records and saw there had been 10 complaints over the previous two years. We saw there was a response to each complaint and that the service had responded appropriately. The deputy manager explained how new people to the service were given information about how to complain, and this was shared with relatives. Relatives we spoke with told us they knew how to raise a complaint, but that at that time none of them wished to raise a complaint.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager who had left their employment. There was a new manager in place who was applying to register with us. The service had experienced three changes in manager in the last two years including gaps where no manager was in place.

We looked at the checks and audits which would be carried out on a regular basis in the service, such as health and safety or record keeping. As we found gaps in audit records and issues about health and safety, infection control and the quality of care plans which had not been identified in earlier checks and audits we found the process had not been robust. This had been due to a lack of leadership in the home and effective oversight by the provider. We saw that issues had been identified at previous checks by the provider, but that these remained incomplete due to the absence of a manager at the time. When we spoke to the new manager about this they told us a recent quality audit had found similar issues to those found at this inspection. The quality auditor from the provider was open about the issues they had found and was working with the new manager to resolve these issues.

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

People and relatives reported to us that their experience was that the home was well led and they knew the staff and deputy manager well. They told us they were aware of changes in management and some relatives told us they had met the new manager and found them approachable. Some relatives told us the ongoing issue of people entering other people's room uninvited remained an issue. One told us they had taken anything of value out of their relative's bedroom room to keep them safe. No one we spoke with told us they had any complaints, and all felt able to raise them if they did occur. External professionals told us they thought the home had been well led, but had noticed some changes when the deputy was managing alone and that staffing was sometimes an issue.

The new manager held daily meetings with the heads of key areas such as care, kitchen, domestic etc. These allowed for improved co-ordination between the teams and sharing of good practice. This ensured they were able to deal with any issues and use all the resources and information in the service to effect change. Staff we spoke with about these new 'flash meetings' told us they felt these were effective and improved their overview of the whole service.

The deputy manager assisted us at inspection and was open and transparent with us about the issues in the home. If we brought anything to their attention they acted quickly and brought us information as requested. When we gave the new manager feedback later after they returned from leave they were able to tell us about progress made and what actions they were taking to improve the service. The new manager was clear in their requirements as a registered person, sending in required notifications and reporting issues to the local authority or commissioners.

The staff told us about the links the home had with the local community. There were links with the local

school and the local churches, as well as encouraging student or work placements in the home.

The deputy manager told us about the staff and residents surveys or questionnaires they carried out. For people these were carried out for each floor to assist staff to respond to the people there. Families and relatives were also surveyed regularly and the most recent survey was in progress.

We saw records of staff meetings where the new manager had highlighted areas of dated practice and that action had been taken to address this. We also saw the provider had plan to improve the quality of staff training and persons centred care for people with a dementia related condition.

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 9 HSCA RA Regulations 2014 Person-centred care The registered person had failed to ensure that they designed care or treatment with a view to achieving service users' preferences and ensuring their needs are met. Regulation 9 (3) b

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 The registered person had not ensured the privacy of service users Regulation 10 (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 11 HSCA RA Regulations 2014 Need for consent The registered person had failed to ensure that care and treatment of service users was only provided with the consent of the relevant person. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had failed to assess the

Treatment of disease, disorder or injury	risks to the health and safety of service users of receiving the care or treatment and done all that is reasonably practicable to mitigate any such risks. Regulation 12 (2) (a) (b)

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 registered person had failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. And to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. Regulation 17 (2) (a) (b)

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 failed to ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed. And that staff receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation (1) (2) (a)