Willow Cottage Care Home Limited

Willow Cottage Residential and Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 1, 2 and 3 March 2017 and was unannounced. The last inspection was carried out on 14 January 2015 and there were no breaches of legal requirements at that time.

Willow Cottage Residential and Nursing Home is a care home with nursing care for up to 34 predominately older people. People have general nursing care needs and some are living with dementia. At the time of our visit there were 24 people living at the home.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008.

We found a number of breaches of the Health and Social Care Act (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.

Appropriate steps were not taken to mitigate the risks to people. Risk assessments were not adequately completed and lacked essential detail about the risks to people.

Staff knew people well enough to understand their preferences and were familiar with the Mental Capacity Act 2005 (MCA). However people's mental capacity to make day to day or significant decisions had not always been assessed. Mental capacity forms that were in place lacked essential detail. It did not give guidance to staff regarding information about best interest decisions made and reasons for the decision.

People's care records did not reflect people's needs and preferences. Care records lacked essential detail regarding people's needs and how their individual needs should be met.

We found that the home had some systems in place to assess and monitor the quality of service. However, other audits undertaken had not been effective as we had identified areas that require improvement that were not picked up. Peoples' feedback had been sought through questionnaires and meetings.

Staff were knowledgeable about recognising the signs of abuse. All staff had received training in

safeguarding adults.

Medicines were administered to people safely by staff that had been trained.

The registered manager conducted pre-employment checks prior to staff starting work, to ensure their suitability to support people who lived in the home. Staff were not able to work until these checks had been completed.

Staffing numbers on each shift were adequate to ensure that each person's care and support needs could be met.

People were satisfied with the quality of the food and drink provided. Food and fluid intake was monitored where risks of weight loss or dehydration had been identified. Arrangements were made for people to see their GP and other healthcare professionals as and when they needed to do so.

Staff received induction and training. A training programme was in place and staff had been encouraged to complete all mandatory refresher training. Staff had supervision meetings and team meetings were held to support them in their role.

People said they were treated in a kind and caring manner. We observed that staff treated people with dignity and respect. People were able to make choices about the way they were cared for.

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 safe care and treatment and steps were not taken to mitigate the risks. Risk assessments lacked the essential detail.

There were sufficient numbers of staff on duty to meet people's needs.

People were protected by staff who knew how to recognise and report suspected abuse.

People received their medicines as prescribed and intended. Recruitment procedures were robust.

Is the service effective?

Requires Improvement

The service was not always effective.

Whilst staff supported people to make decisions about their care, the principles of the Mental Capacity Act 2005 (MCA) had not been complied with.

People received care and support from staff who were knowledgeable about their needs. Staff received effective support, supervision and training.

People received a nutritious and balanced diet.

Is the service caring?

Good

The service was caring.

People were supported to be independent by kind and caring staff.

People were treated with dignity and respect.

People said they were very happy with the care and support they received.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care records did not reflect people's needs and preferences. They lacked essential detail regarding people's needs and how individual needs should be met.

Referrals had been made promptly to a range of health professionals when people's needs had changed or they had become unwell.

Staff were knowledgeable about people's support needs. A wide range of activities were available that people enjoyed.

There were systems in place to respond to complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

The providers had systems and processes for assessing and monitoring the quality of the home, however these were not always effective. Audits undertaken had failed to identify the shortfalls within the home.

Significant events and incidents were not always communicated to the Care Quality Commission (CQC) as required by law.

Willow Cottage Residential and Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 1, 2 and 3 March 2017 and was unannounced. The inspection team consisted of two, one adult social care inspector and a specialist advisor with professional knowledge of services for older people.

Prior to our visit we asked for a Provider Information Return (PIR). The PIR is information given to us by the provider. The PIR also provides us with key information about the home, what the home does well and improvements they plan to make. We reviewed the information included in the PIR along with other information we held about the service. This included notifications we had received from the home. Services use notifications to tell us about important events relating to the regulated activities they provide.

We contacted seven health and social care professionals as part of our planning process and invited them to provide feedback on their experiences of working with the home. We received a response back from two professionals.

Some people were able to talk with us about the care they received. We spoke with three people who lived at the home. We also spoke with the relatives of two people. We sat and observed other people who were unable to communicate.

We spoke with eight staff, including the registered manager, operations manager, one registered nurse,

activities organiser and four care staff.

We looked at the care records of four people living at the home, five staff personnel files, training records for all staff, staff duty rotas and other records relating to the management of the home. We looked at a range of policies and procedures including, safeguarding, whistleblowing, complaints, mental capacity and deprivation of liberty, recruitment, accidents and incidents and equality and diversity.

Requires Improvement

Our findings

People who lived at the home told us they felt safe. One person when asked said "I am safe here and looked after very well by the staff". Another person told us they felt safe and felt their belongings were safe. One visiting relative that we spoke with said "I am really impressed with the home and if I felt my relative wasn't safe I would have moved them by now".

Staff we spoke with had an understanding of their role in protecting people and making sure people remained as safe as possible. Staff had access to a safeguarding adult's policy, which included all relevant contact telephone numbers and a copy of the local authority's multi-agency safeguarding adult's policy. Staff had access to a Whistle Blowing policy. The Whistle Blowing policy protects an employee who wants to report unsafe or poor practice. All staff spoken with said they would feel confident to report poor practice.

People did not always receive safe care and treatment and steps were not taken to mitigate the risks. Bed rails were incorrectly fitted and were not in line with guidance from the Medicines and Healthcare products Regulatory Agency (MHRA). The MHRA regulates medicines, medical devices and blood components for transfusion in the UK. Whilst looking around the home we found nine people's beds had bedrails fitted that were not secure and were not fitted at the correct height in line with the guidance BSEN 60601-2-53:2010 from the MHRA. An example being one person's bedrails could slide up and down the frame and could have caused entrapment or injury. One person's bedrails measured 19cm from the mattress to the top of the bed rail. Another person's bedrails measured 14cm from the mattress to the bedrail. The MHRA states that the measurement should be 22cm from the mattress to bed rail. Risk assessments were not adequately completed for the use of bedrails and lacked essential detail about the risks to people. We showed the registered examples of how bed rails were not safe for people This meant equipment used for providing care or treatment to people was not always safe or used in a safe way. People were at risk of falling out of bed or at risk of entrapment.

People's pressure mattresses were not always set at the correct pressure in line with people's body weight. An example being one person's mattress was set at a pressure of 90 but there weight was 71.5kg. Another person's mattress was set at 90 but there weight was 48.8kg. We found that the mattress pressure for two people was unable to be recorded due to any error message displayed on the air flow machines. We showed the registered manager examples of how the mattress pressures were not safe for people. We also advised them of the two faulty air flow machines. We also spoke to the operations manager who immediately went around the home to correct people's pressure mattress settings.

On the second day of the inspection the operations manager told us they were concerned with our findings and would look to order new beds with fitted bedrails to use if they needed these. They told us they had taken the two faulty air mattresses out of use and had replaced with functioning mattresses.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed the safety certificates for the building and found all relevant safety and maintenance checks had been carried out, and safety certificates were in order. This meant that the building and the equipment including moving and handling equipment were maintained and safe to use. For example we saw evidence of gas and electric safety certificates, hoist servicing and portable appliance testing (PAT).

People received their medicine from staff who had received training in medicines management and had been assessed as competent to administer them. We observed medicines being administered to people and noted that appropriate safety checks were carried out and the administration records were completed. Staff told us that they had completed medicine management training and had their competency checked before they were permitted to administer medicines unsupervised. The registered nurse wore a red tabard to indicate to other staff, people who lived at the home and visitors that they were not to be disturbed during the medicine round. We observed that there were no interruptions.

All medicines were stored accordance with legal requirements, such as locked cupboards, medicines trolleys and fridges. Unused or out of date medicines were returned promptly to the local pharmacy in a timely manner. Staff had access to guidance on the safe use of medicines and the medicines policy.

We recommend the MAR charts with instructions of where topical medicines should be applied are kept in people's rooms. Topical medicines were already kept in people's rooms but MAR charts were not. This would ensure the staff signed at the time medicines they were administered as well as having clear instructions.

Staff employed at the home had been through a robust recruitment process before they started work, to ensure they were suitable and safe to work with people who lived at the home. An administrative assistant had the responsibility to oversee the necessary checks were requested and received back. Records showed that all necessary checks had been made and verified by the provider before each staff member began work. These included reference checks, Disclosure and Barring Service (DBS) checks and a full employment history check. This enabled the registered manager to confirm that staff were suitable for the role to which they were being appointed to.

We found that there were sufficient staff on duty to meet people's needs and call bells were answered promptly. We noted that care staff did not rush people to get up in the morning or to eat their meals and staff took time to chat with people. People and their relatives told us that they had no concerns about staffing levels and there were always enough staff on duty. One relative said, "I visit the home most days and sit and observe. There appears enough staff on duty". Another relative said, "Generally they have enough staff on and they usually answer the buzzer unless they have emergencies of course." The registered manager told us they monitored staffing levels at the home. At the time of our inspection the home had a number of bed vacancy's but care staffing levels had been maintained in anticipation of the bed vacancy's being filled.

The upstairs sluice was an open 'hopper system' where staff emptied and cleaned peoples commode pots. We observed staff cleaning people's commode pots whilst wearing gloves and an apron. From speaking to

staff we found that the home did not have protective eye wear for staff to use. This would protect staff from splash back of people's bodily fluids.

We recommend the instructions of how to use the 'hopper system' are displayed in the sluice area. Protective eye wear should also be purchased for staff to wear whilst emptying and cleaning commode pots. This would protect staff from splash back of bodily fluids.

Requires Improvement

Our findings

People were complimentary about the staff and their abilities. One person said, "The staff look after me well. They work very hard and help reassure me when I get worried". Another person said, "I am happy with the care I receive and the staff seem to have a lot of knowledge".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. These safeguards are there to make sure that people are looked after in a way that does not inappropriately restrict their freedom.

We checked whether the home was working within the principles of the MCA. The care records we reviewed contained limited assessments of people's capacity to make decisions. One example was where a person had their medicines administered covertly. The registered manager had completed a 'covert administration form' which was not dated. The GP, family and pharmacist had signed this form. It deemed the person to have limited capacity however the form lacked essential detail about this. It did not give guidance to staff regarding the best interest decision made, reasons for the decision and how the medicines should be administered covertly.. Another example was some people's capacity had not been assessed in relation to the use of bedrails and floor sensors mats. This could be seen as a form of restraint where a person did not have capacity. Care records did not describe the efforts that had been made to establish that the least restrictive option for people and the ways in which staff had sought to communicate choices to people. Although staff and the registered manager had received training regarding MCA this had not been effectively put into practice. This meant people's needs were not always appropriately recognised because staff did not have the appropriate knowledge and skills.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager was aware of their responsibilities in making sure people were not deprived of their

liberty. We reviewed care records which demonstrated Deprivation of Liberty Safeguards (DoLS) applications had been submitted to the local authority for people who used the service. These were submitted as some people could not freely leave the service on their own, also because people required 24 hour supervision, treatment and support from staff. The DoLS provide a legal framework and allows a person who lacks capacity to be deprived of their liberty if done in the least restrictive way and it is in their best interests to do so. At the time of our inspection one person's application had been authorised by the local authority. Records confirmed the registered manager had submitted three further applications for people to the local authority and were awaiting a decision to be made.

New staff completed a period of induction and shadowing with more experienced colleagues. We were told new staff also worked through the Care Certificate as part of their induction. The Care Certificate identifies a set of care standards care workers should consistently adhere to. Staff told us they felt supported by senior managers working at the home. We found staff received regular supervision and an annual appraisal. Supervision is regular, planned and recorded sessions between a staff member and their manager to discuss their work objectives and wellbeing. An appraisal is an annual meeting a staff member has with their manager to review their performance and identify their work objectives for the next 12 months. The operations manager had plans in place to change the format of staff supervision and appraisal meetings to capture further information around staffs performance and development.

Staff were provided with the training and support they needed to carry out their work. They told us they had regular training opportunities, which involved completing workbooks and face to face training. Several staff spoke positively about training and said they had completed a range of training which included first aid, fire safety, end of life, safeguarding, MCA, moving and handling and nutrition.

A variety of drinks and snacks were available for people throughout the day. Stations of food and drinks were in each lounge including fresh fruit, biscuits and drinks. We observed staff regularly offering this to people. People also had access to juice and water in their rooms along with snacks.
The daily menu was attractively displayed on each table within the dining areas of the home. The four weekly menus were also displayed in various communal areas around the home. Since the last inspection the home had changed its food production process to cook and chill. People told us they enjoyed the food which appeared nicely presented. People and their relatives told us they enjoyed taking part in food tasting sessions and had a great influence about menu choices Staff told us peoples dietary requirements were catered for along with individual choices. The operations manager spoke positively about changing over to a cook and chill process. They said they worked closely with people and relatives and that food tasting sessions were fun and involved people in the process.

Care documentation showed people's nutritional needs were assessed and kept under review. People's care records contained information about people's nutritional intake and the support they needed to maintain good health. The registered manager monitored peoples weight and showed us records of a three month over view they referred to of people's weight. The home used a nationally recognised assessment called 'Malnutrition Universal Screening Tool' (MUST) to monitor people's weight. The deputy manager told us seven people were at risk of malnutrition. Records confirmed people's weight gain or loss was monitored so any health problems were identified and people's nutritional needs met.

Good

Our findings

People we spoke with said they were well cared for. Comments included "The staff are very caring and do their best to care for us all"; "I am very well cared for and like the fact you can have a laugh with the staff at the same time"; "Staff here are wonderful. They all care about us and do a very good job". One healthcare professional said "I am always made welcome when I visit, and the staff always show the patient's respect and are mindful of their dignity. Their approach is very caring".

We spent time at the home observing how people were cared for by staff. Throughout our inspection people were cared for and treated with dignity, respect and kindness. People seemed at ease with staff. We sat and observed the lunch time period on the ground floor the first day of the inspection and upstairs on the second day. Where people required one to one support this was provided with respect and dignity, people were not rushed and staff talked with them about their day to day lives. One person felt unwell during lunch and refused to eat anything. We observed staff were very attentive towards the person who appeared tearful. They offered reassurance and sat with them whilst waiting for the nurse to come check them over.

Staff consistently supported people throughout the day to be as independent as possible in a calming, friendly and reassuring way. We observed staff spoke gently with people, smiled, encouraged and provided reassurance when needed. One example being was a person appeared distressed and was calling out from their bedroom. We saw a staff member enter the person's room with calming approach. They sat and reassured the person and held there hand asking them what was wrong. The staff member assisted the person to have a drink and a snack whilst still sitting with them holding their hand. Although the person could not communicate what was wrong it was clear the staff members caring approach had been effective.

There were a number of notice boards located near to communal areas which displayed information about services and events which people could access if they wished. This included details of entertainment. Information about advocacy services was also made available to people. No one at the time of our inspection required the support of an advocacy service; however the registered manager and staff knew the circumstances of when advocacy services would be required.

External professionals we spoke with told us they felt the staff had a mutual understanding with the people living in the home and were able to provide care to people in a kind and compassionate way.

The laundry service was efficient. People told us that their personal belongings were nicely laundered and returned to them in good time. The laundry assistant demonstrated a caring approach to ensuring people's

clothing and other items were treated with respect. We received several compliments about how well items were laundered. One relative told us how their family member liked to wear designer clothing. We were told some of their clothing was hand washed in accordance with the instructions and well maintained. When items were returned to the persons wardrobe this was always put away in a good order just how the person liked.

Family members and other visitors were welcomed. Staff greeted family members, provided them with information relevant to their relative's progress and offered them with refreshments. Family members said they were always made to feel welcome and that there were no restrictions placed upon them when visiting their relative.

We recommend chair protectors which were called Kylies by the staff are removed from the lounge chairs. This would highlight to others that people have continence needs and does not respect people's dignity.

Requires Improvement

Our findings

Throughout our inspection we observed people being cared for and supported in accordance with their individual wishes. Staff we spoke with appeared knowledgeable of people's care needs. Relatives commented, "I trust the home caring for X. As I do not live locally the home ring me with regular updates regarding my relatives wellbeing" and "If my relative is unwell the staff pick this up quickly as call the doctor".

People's care records did not fully reflect people's needs and preferences. Records confirmed care plans were reviewed on a monthly basis. However, they lacked essential detail regarding people's needs and how individual needs should be met. An example being one person's care file had a cognitive care plan which advised staff they could get very confused, muddled in communication and hallucinate. It did not guide staff what to do if they displayed these characteristics or how this affected them. Another person's care plan had a personal hygiene care plan in place and required assistance of two staff. The care plan did not capture how the person liked to be cared for or how care should be given. Care plans had not been developed to help guide staff on how to manage people's care needs. They were not personalised and did not include enough information on people's likes, dislikes and personal preferences.

Pressure relieving equipment such as pressure mattress's and pressure cushions was available for people to use. The registered manager told us the district nurse team supported the home with grading people pressures sure. They also helped the home by suggesting treatment plans and provided advice. Care records lacked essential detail relating to the management of wound care. We looked at care records for one person with a pressure sore and another for a person who had a wound. We found that although photographs were taken of pressure sores and wounds to monitor the healing process they were not dated and loosely kept together. Photographs did not always state the site of the body wound. Written records regarding wounds lacked essential detail around the healing process. Examples being recorded in one person's notes was "Dressing renewed as per plan" and "Dressing changed as soiled".

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care records evidenced referrals had been made promptly to a range of health professionals when people's needs had changed or they had become unwell. These included district nurses, doctors, specialist nutrition nurses, chiropodist and opticians. The local doctor surgery visited weekly and provided a house surgery. If a person required a GP visit outside of the weekly visit this would be arranged as required. We asked

professionals if they felt the home were responsive in making referrals. Comments included "The staff contact me if they need advice for tube or stoma management, and also if they have any concerns about a patient's weight/intake. Weight/intake issues I refer on to the managing dietician. Any recommendations I make are acted upon by staff and they will refer back to me if needed", "The nurses and staff are responsive and will call me for advice or if they would like a person seen".

The provider had a complaints policy and procedure in place and people were made aware of this when they moved into the home. Records confirmed complaints had been investigated by the registered manager or operations manager in accordance with the homes complaints policy. People we spoke with knew who they needed to talk to if they had any issues or concerns. People told us that they would feel comfortable raising any concerns they might have about the care provided.

People were offered a range of activities and the activities programme was displayed on noticeboards in both lounges of the home. An activities coordinator was employed to help meet the social needs of people who lived at the home. We observed people taking part in arts and crafts which involved making jewellery boxes. These sessions were well attended by people. People were engaged in conversation with others and relatives. Other activities included quiz games, reminiscence and going out with staff. We spoke with the activities coordinator who was enthusiastic and told us how involved people were in activities. Records were kept by the activity's coordinator which identified the activity's people took part in and if they refused the reasons why.

Requires Improvement

Our findings

Staff had mixed views when asked if they felt the home was well led. Two staff we spoke with felt morale at the home was low and that they did not feel valued by management of the home. Three staff spoke positively about working at the home. Comments included, "I am happy working at the home and enjoy my job. I like to know I have tried my best each day" and "I work with a very good staff team who help each other. The registered manager will help us when needed".

Although the registered manager was aware when notifications of events had to be sent in to CQC there had been two occasions when this has not been done. A notification is information about important events that have happened in the service and which the home is required by law to tell us about. On 29 November 2016 one person was taken to hospital and required hospital treatment after a fall at the home. On 21 December 2016 another person had fallen at the home and required treatment at the hospital. Both incidents were reportable to the CQC. The registered manager had failed to submit a notification of serious injury to the CQC.

This was a breach of Regulation 18 Notification of other incidents Health and Social Care Act 2008 (Registration) Regulations 2009.

There were various systems in place to ensure that the home was reviewed and audited to monitor the quality of the service provided relating to people care. The home had a programme of audits and quality checks and these were shared out between the registered manager and an auditor who worked at the home. Audits relating the management of medicines, nutrition and care records were completed on a monthly basis.

However effective audits had not been untaken of the building in relation to repairs and decoration. We found areas of the home were in need of redecoration and repair. Flooring in many areas of the home were in need of replacement. For example downstairs outside of the manager's office the flooring had large areas which were faded and discoloured. Some parts of flooring had started to become unstuck and tape had been used to prevent people from falling or tripping. Parts of the building looked tired and did not appear homely for example paint work within corridors and toilets and doors within the home. Some bedrooms were in need of decoration. For example one person's room had a previous water leak that had been rectified and repaired however it had not been repainted.

Other audits undertaken had not been effective as we had identified areas that require improvement that

were not picked up. This was in relation to the use of bedrails, pressure mattress's, MCA documentation, care plans and the monitoring of the home. The operation manager told us they were supporting the registered manager and visiting weekly. On the second day of the inspection the operations manager put together an action plan of areas they planned to work on. This was useful information however it did not identify the specific areas that required improvement, changes needed or any timescales.

This meant the registered manager had failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity.

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

Information was communicated to staff through handovers and at staff meetings. The registered manager told us they recognised staff achievements through holding employee of the month award. Staff were nominated to achieve this because of something they have achieved or by a compliment made about them. One member of staff who had received an award told us it made them feel valued and gave them recognition for the work they carried out. They said It reassured them they were doing a good job that was appreciated.

The registered manager said they felt supported by the provider. The registered manager said the provider was always at the end of a phone for advice and support. An operations manager was employed by the provider to support the home and visited several times each month. A registered manager from another home also visited the home with the operations manager. We were told care plans were being revamped and updated and they were supporting the registered manager to implement these changes.

People, their relatives and staff were asked for feedback through surveys and both formal and informal meetings. Minutes of resident forum meetings were distributed so that people had access to them. Action was taken as a result of the feedback received. For example, people ideas were implemented into the activities and entertainment programme. This showed that people were empowered to voice their opinions and could be confident they would be listened to and appropriate actions would be taken to improve the home. Next of kin meetings had taken place with relatives. The operations manager said they hoped with encouragement more relatives would attend in the future to enhance communication.

All accidents and incidents were analysed monthly by the registered manager. The operations manager visited the home regularly and was made aware of any trends picked up in relations to falls. The registered manager followed up on each accident report and analysed what may have caused each person to fall so that preventative action could be taken.

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 18 Registration Regulations 2009 Notifications of other incidents The registered manager had failed to submit notifications to the CQC as required by law. Regulation 18 (2).

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 Care plans were not person centred and did not advise staff of how people's needs should be met. They lacked essential detail. Regulation 9 (1) (a)(b)(c)

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 People were not being assessed in relation to their mental capacity to make decisions. 11 (1) (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment

Diagnostic and screening procedures Treatment of disease, disorder or injury	Equipment used for providing care or treatment to people was not always safe or used in a safe way. This meant the risks to the health and safety of people of receiving care or treatment had not always been considered. 12. (2) (a), (e).

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 manager had failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. Regulation 17 (2) (a).