Tradstir Limited

# Partridge House Nursing and Residential Care Home

**Inspection report**

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## Ratings

| Overall rating for this service | Requires Improvement |
|---|---|
| Is the service safe? | Good |
| Is the service effective? | Requires Improvement |
| Is the service caring? | Good |
| Is the service responsive? | Requires Improvement |
| Is the service well-led? | Requires Improvement |

## Overall summary

We inspected Partridge House Nursing and Residential Care Home on 14 November 2014. This was an unannounced inspection.

Partridge House is purpose built, recently taken over and now owned and maintained by Tradstir Limited. The service provides nursing care, across three units, for 38 older people with increasing physical frailty, many living with dementia or other mental health needs.

The registered manager was present throughout the inspection. A registered manager is a person who has

# Summary of findings

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 experiences of people at the home were positive overall. People told us they felt safe living at the home, staff were kind and compassionate and the care they received was good.

We found systems and processes to maintain an effective service required improvement. Individual care plans did not consistently reflect people's capacity to make specific decisions, or record whether such capacity had been appropriately assessed and managed. Capacity issues were recorded in a generic way and there was little evidence of people's consent to care and treatment being obtained. This did not demonstrate a good understanding of capacity and consent issues.

There was little evidence of any social stimulation, across all three units, in the form of any organised activities. During our inspection we observed people sitting in communal areas or in their room, for long periods of time with very little interaction, either with staff or each other.

Care plans were disorganised, cumbersome and poorly maintained, with information often difficult to track and not always current or accurate. There was also little documentary evidence that plans were consistently reviewed and updated to reflect any changes to risk or the care and treatment being provided. These Issues related to capacity, consent, personalised care planning and activities that reflected shortfalls in the auditing systems and overall management of the service.

We found that Partridge House was a safe and secure environment. We observed staff speaking with people in a kind and respectful manner and saw many examples of good natured and professional interaction. Staff were aware of the values of the service and understood the importance of respecting people's privacy and dignity.

Robust recruitment and selection procedures were in place and appropriate checks had been undertaken before staff began work. Medicines were effectively managed and were administered safely to people.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this 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?**

Good

The service was safe.

Staff knew how to recognise and respond to abuse appropriately and had a clear understanding of safeguarding procedures.

People were protected from avoidable risk because effective systems were in place for identifying, managing and monitoring risk.

Medicine was managed and administered safely and people confirmed they received their medicine on time.

People received care in an environment that was clean and tidy and adequately maintained.

**Is the service effective?**

Requires Improvement

The service were not effective.

Individual care plans did not always reflect people's capacity to make specific decisions and there was little documentary evidence that people's consent to their care and treatment had been routinely obtained.

Care plans were inconsistent, cumbersome and poorly maintained, with information often difficult to track and not always current or accurate. A lack of regular auditing and reviewing of plans meant they did not always reflect people's changing needs.

People told us that overall they received effective care and the food was good. They said they had a good choice of quality food. We saw people were provided with appropriate assistance and support and staff understood people's nutritional needs.

**Is the service caring?**

Good

The service was caring.

People spoke very highly of the staff and told us they were happy and satisfied with the care and support they received. This was supported by our observations during the inspection, of staff displaying warmth and sensitivity in their interaction with people.

Staff were kind, caring and compassionate and treated people with dignity and respect.

People said that they had access to their care plans and were supported to make choices. They were often involved in decisions which related to their care and treatment.

# Summary of findings

**Is the service responsive?**

Requires Improvement

The service were not responsive.

There was an almost total lack of social stimulation, across all three units throughout the service, in the form of any organised or personalised activities.

There was very little information recorded in care plans about personal history or details of the individual's interests, likes and dislikes.

There was a complaints procedure in place and people and their relatives felt comfortable raising any concerns or making a complaint. They were also confident their concerns would be listened to and acted upon.

**Is the service well-led?**

Requires Improvement

The service was not well led.

Inconsistent auditing processes resulted in shortfalls, including care plan monitoring, capacity and consent issues and the provision of meaningful activities.

Systems were in place to obtain the views of staff, people and visitors. People and their relatives spoke positively of the current management of the service and told us they felt listened to and involved.

Accidents and incidents were not consistently monitored to identify learning points and emerging trends.

Staff told us they felt valued by the manager and deputy manager, who they described as "approachable and very supportive."

# Partridge House Nursing and Residential 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We inspected on 14 November 2014. This was an unannounced inspection.

The inspection team comprised of two inspectors, a specialist nurse advisor and an expert by experience who had experience of dementia care services. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed 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. We also reviewed notifications received and other information we held about the service.

During our inspection we observed how the staff interacted with people. We also observed medicines being given, lunchtime support and a staff handover between shifts. We saw how people were supported in all three units. We also reviewed nine care records, staff training records, and records relating to the management of the service such as audits and policies.

We spoke with 11 people who use the service and three relatives. We also spoke with the registered manager, the deputy manager, three nurses, four care workers and two visiting social workers.

We contacted external healthcare professionals who were involved in the lives of people at the home, including a contracts officer and a clinical quality and safety manager from the local Clinical Commissioning Group.

Good

# Is the service safe?

## Our findings

People told us they felt safe living at the home One person told us, “If you ring a bell they come at once. If I was worried about anything I would go straight to the manager.” Another person told us “I feel very safe here.” Relatives spoke positively about the service, they had no concerns about the way their family members were treated and felt that they were safe. One relative told us “My mother requires 24 hour care but she’s safe and she has been much better under the new management.”

This positive feedback was supported by comments from healthcare professionals and other visitors to the service. The local Clinical Commissioning Group described the service as “a clean, happy and welcoming environment.” They also said, following a recent visit to the service “At no stage was it felt that residents were unsafe or uncared for in their environment.”

The provider had safeguarding policies and procedures in place. Training records showed that all staff had received safeguarding training. Staff also told us they felt people were safe, the training was good and staffing levels were sufficient to ensure people’s safety. Three staff members were able to give a clear explanation regarding what constituted abuse, they said they had completed e-learning (learning online) and they demonstrated a clear insight into their roles and responsibilities to report concerns. They were able to explain different types of abuse and how this might relate to the people they supported. The staff were also aware of the home’s whistle blowing policy. One member of staff told us “I would report any concerns or complaint to the nurse in charge or the manager and I would check up later to see what had been done. If I was not happy with the reply I would go to social services or CQC.”

Individual risk assessments were in place which detailed the level of support people required at the home and when out in the community. There were adequate numbers of staff on duty to support people safely We saw staff using gentle reminders and prompts for people who were confused or wandering. We also observed call bells being answered promptly.

Medicines were administered safely to people. We observed a lunchtime medication round. We saw that, where appropriate, people were assisted to take their medicines sensitively, they were not rushed and simple explanations, appropriate to people's level of understanding were provided. Medicines were well managed. We observed two nurses counting in the medicine of a person that had arrived in the morning. The medicines were double checked and signed for by both nurses.

Medicine was stored safely and correctly in cabinets in a locked room. Controlled drugs were well managed and those checked with the nurse matched the records. There were no gaps in signing on Medicine Administration Record (MAR) sheets and the MAR sheets had colour coded times for administration. Between shifts, we observed a handover of the keys for the medicine trolleys and cupboards, with the incoming and outgoing nurse signing for the keys. There was a clear system for disposal of outdated medicines. Where covert medicine was in use, there was a clear plan in place and a letter of authorisation signed by a GP.

Recruitment practices were robust and relevant checks had been completed before new staff started work. This helped to ensure that people were safe. We looked at the recruitment and personnel records for members of staff and found that they contained evidence that Disclosure and Barring Service (DBS) checks had been completed. (The DBS checks have replaced the Criminal Record Bureau (CRB) disclosures.) We saw that the application forms had been completed appropriately and in each case a minimum of two satisfactory references had been received.

Requires Improvement

# Is the service effective?

## Our findings

People and their relatives spoke positively of the service, the support staff and of the healthcare provided. One person told us, "Doctors visit when called and all the nurses work hard for the residents." Another person told us "I see the dentist every six months." One relative thought the medical care was "excellent." He told us "When my wife came in here two months ago she couldn't talk. Now after treatment she can hold a good conversation – and she can come home for Christmas!" Another relative told us "I am generally very pleased with the standard of care for my relative and the staff are all very caring and wonderful. The food is good, I did have some concerns around their fluid intake and started coming in to ensure this was happening but it is much better now."

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). The manager told us that nobody at Partridge House was currently subject to a DoLS authorisation, although they were "monitoring the situation." We saw that staff were provided with guidance and information regarding effective risk management, to help ensure people were protected. Training records demonstrated that staff had received or were booked to undertake training on the Mental Capacity Act 2005 (MCA) and DoLS.

Staff we spoke with had some knowledge of mental capacity and deprivation of liberty issues. They told us they would always assume that people had the capacity to consent to the care they were being provided with. However care plans did not consistently reflect this. Capacity issues were recorded in a generic way, for example, (Resident) has the capacity to make decisions about their care, treatment, safety and support at Partridge House'. There were also comments such as 'Resident) does not appear to feel pain' or 'does not appear to have capacity.' Records to show that consent had been gained for care or treatment (other than for the recent flu injections) were either inconsistent or not available. This did not demonstrate a good understanding of capacity, choice and consent issues.

This is a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There was little recorded evidence of multidisciplinary meetings (meetings involving social workers and health care professionals) to ensure that people's best interests were upheld. However the manager told us that best interest meetings were held on a regular basis but acknowledged that they were not always recorded. This was supported by visiting social workers who confirmed that they had been involved in such meetings.

Health action plans were in place for medical reviews and assessments identified dietary requirements and where necessary the involvement of the dietetic team. Less clear was the input from other health care professionals including speech and language therapy, chiropody and occupational therapy, as this was poorly documented.

Care plans were inconsistent and did not always reflect the level of support that we observed and people described to us. The documents themselves were cumbersome and poorly organised and maintained, with information often difficult to track and not always current or accurate. There was little documentary evidence that plans were regularly reviewed and updated to reflect any changes to risk or the care and treatment being provided. We reviewed the risk assessments of 10 people. The documents themselves were often cumbersome, difficult to track and not always current. Examples of this were seen where risks to people's safety were identified but there were no clear plans to manage the risk, monitor changes or to support staff in how to manage the risk. There was no evidence to demonstrate that care plans were regularly reviewed and updated to reflect any changes to risk or the personalised care and support being provided. People's choices and preferences were not always met because documentation did not consistently reflect people's needs.

A relative told us "I have told staff what my mother is interested in. She is from farming stock, enjoys most animal programmes, particularly Country File." When we looked at this person's care plan, there was no record of this information. Consequently staff were unaware of this person's particular interest and therefore not responsive to their need. While talking to a member of staff, they told us "Person centred care should be focussed on each individual's care and wellbeing. It is difficult when you can't relate to life stories. An example of this was that one person loved anything to do with steam trains but as the care plan did not show this it was ages before staff found out. We could have been doing something about it sooner."

However, another member of staff was very clear when they told us "People who use the service always come first."

Requires Improvement

# Is the service effective?

This highlighted once again that what we read in care plans did not always reflect or correspond with what we observed and what we heard. We discussed these issues with the manager who again acknowledged the shortfalls in recording information. They told us "We obviously need to get better at recording what we do. We're doing it - responding to their needs - but we don't always have the evidence to demonstrate what we do.".

People's nutritional needs were assessed and recorded and records were accurately maintained to ensure people were protected from risks associated with eating and drinking. We saw that people were consulted about their food preferences each day and were given options. However this choice was given verbally with no visual prompts such as pictorial menus or people being shown plated meals and asked which they would like. Guidance was in place for special requirements such as fluid thickeners, however, four food and fluid charts we tracked had not been completed since the afternoon of the previous day. This did not reflect good practice and was discussed with the manager in relation to the standard of record keeping.

This is a breach of Regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us they were happy with the support and most of the training they had received whilst they had been working at Partridge House. One member of staff said, "The training has been really useful and I feel confident doing what I'm doing." Staff also spoke very positively about the support they received from the manager and other colleagues. One member of staff member told us "The manager is very supportive and very approachable and we also support each other here."

However, despite such positive comments, we found shortfalls in the provision of formal staff supervision and appraisals. In records we were shown staff supervisions and appraisals were out of date and there had been no recent staff meetings held. This was confirmed by staff who told us that their supervisions and appraisals were not up to date and that there had not been a staff meeting for some time. This was discussed with the manager and deputy manager who acknowledged that "some things have slipped because of all the changes." However they assured us that formal supervision sessions and annual appraisals was being reinstated, with immediate effect and a full team meeting was already planned for the following week. To support this, we were shown a timetable and schedule for staff supervisions and appraisals. .

All staff had completed induction training, compatible with the Skills for Care Common Induction Standards. The manager told us that in addition to essential training, staff received training specific to the needs of individual clients in this home, including epilepsy, diabetes, dementia, pressure care, continence and nutrition. This was confirmed by staff we spoke with and supported by training records we were shown.

We discussed, with the registered manager and deputy manager, the large amount of training that was currently provided by eLearning and also the need for a higher level of dementia care training, They acknowledged that a more varied range of training methods would be beneficial and assured us that the new providers were currently reviewing the quality and effectiveness of staff training, including more comprehensive dementia awareness, to promote a deeper understanding of people's needs

During lunch time, we observed there were sufficient staff to ensure that time was taken to support each person who needed assistance. Staff did not rush people, they explained to people what the food was and chatted during the meal. A member of staff told us that specialist diets, including diabetic and gluten free meals were catered for as required. One person told us "If we don't like something we get an alternative." A relative we spoke with told us "Food has improved considerably under the new regime - it was awful at one time." During the afternoon we observed that one person asked for a sandwich. This was provided by staff.

People were assigned a named key worker who coordinated their day to day healthcare needs. We saw evidence that, as far as practicable, people were involved in completing their health action plans, which were personalised, reflecting their individual health care needs. Health action plans included dates for medical appointments, medicine reviews and annual health checks.

The registered manager confirmed that people who used the service were registered with local GPs and had access to other healthcare professionals and services as required. We saw that they made timely and appropriate referrals, for external advice and support. Staff we spoke with described

Requires Improvement

# Is the service effective?

the effective links and close working relationship with the community teams, including occupational therapists and dieticians. This was confirmed by healthcare professionals we contacted, as part of the inspection process, who spoke of “effective communication and good working relationships.”

Good

# Is the service caring?

## Our findings

People and their relatives spoke positively about the kindness and caring approach of the staff. They told us they were happy with the care and support provided at the home. People described the staff in terms of "lovely", "very kind" and "friendly" and there were lots of smiles. Staff routinely involved people in their individual care planning and treated them with compassion, kindness, dignity and respect. One person told us "They ask me about my needs - they couldn't be better." Another person told us "I am very happy here. The staff always see me when I need them. They wash and dress me and are all very kind." People also said they were offered choices and confirmed staff knew about their preferences and daily routines. One relative told us "It is much better under new management. They want people to feel good."

We saw that positive caring relationships had developed between people and staff. Observations during the day showed that staff were very kind and caring in their relationships with the people they supported. When staff were around people there was a calm and supportive atmosphere. We observed staff crouching down to the level of people in chairs and wheelchairs to speak with them as they discussed and sensitively explained what was happening next.

The manager confirmed that everyone at the home had their own key worker. One person told us "I like my key worker, they go shopping for me." Another person made the point that care and support was provided by all staff. They said "I don't think I have a keyworker, but I can ask for help from anyone." Staff told us that regular keyworker meetings were held, which helped to develop and maintain positive relationships and "keep up to date with what people need."

Staff spoke sensitively with people and treated them with both dignity and respect. Staff clearly understood the importance of privacy and dignity, particularly in relation to supporting people with their personal care. This was confirmed by people who told us that when staff were providing personal care, doors were closed and curtains drawn. One person told us "I have a Zimmer frame and the staff always walks behind me to see I don't fall. They give me a bath in bed and a proper bath once a week" Another person told us "They talk to me and treat me as one of them." Staff told us that, in accordance with their individual care plans, people not able to express their choices verbally were offered visual prompts, such as two items of clothes to choose from.

People we spoke with felt confident asking staff for help and they confirmed they felt involved in their care. People were able to express their views and were involved in making decisions about their care and support. They were able to say how they wanted to spend their day and what care and support they needed. We regularly observed people approaching staff for support with their personal care needs.

Staff were aware of the equality and diversity policy and demonstrated some understanding of equality and diversity issues. They said they had completed e-learning training related to this and confirmed that people's wishes in respect of their religious and cultural needs were respected. One member of staff told us "People are supported to go to the church of their choice or attend services held in the home."

Communication between staff and people was sensitive and respectful. We saw people being supported with consideration and gently encouraged by staff to express their views. People were able to make choices about their day to day lives. We saw that people were able to decide what time they got up and how they spent their day. Due to their condition, many people were unable to fully express their views verbally. They were supported to make choices and express their views by the use of signs and pictorial prompts. We observed that staff involved people, as far as possible, in making decisions about their care, treatment and support. Relatives confirmed they were involved in their care planning and reviews. They said they were kept well-informed and had regular contact with the key worker and were made welcome whenever they visited. One relative told us "I can see the care plan whenever I like. It's kept in a cupboard. Sometimes I ask to see it but it doesn't change much."

Requires Improvement

# Is the service responsive?

## Our findings

There was a programme of activities and an activities co-ordinator was employed to work across all three units. However, observation during the day showed that any minimal activities provided seemed to be focussed on people who were more able to take part. An example of this was that one person went to an art class in the morning with the day care co-ordinator and another member of staff. The vast majority of people were left unsupervised for long periods of time during the busy morning.

Comments from people regarding the very limited activities available, including "They ask me if I want to do something and include me." "I don't do nothing." "I like TV magazines but can't see very well." "They have singing on Wednesday." "I go for a walk on Wednesday mornings, to get to know people I live with – and I water the flowers."

For the whole day, besides staff occasionally speaking with them, there was no motivation or stimulation for the other people, either in the communal areas or in their rooms. In the afternoon, the person who had been out in the day was given some word puzzles to complete by the day care person but no one else was approached or motivated to take part in an activity. This absence of any stimulation could lead to social isolation and a loss of skills, motivation and interests for people. We were told that some people were supported to go out to the community café and Salvation Army centre twice a week. However, when we clarified this, it appeared that only three people were involved in this particular activity. This demonstrated a significant lack of any meaningful or personalised activities, reflecting people's needs, interests and preferences.

This is a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were involved in making decisions about their care wherever possible. We found that people had their individual care and support needs assessed before they moved into the home. People told us that they were involved in the assessments and generally felt that their voices were heard. One person told us "I talk to my key worker, she knows what I like." We were told by another person that they felt "involved" and that the staff listened to them. One relative told us "I sometimes discuss my mother's plan with staff."

Staff said they got to know people and what they want and need, through spending time with them and their relatives and reading their care plans. We had some concerns regarding the structure and content of care plans. Although we found people's needs were regularly assessed, the way documentation was arranged meant there was a risk that people may not always receive responsive care as consistent documentation was not in place. In the plans we looked at, there was very little information recorded regarding personal history or details of the individual's interests, likes and dislikes. The 'About me' and 'Moving in' sections, that formed part of the assessment and care planning process, had not been completed. Consequently some care plans were task orientated and did not reflect or consider people's personal preferences.

The overall assessment process and risk assessment were combined with the care plans, which made them difficult to follow and could cause confusion relating to planned and actual outcomes. Updating was therefore difficult when incidents occurred that required a re-assessment of risk. We also found that the pre-assessment section (undertaken prior to accepting a person for admission) was at the end of the care planning process. This should be used as a basis for determining risks and planning of care. Individual risk assessments were completed when required and included falls, medication, nutrition and risk of choking. Guidance on risk areas was good but evidence of consent for high risk elements, including bed rails, was inconsistent.

People and relatives told us they knew how to make a complaint but this had not been necessary. The manager confirmed that they welcomed people's views about the service. They said that any concerns or complaints would be taken seriously and dealt with quickly and efficiently, ensuring wherever possible a satisfactory outcome for the complainant. A family member said they were aware of the home's complaints procedure. They told us that when they had raised concerns it was taken seriously and acted upon. Three staff told us that if they received a concern they would record it and pass on to the unit nurse or manager.

Requires Improvement

# Is the service well-led?

## Our findings

People and their relatives were aware of the management arrangements at the home and felt there was effective leadership within the service. There was a registered manager in post. .People told us they were confident in the registered manager and staff team. One person told us "I would tell them if I was unhappy. It is wonderful the way they let you get on with your life." Another person told us "I am very happy here and have no complaints." Relatives we spoke with were also very positive about the manager. One relative told us "I think the manager is excellent and always very approachable." Another relative told us "The manager must be good, he has to deal with lots of people every day. He's a very busy man but always makes time to speak with us and everything is fine."

There was a lack of regular and effective auditing and monitoring of the quality of the service. The registered manager and deputy manager were not aware of the process of assessing and recording of people's capacity to make specific decisions and their consent to care and treatment. As part of their governance responsibilities, the management should have been closely monitoring the structure and content of care plans. They should also have ensured the day to day provision of social activities was reflecting people's identified interests and preferences.

The registered manager told us they were responsible for undertaking regular audits throughout the service. Records showed that such audits included health and safety, which incorporated fire safety, electrical checks and updating environmental risk assessments. Other audits included medication and infection control reviews. There was also a system in place for recording accidents and incidents. We reviewed a sample of these and found recordings included the nature of the incident or accident, details of what happened and any injuries sustained. However, we could not identify how the provider monitored or analysed incidents and accidents to look for any emerging trends or themes, or how their findings were used to inform reviews of care plans and risk assessments. This meant that there was an increased likelihood for such accidents or incidents reoccurring, as preventative measures were not routinely implemented. Consequently there was a potential risk to people's health and welfare.

This is a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People and their relatives confirmed they were asked for their views about the service. They told us they felt "informed" and also said they were involved in care plan reviews. One relative told us The manager is aware of what is needed. We were never asked in the past but it has certainly changed for the better."

Staff spoke of a far more open culture, since the changes. They said they also had more confidence now in the way the service was managed and described the manager and deputy manager as "approachable" and "very supportive." Staff also spoke positively about the changes they had implemented since they took up their posts. They said the service was now more open and inclusive and they felt able to raise any concerns and complaints and they were confident they would be listened to and acted upon. One member of staff told us, "You can talk about your problems with the manager and there is a much better atmosphere here now." Both the manager and deputy manager told us they operated an 'open door policy' and said that anyone in the home was welcome to raise or discuss "any issue at any time." This was supported by our observations during the inspection and confirmed through discussions with people, their relatives and members of staff.

The service had a whistleblowing policy. Staff told us they would not hesitate to raise concerns about poor practices and were confident their concerns would be listened to and acted upon. They said they were happy and motivated working at the service and described the morale amongst staff as "good" and "much better now."

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment<br>**Records to show that consent had been gained for care or treatment (other than for the recent flu injections) were either inconsistent or not available.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation and nursing or personal care in the further education sector<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services<br>**There was an almost total lack of any meaningful or personalised activities, reflecting people's needs, interests and preferences. Regulation 9 (1) (b) (I)** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision<br>**Inconsistent auditing and monitoring systems resulted in shortfalls in care planning and a lack of robust analysis of incidents and accidents meant lessons were not learned. Regulation 10 (1) (a); 2 (c) (i)** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records<br>**Inconsistent recording systems, including care plans and fluid charts, put people at risk of inappropriate care or treatment. Regulation 20 (1) (a)** |