Care Quality Commission

Diva Care Limited

Hyperion House

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?	Requires Improvement
Is the service responsive?	Inadequate
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place on 15 July 2015 and was unannounced. Hyperion House provides accommodation for 45 people who require nursing and personal care. 39 people were living in the home at the time of our inspection. Some of the people living in the home had been diagnosed with a type of dementia and others had limited mobility. This service was last inspected in May 2014 when it met all the legal requirements associated with the Health and Social Care Act 2008.

Hyperion House is mainly set over two floors which are accessible by stairs or a lift. The home has a main lounge with an adjoining large conservatory and a dining room. People had access to a private secure back garden.

A registered manager was in place as required by their conditions of registration. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2014 and associated regulations about how the service is run.

We found a number of 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.

People and their relatives gave us mixed comments about the quality of care at Hyperion House. People told us they were bored and staff did not have time to spend any social time with them. Limited activities were available but they were not planned around people's individual interests and preferences. People's needs and risks had not been thoroughly assessed and documented. Their preferences and consent to care had not always been recorded. Home cooked food was provided but people were not always provided with adequate support to ensure they had sufficient food and drinks. Risks assessments for people who had been identified as being at risk were not always completed thoroughly. People's care records did not give staff adequate guidance and support to ensure people's needs were fully met. People's medicines were not managed effectively. There was no comprehensive system to manage people's medicinal creams and pain relief.

People were at risk of cross contamination as good infection control practices and management were not in place. The home's environment did not support people with dementia and help to orientate them to overcome their lack of memory. We have made a recommendation about creating a home environment which supports people living with dementia.

Formal support and training for staff was not effectively managed and monitored to ensure people were being cared for by staff with the appropriate skills. Staff were knowledgeable about recognising the signs of abuse. They knew people well enough to understand their preferences; however they were not all familiar with the Mental Capacity Act 2005 and their legal responsibility on how to support people who lacked capacity. Some people's mental capacity to make day to day or significant decisions had been assessed or recorded but the records were not clear.

There were sufficient numbers of staff to meet people needs although people and relatives felt staff levels needed to increase as they were not always available immediately or able to spend time with people socially.

The registered manager had an 'open door' policy but they had not actively sought feedback from people and their relatives about their experiences of living in Hyperion House. Some quality assurance audits were carried out by the registered manager; however there were no quality audits carried out by the provider. Although the provider had an action plan in place to make improvements to the home.

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

This service was not safe.

People's individual risks had not been thoroughly identified and assessed according to their needs. The cleanliness and maintenance of the home had not been adequately monitored.

People's medicines were not always effectively managed and stored.

Staffing levels did not always meet the needs of people.

Staff were suitably recruited and were knowledgeable about protecting people from abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

People were being cared for by staff who had not been frequently trained or formally supported to meet their needs.

Whilst staff supported people to make decisions about their care, they did not always understand the concept and principles of the Mental Capacity Act and how this impacted people.

People's dietary needs and choices were catered for, although this was not fully recorded. People's fluid intake was not monitored in hot weather.

People were referred to the appropriate health care professionals if their needs changed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Whilst staff interactions were mainly caring when helping people with personal care, there was little social interaction between people and staff.

People's dignity and privacy was not always respected.

Staff did not always attend to people's immediate needs which caused them stress. The communication needs of people with dementia were not fully understood by staff.

People and their relatives gave mixed comments about the approach of staff, some felt some staff were more caring than others.

Is the service responsive?

Inadequate

The service not responsive.

People's care needs were not always assessed, recorded and met. There was limited recorded guidance on how people should be supported.

Summary of findings

Activities were not centred on people's social interests and wishes.

Relatives told us their concerns were listened to by staff and acted on.

Is the service well-led?

Requires Improvement

The service was not well-led.

There was no effective system to monitor the quality of care and treatment being delivered. Feedback about people's experiences of living in the home was not actively gained. Action plans had been produced to address the refurbishment of the home but did not reflect the needs of people living in the home with dementia.

Significant events and incidents were not always communicated with CQC in a timely manner.

The culture of the home was not always focused on the needs of individual people.

Hyperion House

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 2014, 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 15 July 2015 and was unannounced. The inspection was led by an inspector and accompanied by a second inspector and an expert by experience. An expert by experience is a person who has personal experience of caring for older people. We carried out this inspection as we had received concerns about the quality of care being provided.

Before the inspection we reviewed the information we held about the service as well as statutory notifications. Statutory notifications are information the provider is legally required to send us about significant events.

We spent time walking around the home and observing how staff interacted with people. The majority of people living at Hyperion House were unable to communicate their experience of living at the home in detail as they were living with dementia; however we were able to speak with three people.

We also spoke with seven relatives, six members of staff and the registered manager. We looked at the care records of five people. We looked at staff files including recruitment procedures and the training and development of staff. We checked the latest records concerning complaints and concerns, safeguarding incidents, accident and incident reports and the management of the home.

Requires Improvement

Is the service safe?

Our findings

People were protected from abuse because the staff had been provided with training on how to recognise abuse and how to report allegations and incidents of abuse. However people's risks were not effectively assessed and managed. Most people had rails fitted around their bed to prevent them from falling out of bed. Whilst the bed rails were checked regularly, we found that some rails were incorrectly positioned and fitted and not always covered with a protected suitable bumper to ensure people remained safe in their beds. There was no system in place to check the setting of pressure relieving mattresses for those people who were at risk of pressure ulcers. An incorrect setting of pressure mattresses increases the risk of people acquiring skin damage.

Records of people's risk assessments were not thorough or adequately detailed to give staff guidance on how to support people to reduce their individual risks. People's risks were not regularly reviewed or reflected across their care records. Fire risk assessments were in place for each person. Staff knew what immediate actions to take in the event of a fire but needed to refer to the fire risk assessments on how to individual support people.

People were not always protected from the risk of infection as the maintenance, cleaning and up keep of the home's environment and equipment had not been maintained adequately. Some bathrooms had cracked sealant around the utilities, woodwork was chipped and some tiles were cracked. This meant that micro-organisms could harbour within the surfaces and increase the risk of infection to people. Some equipment to assist people with their personal hygiene, toileting and transfer needs was rusty and corroded, as were some brackets in the bathrooms. Adequate cleaning of people's bedrooms, beds, armchairs and medical equipment was not carried out and monitored, although cleaning records stated that rooms had been cleaned. A cleaning schedule was in place for most rooms with specific cleaning tasks to be carried out. Completed records showed that these tasks were not always carried out.

Adequate resources were not in place to reduce the risk of infection. For example, there was sharing of equipment such as slings. There were poor hand washing facilities and equipment in some rooms. The sluice did not provide staff with the opportunity to comply with good hand washing techniques as there was no soap or hand drying facilities available. Toilet brushes in most bathrooms were dirty and were not raised off the floor. Toiletries were not labelled for those people who shared bedrooms and therefore there was a risk of cross contamination if toiletries were used by a different person.

Carpets and some pieces of furniture and chairs were heavily stained. One person rested their legs on a torn footrest. The provider shared with us a refurbishment programme of the home but no timescales for the completion of this work was in place.

Most people's oral medicines were managed adequately however there were no systems to manage or store people's medicinal creams. The care records of people who required creams to be applied for medical purposes did not provide staff with adequate guidance of the application required. Some creams were not stored appropriately and had exceeded their expiry date. Other creams had not been dated when opened as recommended with current guidance. In some cases, there was an excessive stock of some people's creams and staff were unsure of which cream was in current use. Some people's creams were not being applied according to their prescription. For example, records showed one person had not had cream applied to their scalp for over a month although the prescription stated it should be applied twice a day.

The registered manager was not able to evidence that people's homely remedies had been approved by their GP prior to their use. There was no monitoring of the stock levels of people's homely remedies.

People's medicines were not regularly reviewed. For example, one person had refused a specific medicine for two months. There was no record that this had been reported to their GP. Regular reviews of people who needed medicines when required such as pain relief were not carried out, therefore staff were unable to determine if these medicines were still effective.

Since our inspection the registered manager has subsequently implemented some systems to address the above issues; however we have not been able to assess whether these new systems have been effective and have improved the quality of care provided.

Requires Improvement

Is the service safe?

Therefore people were not always protected from infection and their risks and medicines were not always managed in a safe way. **This is breach of Regulation 12, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

We observed people's practical support needs being met. Most staff told us that the home was generally well staffed. Staff rotas showed that most days the desired staffing levels were achieved. However people and relatives felt that staffing levels could be better. One relative who was looking for a staff member said, "They don't always come very quickly." Another person said, "Staff are good but they don't have time for conversation." Relatives told us staff did their best but they were always very busy. They were mainly concerned that people were not taken to the toilet in time and did not have to time to socialise with people.

Whilst people were left with call bells; there was no system in place to describe how frequently people who stayed in their bedrooms should be monitored. One staff member said, "We pop in to see them as we go by or when we can."

People were protected from staff who may be unsuitable to care for them. Generally, there were safe recruitment systems in place to ensure that suitable staff were employed to support people. However, the registered manager had not been consistent in evidencing that full Disclosure Barring Scheme (DBS) checks had been carried out although they had received confirmation from the DBS authority that initial checks had been completed. We were told that new staff were initially observed and supervised to ensure they were competent to start their role. A new system has now been implemented to ensure the registered manager has copies of staff's DBS certificates.

Requires Improvement

Is the service effective?

Our findings

People's needs were not always appropriately recognised or met because staff had not received effective support and training to gain appropriate knowledge and skills. Although most staff had received some training deemed as mandatory by the provider such as safeguarding and moving and handling; this knowledge was not always embedded into their care practices. For example, most staff had attended courses in dementia awareness but we observed staff did not always support people who had dementia or shouted out or who required additional attention, in an appropriate manner. Some staff had not received all their required training such as first aid, health and safety and Mental Capacity Act. Nurses had not received relevant update training in clinical practices. This meant that not all staff had current knowledge to carry out their role and their competency skills were not always monitored.

Staff told us they felt supported by the staff team and the registered manager however they had not received regular formal individual support meetings in line with the provider's policy. Where poor practice had been identified, the registered manager had met with staff and addressed the relevant issue. The registered manager met with staff to carry out an appraisal about their personal development however most staffs appraisal meetings were now overdue.

Staff did not always have the skills and knowledge to care for people. **This is a breach of Regulation 18, Health and Social care Act 2008 (Regulated Activities) Regulations 2014.**

The registered manager told us that a programme was in place to provide staff with additional training in person centred care and equality training in the future. They had supported staff to undertake a national vocational qualification in health and social care. The registered manager was aware of the new care certificate guidance and was implementing it within their induction training regime. The care certificate gives providers clear learning outcomes, competences and standards of care that will be expected from staff.

The majority of people had 'do not resuscitate' documents in place on their care records. The completed documents were not compliant with legal guidance. For example, they did not include a reason for the decision to 'do not resuscitate' or whether the person or significant other people had been involved in this decision.

Staff were not always clear about the principles and concept of the Mental Capacity Act (MCA) and the associated Deprivation of Liberty Safeguards (DoLS) The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely.

Staff were able to tell us how they supported people who had limited mental capacity to make day to day decisions. For example, people choose to stay in their bedrooms or what they would like to wear. However, staff were unable to describe the process of how they would support a person to make a specific decision about their life. Although some people's electronic care records included an assessment of their mental capacity when needed; the assessments were unclear and did not obviously relate to specific decisions. There was no documentation that people or significant others had agreed to their care and treatment or the implementation of certain restrictive equipment such as bed rails or consent to photographs. Not all staff had received up to date training in Mental Capacity Act (MCA) and the associated Deprivation of Liberty Safeguards (DoLS).

Staff did not fully understand the principles and concept of the Mental Capacity Act and how this impacted on the right of people to make decisions about their care. **This is a breach of Regulation 11, Health and Social care Act 2008 (Regulated Activities) Regulations 2014.**

The majority of people ate their food on individual tables in the lounge or sat on small group tables in the dining room. The space in the dining room was narrow and restricted due to the storage of equipment around parts of the room. People were mainly supported to maintain a healthy and well balanced diet. Staff knew people well and knew people's preferences and choices in their meals. People who spoke with us said they enjoyed the food provided on the whole. They were asked to choose their meals the day

Requires Improvement

Is the service effective?

before with the help of an album of photographs of the relevant meals. All meals were homemade and cooked on site. Staff told us they would provide alternative meals if the person disliked the meal that was offered such as jacket potatoes. People with specific dietary needs and preferences were catered for; however the details of people's food likes, dislikes and dietary needs were not recorded comprehensively.

Most people who were independent in eating were left to eat without interaction from staff. Staff supported people who were unable to feed themselves. However, staff did not always offer people a choice of drinks or prompt or support people to eat or drink if they were having difficulties.

During our inspection, the home was warm due to the weather. Whilst jugs of juice were available on the side board, people were not offered additional drinks other than at the set times. People were not always woken for a drink when they had fallen asleep. We were told that people's fluid and food intake was not monitored unless people had been identified as being at risk.

Where people's needs had changed the service had made appropriate referrals to other health and social care professionals for advice and support. The home had good contacts with the local surgery and the GPs visited regularly to review the needs of people.

Requires Improvement

Is the service caring?

Our findings

Most people were mainly happy living at Hyperion House but some people described some staff as not always being concerned as they were busy. For example, one person told us they had been ignored by a staff member when they had told them they had felt sick on the day of inspection. They told us they had been sick and had to sit with a mouthful of bile until eventually a bowl had been brought to them. They said, "Staff do not care, I am paying for this and I just get neglected, surely when you are in a nursing home you expect to be treated with care and respect. It is frightening, no one was interested and when I complained they said they were very busy."

We received mixed views from people and their relatives about the care and support they received from staff. People told us, "It's alright" and "Yes, it's nice"; however another person said, "I don't think they (staff) are brilliant but they are not too bad. They are under a lot of pressure and over worked." Relatives said comments such as, "I'm reasonably happy" and "I think the staff are good but they are run ragged sometimes."

We observed staff interacting with people throughout our inspection. Most people sat in the lounge or dining room throughout the day. Whilst the staff approach was mainly caring and kind, most interaction was limited to supporting people with their practical needs and they did not always recognise people's emotional needs. People who sat quietly were not approached by staff unless they called out and needed some assistance. A member of staff was observed talking negatively about a person to another member of staff, over other people's heads in the lounge and said "She's got it on today 'cause she wants a dog."

Whilst staff personal interactions with people were mainly respectful and dignified, we found people's dignity was not always promoted throughout the home. For example, communal clothing was stored in the laundry room which indicated that the home that did not have adequate systems to ensure people always wore their own clothes.

Relatives confirmed that people did not always wear their own clothes. People's care records did not provide staff with guidance on how to support people with their personal hygiene in a dignified and respectful way when they shared rooms with another person. Some bedrooms did not have their own screening equipment to give people privacy when they received support with their personal care.

However, we did observe some good examples of staff being caring and respectful. For example, we saw staff gently reassuring people when they required support with a hot drink. One staff member who supported one person said, "How is that. Are you OK? It might be a little bit hot, have a little taste first." Staff supported this person until they were safe to manage their hot drink independently.

Some people were known to call out when they became distressed or frustrated. Whilst we saw staff react and reassure people, they did not explore other strategies other than verbal assurance which had limited impact. People's care records did not give staff appropriate guidance about the approach they should take when reassuring people. For example, one person's care record stated staff should tell a person that their aggressive behaviour was not acceptable. This demonstrates that staff did not have a clear understanding on how to respectfully care and support people with dementia or cognitive impairments.

Some people's care records stated that they should be assisted to the toilet at prescribed times of the day. Whilst most people told us they were taken to the toilet when needed, a relative told us that 'toileting as one of the biggest issues' in the home. They went on to tell us they had heard people cry out because they wanted to go to the toilet and there was no staff about.

People did not always receive care and treatment that was centred on their needs. **This is a breach of Regulation 9, Health and Social care Act 2008 (Regulated Activities) Regulations 2014.**

Inadequate

Is the service responsive?

Our findings

People's care and support was not always personalised to them. Their care assessments had not always taken into account their social, emotional needs and preferences. There was limited information held about people's backgrounds and their personal interests and preferred social activities. People spent most of their day resting or sleeping in the lounge or sitting in arm chairs in the dining room. Limited activities in the home were provided by all the staff. We observed a short chair based activity in the lounge which only involved five people in the morning. In the afternoon, people were brought to the main lounge to watch an external company who showed them various small animals and reptiles. The registered manager told us they had various external entertainers who visited the home throughout the year.

Activities did not appear to be adapted to meet people's physical/sensory needs or for those people with dementia. There was little social interaction and recreational opportunities for people who stayed in their bedrooms. Several people and their relatives told us they felt lonely and bored. One person said, "I am very lonely; feel very isolated quite honestly it's affecting my nerves. There isn't anything to do. The telly is on all the time but I can't hear it very well. There is nobody to talk to apart from one other resident." Relatives told us that when activities were provided they were always in groups and based in the home and there were no opportunities to go out in the community.

People's personal hygiene preferences were not always met. There were limited opportunities for people to have a regular bath or shower in line with their personal care needs or desires. A list identified which people should be offered a bath on a specific day of the week but there was no audit in place to ensure that it happened in practice. One relative stated that they felt that their loved one 'needs a bath more'. This person's care records stated they last had a bath more than two months ago. Another person told us they had not been offered a bath since moving into the home a week ago and consequently had spent an hour at the sink each day giving themselves a full wash. The registered manager and provider reported that the limited size of the bathrooms caused a logistics problem although a larger bathroom and wet rooms were available but unused on the day of our inspection.

People's personal and social needs and preferences were not always assessed or met**. This is a breach of Regulation 9, Health and Social care Act 2008 (Regulated Activities) Regulations 2014.**

People's care records were inconsistent and did not give staff the guidance they required to support and care for people. People's physical needs and assessments were recorded on an electronic care planning system; however they were not always centred on people's physical as well as their emotional and social needs. The electronic care planning system was difficult to follow and did not provide the reader with an easy overview of each person. Additional paper files including people's medical information were held in the treatment room. Some care records had not been individualised and were often pre-formatted and generic documents. For example, we saw records that stated 'if (name of person) uses pads then change the pads if used.' We were told that the electronic care planning system 'flagged up' when people's care plans needed to be reviewed. However there was no evidence that people or their relatives were either involved or consulted about their treatment plans or their review.

People's care records did not reflect their experience of living in Hyperion House. Some people shared bedrooms; however their care records did not reflect how staff should support people with their personal needs in a shared room or whether people had consented to this arrangement. Their personal preferences and levels of independence were not always documented.

Records of people's risk assessments had not been completed and maintained effectively to give staff clear guidance on how to reduce risks for people. For example, there were no records of pain assessment or pain care plans when people had reported to be in pain. A continence care plan for one person who required a catheter only stated how to empty the urine. It did not provide staff with guidance on when the catheter needed changing, what to do in the event of a blockage or how to reduce trauma to the urinary tract. When asked, the nurse in charge did not know when the catheter should be changed.

There was a high incident of people who had acquired skin wounds such as a tear or ulcer. The reasons for these wounds were not always clear or recorded. Skin wound care plans were not in place and therefore there was no recording of the assessment, treatment plan and

Inadequate

Is the service responsive?

monitoring of people's wounds. Some people's wounds had been photographed but were not dated or named. The home's recordings of the treatment and grading of the ulcers were inconsistent. Recording of when treatment had occurred to the wounds did not always give staff a clear clinical understanding of the status of the wound or required actions. People's treatment records when they were being cared for by external health care professional such as a district nurse were limited. This meant there was no clear documentation of people's progress in their well-being or recommended treatment.

People's care records did not accurately reflect the assessment and progress of their care needs, risks and treatment. **This is a breach of Regulation 17, Health and Social care Act 2008 (Regulated Activities) Regulations 2014.**

The registered manager told us they had not recently received any formal complaints and they dealt with day to day concerns immediately. The registered manager said, "We very much have an open door policy here. Staff, residents and their relatives can always pop in for a chat." People and their relatives told they felt they could raise their concerns with staff if they had a problem.

Requires Improvement

Is the service well-led?

Our findings

The provider's representative or registered manager did not have effective systems in place to monitor the quality of care and service that people received. For example, there were no systems in place to effectively monitor people who had been identified as being at risk of pressure ulcers. The registered manager did not monitor the call bell system to identify if there were any patterns in the frequency of people using the call bells. No clear system was in place to monitor the quality of people's records and whether they reflected people's needs. The registered manager has subsequently implemented some systems to monitor the quality of service; however we have not been able to assess whether these new systems have been effective and have improved the quality of care provided.

Other monitoring systems such as fire safety checks and regular servicing of the hoist and slings were in place. The staff member responsible for maintenance carried out regular checks on equipment and the home's utilities. However, there were unclear guidelines of the expected standards. For example, the home's water temperatures were regularly recorded but there were no acceptable parameters to provide staff with guidance. Standard measurements for the position of people's bedrails were not being used. Electric fans being used to cool down the communal rooms had not been safety tested in accordance to guidance. Accident and incidents had been reported and recorded. The registered manager had reviewed these reports and had implemented changes where needed and shared any learning from these incidents with staff.

No current systems were in place to capture the views of people and relatives about their experiences of living in Hyperion House. We were told resident and relatives meetings were poorly attended and therefore infrequently held. Feedback from staff and other health care professionals visiting the home had not been sought.

Effective governance including assurance and auditing systems were not always in place. **This is a breach of Regulation 17, Health and Social care Act 2008 (Regulated Activities) Regulations 2014.**

The registered manager had run the home for many years and was supported by an administrator and senior staff. We were told that the culture of the home was open and centred around people's needs however we found that not all significant incidents or events that affected the service or people had been reported to us or always done in a timely way. For example, the registered manager was unaware of the grade of some people's pressure ulcers which should have been reported to us. The registered manager and staff did not have a clear understanding of person centred care and how people's dementia and cognitive impairments may affect their behaviour. People's care records were focused around people's physical needs. Staff and care records referred to some people as being 'aggressive and challenging behaviour'. There was no evidence to demonstrate that staff had tried to understand or interpret the reasons for people's behaviour. This was not being monitored or addressed by the registered manager or the provider.

The registered manager had an 'open door policy' which was demonstrated during our inspection as staff were comfortable in seeking advice from senior staff and the registered manager. However, staff were unclear about the values and ethos of the home. One staff member said, "We do the best we can each day; we hear there is going to be change but we don't see a lot of difference."

The registered manager sent weekly management reports to the provider about occupancy and staffing levels and other events such as maintenance or regulatory issues. We were told that a representative from the provider visited the home regularly and was in continual contact with the registered manager. They carried out a 'walk around' assessment to monitor the home's environment. Due to the age of the building some rooms such as the small bathrooms were not accessible to all people. Following our inspection we were sent a copy of an action plan which addressed the redecoration and refurbishment of the home's environment. A programme was in place to upgrade the home and we were told of major works being carried out to the building such as installing a new boiler to deal with the inconsistent water temperatures around the home and a new kitchen floor.

Whilst the action plan addressed major works and issues such as replacing the flooring and lighting, it did not consider or reflect the environmental needs of people who live with dementia and other sensory and physical impairments.

We recommend that the service considers current guidance on dementia friendly environments.

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	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People did not always receive care and treatment that was centred on their needs. People's personal and social needs and preferences were not always assessed or met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Staff did not fully understand the principles and concept of the Mental Capacity Act and how this impacted on the right of people to make decisions about their care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not always protected from infection and their risks and medicines were not always managed in a safe way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People's care records did not accurately reflect the assessment and progress of their care needs, risks and treatment. Effective governance including assurance and auditing systems were not always in place.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff did not always have the skills and knowledge to care for people.