Life Style Care (2011) plc

Kings Court Care Centre

Inspection report

Kent Road
Swindon
Wiltshire
SN1 3NP
Tel: 01793 715480
Website: http://www.lifestylecare.co.uk/kings-court/

Date of inspection visit: 31 July 2015
Date of publication: 22/09/2015

Ratings

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

Overall summary

We inspected Kings Court Care Centre on the 31 July 2015. Kings Court provides residential and nursing care for older people over the age of 65, some of the people living at the home were living with dementia. The home offers a service for up to 60 people. At the time of our visit 38 people were using the service. This was an unannounced inspection.

We last inspected in September 2014 and found the provider Was meeting all of the requirements of the regulations at that time.

There was not a registered manager in post on the day of our inspection. The last registered manager left in May 2015. The service were in the process of recruiting a new manager. 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.

Summary of findings

Staff were task focused and did not always involve people or respect their preferences. Staff did not always know the people they cared for. People's preferences were not recorded in their care plans and contained limited information on people's lives and interests.

People told us there was not always things to do and that life in the home could be boring. Some people went long periods of time without any contact with care staff. There was an activity co-ordinator, however not all activities provided by the activity co-ordinator and staff were structured to meet people's needs.

People did not always receive their medicines as prescribed. Where people were prescribed as required medicine, such as pain relief medicine, they did not always receive this medicine. Staff did not always keep an accurate record of when they had assisted people with their medicines.

Staff protected people from the risks associated with their care. However, one person was at risk of pressure damage and staff were not always ensuring this person's needs were being met.

There were enough staff deployed by the provider to meet people's needs. However, staff did not always receive the training and support they needed to meet people's needs. Staff did not always have clear leadership to ensure people received personalised care daily.

The provider was aware of a range of concerns at the home, however action had not always been taken to address these concerns. Not all staff felt supported and staff lacked direction from management and senior staff. There was not a caring, open or transparent culture in the home and staff were not aware of the providers culture, aims or goals.

People told us they felt safe in the home, staff had a good understanding of safeguarding and the service took appropriate action to deal with any concerns or allegations of abuse.

People and their relatives told us their complaints were acted on by the management team. Relatives felt staff were approachable.

People had access to appropriate food and drink and were supported to access external healthcare services.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of 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?

Requires Improvement

The service was not always safe. People did not always receive their medicines as prescribed.

The risks to people had been identified and staff knew how to protect people from these risks. However, one person who was at risk of pressure damage needs were not always being met.

People told us they felt safe and staff had a good knowledge of safeguarding. The provider ensured there were enough staff deployed to meet the needs of people.

Is the service effective?

Requires Improvement

The service was not always effective. Staff did not always receive appropriate training and support to meet the needs of people living at the home. Not all staff had an understanding of the mental capacity act.

People had access to sufficient food and drink. Staff ensured the needs of people with specific dietary needs were met. People had support to maintain their on-going healthcare needs.

The management ensured where people were deprived of their liberty, the authorising authority were informed. Care was provided in the least restricted way.

Is the service caring?

Requires Improvement

The service was not always caring. Care staff did not always know the people they cared for. Staff did not understand what was important to individual people, or how their care should be provided to meet their needs and preferences.

While there were many positive interactions, staff did not always engage people or involve them in their care.

Staff ensured people's privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care staff were task focused and did not ensure people were at the centre of their care. People's care plans were not always current and accurate.

There were not enough activities for people living in the home. Activities were not structured to meet the preferences of people.

People and relatives told us they knew how to complain and felt the management team responded to all complaints.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well led. The provider had an action plan to improve the service, however a number of actions had not been completed.

Audits identified concerns with care plans, the management of medicines and infection control. However no actions had been taken following these audits.

There wasn't a registered manager in post. People, their relatives, staff and stakeholders were concerned about the lack of consistency regarding the registered manager.

There was not a caring culture in the home. Staff were not aware of the provider's culture or aims or goals. Staff were not always supportedmanaged to ensure the service ran well.

Kings Court Care Centre

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.

This inspection took place on 31 July 2015. This was an unannounced inspection. The inspection team consisted of three inspectors, a specialist advisor in nursing care and an expert by experience. 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 visit we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. This enabled us to ensure we were addressing potential areas of concern. We spoke with local authority safeguarding and contracts teams.

We spoke with 11 of the 38 people who were living at Kings Court Care Home. We also spoke to six people's relatives and visitors. We used 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 talk with us.

We spoke with two registered nurses, five care workers, an activity co-ordinator, the deputy manager, a regional manager and two support staff employed by the provider. We looked around the home and observed the way staff interacted with people.

We looked at 10 people's care records, and at a range of records about how the home was managed. We reviewed feedback from people who had used the service and their relatives.

Requires Improvement

Is the service safe?

Our findings

People's medicines were not managed safely. Five people had not received their medicines as prescribed in July 2015. When we checked people's prescribed medicines against their medicine administration record (MAR) charts we found records did not accurately reflect the stock. Care and nursing staff had signed to record they had given people their medicines on MAR charts, however they had not assisted people to take this medicines. When we discussed this with nursing and care staff they were unable to account for the discrepancies.

Care and nursing staff did not always keep an accurate record of people's prescribed medicines. One person had been prescribed pain relief. We saw this person's medicines had run out the day before our inspection and care staff had not been able to give this person their medicine on four occasions. We discussed this with a nurse who could not find this medicine. Later in our inspection this person's pain relief medicines had been found.

These concerns were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People told us they felt safe living at the home. Comments included: "Oh yes, the people around here, they look after me", "I am never left uncomfortable, I get my medication at the right time", "Yes, I feel safe" and "I feel safe here." Relatives told us they didn't have concerns about the safety of their loved ones. One relative told us, "Yes, she is definitely safe here. Another relative said, "We like the home, we have no concerns."

Staff had knowledge of types of abuse, signs of possible abuse which included neglect, and their responsibility to report any concerns promptly. Staff told us they would document concerns and report them to the registered manager, or the provider. One staff member said, “If you see anything concerning you need to report it to the manager.” Another staff member added that, if they were unhappy with the manager’s or provider’s response, "I would go straight to CQC.” Staff told us they had received safeguarding training and were aware of the local authority safeguarding team and its role.

The regional manager and deputy manager raised and responded to any safeguarding concerns in accordance with local authority safeguarding procedures. Since our last inspection the provider had ensured all concerns were reported to local authority safeguarding and CQC. They also ensured all action was taken to protect people from harm.

People had assessments where staff had identified risks in relation to their health and wellbeing. These included moving and handling, mobility, social isolation and nutrition and hydration. Risk assessments enabled people to stay safe. Each person's care plan contained information on the equipment and support they needed to assist them with their mobility. For example, staff ensured people's pressure relieving mattresses had been set in accordance with their needs.

Staff had identified one person was at risk of depression and was often in pain. Staff had documented this on pain charts and had clear guidance to support the person with these needs. These needs had been discussed with the person's GP who had prescribed anti depressants and pain relief medicine. We observed this person and they were comfortable and happy during the course of our inspection.

One person's relative told us they were informed by staff that their relative was at risk of falling. They spoke positively about the support staff had provided to protect the person from harm. They told us, "They have put a crash mat by her bed. I was surprised when I saw it, they told me that she had a bad night and they didn’t want her to fall out of bed." Staff told us they had put this to protect the person from harm if they did fall from bed.

People told us there were enough staff to meet their needs. Comments included: "I very rarely wait to long", "sometimes the staff are busy, however I don't wait to long" and "I can get staff, not a problem." One relative told us, "Yes I think there are enough staff, there are lots of them about." Staff also supported these comments and told us there were enough staff to meet people's needs. One staff member told us, "I think there is enough staff."

There was a calm atmosphere on the ground floor of the home on the day of our inspection. Staff were not rushed and had time to assist people in a calm and dignified way. We observed staff taking time to talk to people throughout the day. On the first floor we found there were enough staff to meet people's needs, however staff were not always organised or led in an effective way.

Requires Improvement

Is the service safe?

The provider had a system for ensuring there were enough care workers deployed to meet people's needs. The provider assessed how many staff were needed to meet people's needs. The deputy manager told us the amount of staff deployed would depend on people's needs. Staff rotas showed the numbers of staff required were on shift.

Records relating to the recruitment of new staff showed relevant checks had been completed before staff worked unsupervised at the home. These included employment references and disclosure and barring checks (criminal record checks) to ensure staff were of good character.

Requires Improvement

Is the service effective?

Our findings

People and their relatives had mixed views about the skills and caring nature of care staff. Comments included: "Yes the staff are OK they understand me. They know what they are doing", "A lot of the carers are foreign. I don't understand them and they don't understand me'" and "there is a couple of them who seem lazy". One relative told us, "quality staff, but some just don't care." Another relative said, "the staff are caring, however their English isn't good." We observed some staff and saw English was not their first language. We discussed these concerns with the deputy manager and regional manager who informed us they provided training for staff around English and would support them with any needs.

Staff did not always have the training they needed to meet people's needs and ensure their safety. Some staff we spoke with had not had training around the Mental Capacity Act (which provides the legal framework to assess people's capacity to make certain decisions, at a certain time), dementia, infection control or fire safety. One member of staff told us they had not received this training, however felt they had had plenty of training. Another member of staff when asked about the Mental Capacity Act told us, "I think this is to do with health and safety." We discussed these concerns with a training manager employed by the provider. They informed us the provider had employed support staff for the home to provide training. This training would be focused on the new care standard and would ensure staff had the training they needed to meet people's needs.

We spoke with staff about fire safety and the actions they would have to take to ensure people were safe. Each staff member informed us of different actions they would take, however no member of staff had the same explanation of the actions they would take. We discussed this concern with the training manager, deputy manager and regional director who informed us that all staff had received fire training. They also informed us they would act on this concern immediately.

Some staff told us they had not felt supported working at the home, however felt things had improved recently before the inspection. Not all staff had received a supervision (one to one meeting with their line manager) or annual appraisal. Records of supervision were recorded for some staff however these were usually in response to concerns identified by the management of the service. One staff member we spoke with told us they had concerns around their use of language, however they told us there had been no opportunity for them to discuss this at supervision. They said, "my last supervision was with the previous manager and that normally happens six monthly or yearly." Other staff told us they had not had a supervision in 2015.

This lack of staff support isThese concerns were a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The provider ensured that where someone lacked capacity to make a specific decision, a best interest assessment was carried out. For one person a best interest decision had been made as the person no longer had the capacity to understand the risks to their health if they left the home without support. The manager made a Deprivation of liberty safeguard (DoLS) application for this person. DoLS is where a person can be deprived of their liberty where it is deemed to be in their best interests or for their own safety.

The provider had identified a number of people who they believed were being deprived of their liberty. They had made DoLS applications to the supervisory body. These applications included the reason they have made the application, which referred to the individual person's safety. People's care plans also contained mental capacity assessment information for specific decisions such as consent to care and accommodation.

People were supported to maintain good health through access to a range of health professionals. These professionals were involved in assessing, planning, implementing and evaluating people's care and treatment. These included GPs, psychiatrists, district nurses, community mental health nurses and speech and language therapists.

Some people were supported by care workers to eat and drink with thickened fluids because they were at risk of choking. These people had been assessed as at risk and speech and language therapist (SALT) guidance had been sought and followed. We observed staff prepare people's drinks in line with this guidance. Where care staff had concerns over people losing weight they contacted the person's GP. People were supported with dietary supplements and were given support and encouragement to meet their nutritional needs.

Requires Improvement

Is the service effective?

People spoke positively about the food and drink they received in the home. Comments included: "The food is all right", "I enjoy my food", "I have a good lunch here." One relative told us, "I think she gets enough food and drink. The food is OK."

One person told us how they had regular choice over their meals. We observed people were given choice around their lunch. People were supported to make decisions on what meal they wanted, or if they wanted a home cooked alternative provided by a chef who had been supplied to cover the home. People we spoke to enjoyed their lunch. One person said, "it was quite nice."

The home's staff were all aware of people's dietary needs and preferences. We spoke with kitchen staff who had been supplied by the provider to cover for the day, they told us they had all the information they needed and were aware of people's individual needs. People's needs and preferences were also clearly recorded in their care plans. One relative told us, "My mum cannot have dairy products." Staff had provided diary free milk to ensure the person's dietary needs were met.

Requires Improvement

Is the service caring?

Our findings

Staff did not always take time to sit and engage with staff. We observed staff spend time with people in communal lounges without talking with them or engaging them. Additionally we saw staff going in and out of people's rooms, without introducing themselves or saying hello to people. One staff member walked into the person's room and quickly left, the person was anxious and called out after the staff member had left the room.

Staff did not always assist people with their meals in a respectful manner. We observed one staff member assist someone with their lunch. The person was distracted, looking out of the dining room. A staff member kept moving the food to the person's mouth which they kept rejected. Staff did this without talking to the person. The person was agitated and was loudly calling for attention, which made other people eating in the dining room distressed. One person told us, "I can't stand all this screaming." We also observed staff did not identify when people were struggling with their lunch. One person had chips which were too long for them to swallow, staff had not identified this.

Two people living on the first floor were receiving one to one care to ensure their care and wellbeing needs were met. We observed care staff who were providing one to one care They were often sat reading care plans or in silence and during our observations we saw that staff did not engage with the people they were caring for. Staff comments included: "one to one's are boring, residents sleep, and make wake them up offer a drink", "one to ones are hard" and "we do not have time to read the books [care files], I read them when working one to one with someone else." We discussed this concern with the deputy manager and regional director, who informed us they would look into the concern it..

Not all staff knew the people they cared for. When we asked staff about the people they cared for they were not always able to tell us about their likes or preferences. People's care plans did not always contain information about people's life histories or preferences. One staff member told us life histories weren't in their care plans, they said, "It's not there." Another member of staff said, "I would read life history if this was there."

These concerns were a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People spoke positively about the care staff and the support they receive. Comments included: "They are good now, we have one carer who is lovely", "I think the world of the nurses" and "I think the staff are caring." One relative told us, "From what I have seen they care OK."

In the afternoon we observed positive interactions between people and staff. One staff member assisted a person with their drink, they did this in a patient and dignified manner. The person was happy and content throughout our observation. We observed another staff member reassuring a person who appeared anxious, they took time to talk to them, engaging them at eye level. The person was calm and happy.

Staff spoke positively about "virtual dementia" training they had received. Three members of staff told us this training had helped them bring new and improved practices in to the home to care for people. One staff member said, "I changed the way of speaking, lower tone of voice." They told us this had been beneficial to them.

We spoke with two members of staff who spoke confidently about the people they cared for and told us how they ensured they were at the centre of their care. One care worker told us, "one family would ask me to talk to their relative in my own language or to sing a song to them when the client is distressed." They told us how this helped reassure the person.

One person's relative spoke positively about how their relative was supported to maintain their appearance. The relative told us they visited twice a week, on different days and they said their mother "always looks nice, clean and hair done". We saw this person who was presented how she chose to and in line with their care plan.

Requires Improvement

Is the service responsive?

Our findings

People told us there was not a lot to do in the home. Comments included: "I get bored, sometimes I just look out of the window. I like films and music, however it doesn't happen much", "There are no activities and I never go out into the garden" and "there's not a lot going on." One relative told us, "There are no activities in here, we were concerned that there is no stimulation."

The home had an activity co-ordinator who was providing activities to people in the home. They encouraged staff to carry out activities for people. We observed one staff member was decorating a banner for an upcoming fete. Five people were in the room, however only two people were able to talk with the staff member, none of the people were able to be fully engaged in the activity. two of the people fell asleep quickly, and were left until lunch was served.

We observed four people on the ground floor who stayed in their own rooms. These people went without engagement from staff for long periods of time. We spoke with one person who told us, "I stay in my room. I don't know if staff come and see me because I usually go to sleep, as there isn't much else to do."

On the first floor we observed two people who were still in bed just before lunch. Staff had tried to assist these people to get up, however they had chosen not to. Following this staff had left these people in their rooms, without assistance and with their curtains closed. We raised this to the nurse in charge who took action to ensure people were supported in time for their lunch.

People's care plans were not always personalised and did not always contain people's life histories, hobbies or interests. There was limited information of how people wished to spend their time in the home, what was important to them or how they wished to spend their days.

One person was receiving care for a pressure sore which had developed prior to our inspection. Staff had clear instructions from healthcare professionals to ensure the person was assisted with fluids and to reposition to prevent any further damage. The person also had equipment needed to protect them from further harm and keep the comfortable. Repositioning and fluid charts for this person were not always being completed. We observed staff did not assist this person with fluids or repositioning. During the inspection the person was agitated and called out for assistance, however staff did not arrive. We raised this concern with the deputy manager, who gave staff clear instructions. After this time, staff were assisting this person in line with their assessed needs.

These concerns were a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Some people spoke positively about the activity co-ordinator and the support they provided. One person told us the activity coordinator spent time with them. We observed the activity coordinator spending one to one time with a person, they assisted them with a drink. The person was happy throughout the observation. Relatives spoke positively about the activity coordinator. One relative said, "there are activities like bingo and they [relative] go out into the garden often."

We observed five people enjoying a game of snakes and ladders with care staff and the activity co-ordinator during the morning of our inspection. Each person was supported by care staff to be involved by throwing their dice. People enjoyed the game. One person said, "I haven't played this in a while, it's fun."

People's care plans often included detailed information relating to their health needs. They were written with instructions for staff about how care should be delivered. However, these were not always clearly written or accurately reflected people's needs. For example, one person's dietary needs had changed and these had not been accurately recorded. The weight of another person had not been recorded twice, both records were different and could not provide staff with correct information. People's care plans and risk assessments had not always been reviewed monthly in line with the providers policy, and where changes in need were identified, the plans had not always been changed to reflect the person's needs. The regional director and deputy manager were aware of these issues and they informed us that all care plans were being audited. The majority of care plan's we looked at had been audited by staff employed by the provider. However a number of concerns raised in these audits had not been acted upon. One staff member said, "records are one of our major issues."

Requires Improvement

Is the service responsive?

Relatives told us they were involved in people's care and were informed when changes had been made. One relative told us how they were given information when their relative had fallen, and spoke confidently about the action staff took to reassure them.

People and their relatives told us they knew how to raise complaints. Comments included: "I will tell staff if I had a concern", "if any problems, the deputy is responsive and anything would be dealt with" and "I complain by telling the carer ." One relative had told us how they had raised a complaint about their relatives clothes. They said, "We complained that she kept running out of clothes and when we came in she had someone else's clothes on. They have sorted that out now."

There was a complaints policy which clearly showed how people could make a complaint and how the provider would respond to this complaint. The majority of complaints had been responded to in accordance with the provider's complaints policy. One complaint had been acknowledged but had not been investigated. No one had followed up on this complaint. We raised this concern with the regional director who informed us they would take action to ensure this complaint was investigated.

Inadequate

Is the service well-led?

Our findings

People and their relatives had mixed views on the management of the service and told us their views were not always listened to or respected. Comments included: "All meetings have been stopped, the home has changed for the worse", "I don't know what to say about this home, it is not working at the moment and the last 6 months it has been bad", "there are no meetings" and "I don't know who the manager is. I have never heard of a relatives meeting being held."

There was no record of recent relative and resident meetings being carried out at the service. The provider carried out an annual quality assurance survey which was last carried out in 2014. This showed a positive view of the home. Since this time two registered manager's have left the service and no further surveys of people and their relatives have been made.

There was not a registered manager in post on the day of our inspection. The last registered manager left in May 2015. 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. Since May 2015 a manager was recruited, however they shortly left the provider. Since this time a regional director for the provider had been supporting the deputy manager with day to day management of the home. They were in the process of recruiting a new manager for the service.

The provider had an action plan which had been implemented following a range of safeguarding concerns and complaints since January 2015. The action plan was informed by concerns identified in audits carried out by the provider around management of medicines, infection control and care plans. A number of actions on this action plan were stated for completion prior to our inspection. However, actions had not been taken. Medicine audits identified concerns similar to those found at our inspection. However, action had not been taken from this audit to address these concerns.

Audits also identified concerns around a lack of activities and concerns over people's care plans. While action was being taken regarding people's care plans, no action had been taken around activities and there was no clear acknowledgement in the service's action plan. Care plan audits had being carried out since May 2015. However, actions had not been completed following these audits.

The service was not monitoring incident and accidents. We discussed this with the regional director and the deputy manager who informed us this information was stored by the provider. We asked for this information to be provided to us. However, this information was not supplied. The management in the service did not have direct access to this information, therefore they would not be able to use it to identify concerns regarding incidents and accidents.

Staff told us they had felt unsettled by changes to the management and provider. Comments included, "things are not settled here", "new rules and ideas, staff are confused" and "new managers come, they have new rules, we [staff] are not sure who to follow." We observed staff on the first floor were often disorganised and lacked direction. There was limited presence of management on the first floor. This had an impact on people as staff did not ensure people's needs were being met. People were left in bed and staff were not directed or managed to provide activities or support people with their daily needs. When we raised concerns regarding people's care on the first floor action was immediately taken. Following this the atmosphere on the first floor was calm.

Staff we spoke with were not able to tell us about the aims of the provider or the culture the provider wished to promote within the home. Staff did not always feel there was an open culture to raise concerns. We raised this concern with the home's training manager who informed us the new provider has a culture which will be promoted through training being rolled out to all staff. The regional director and deputy manager told us they would speak to staff to help promote an open culture in the home.

During the inspection we found people's confidential records were being stored in the home's hair salon and activity room. This included people's care documents and documents relating to people who no longer lived at the home. We informed the regional director of this concern and they told us they would act on this immediately.

These concerns were a breach of regulation 179 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulations was not being met: People did not always receive their medicines as prescribed. Care and treatment was not always provided in a safe way for people using the service. Regulation 12(b)(f)(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Systems established to ensure compliance were not always operated effectively to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. Regulation 17 (1)(2)(a)(e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Persons employed by the service provider did not always receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out their duties. Regulation 18 (2)(a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: People's care and treatment was not always appropriate or reflective of their needs and preferences. Regulation 9 1(a)(b)(c).