Risedale Rest Home Limited

# Risedale Rest Home Limited

## Inspection report

52-56 Percy Road
Whitley Bay
Tyne and Wear
NE26 2AY

Tel: 01912527262

Date of inspection visit:
16 May 2017
23 May 2017

Date of publication:
21 August 2017

## 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 16 and 23 May 2017 and was unannounced. We last inspected the service on 6 and 7 May 2015 and found the provider was meeting the regulations we inspected against.

Risedale Rest Home provides residential care for up to 17 people. Most of the people who are cared for at the home are older people, and some people who use the service have mental health needs. At the time of our visit there were 11 people living at the home.

The home had a registered manager who had been unexpectedly absent from the home since April 2017. 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.

During this inspection we found the provider had breached the regulations relating to safe care and treatment; person-centred care; staffing and good governance. In particular, we found the provider had not been effective in assessing risks to people's wellbeing and safety. The provider had also not ensured risks posed to people and others were managed appropriately.

Due to the registered manager's absence from their post there was a lack of leadership and management in the home. The interim management arrangements were unclear and many aspects of the home had lapsed. This included essential training, supervision, appraisals, meetings for people and staff and some quality assurance checks. Staff were also unable to locate important information we required to provide assurances the building was safe, such as electrical and gas safety checks and an up to date fire risk assessment.

The provider was unable to evidence there were sufficient staff on duty to meet people's needs in a timely manner. Staff told us staffing levels were insufficient and people gave mixed views about there being enough staff.

Care plans were not personalised and lacked sufficient detail to accurately describe the care and support people required. Two people who moved to the home in March 2017 did not have care plans in place when we inspected.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible; the policies and systems in the service do not support this practice. We have made a recommendation about this.

People and relatives said the care provided at the home was good. People said staff were caring and treated them respectfully. They also said they felt safe living at the home.

Records confirmed medicines were administered by trained and competent staff. People and relatives told us they received their medicines in a timely manner.

Staff had a good understanding of safeguarding including how to report concerns. Previous safeguarding alerts had been referred to the local authority safeguarding team and investigated in line with expectations.

Incidents and accidents were logged, investigated and analysed to ensure appropriate action was taken to keep people safe.

People were supported to have enough to eat and drink in line with people's needs. Relatives told us staff supported people to access health care when required and they were kept informed.

People had opportunities to take part in activities in the home, such as bingo, cards, dominoes, quizzes, exercise sessions, sing-alongs and a Sunday church service.

People did not raise any complaints with us but knew how to do so if needed. The provider had not received any complaints about the home.

The provider was in the process of looking to employ an interim manager for the home. Shortly after our visit they confirmed they had employed an experienced manager to oversee the home during the registered manager's absence.

Relatives said the home had a welcoming and friendly atmosphere.

The provider received positive feedback from people, staff and health professionals during the most recent consultation in August 2016.

## 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.

The provider did not have effective systems to assess and manage risks to people's wellbeing and safety.

Evidence was not available to confirm some important health and safety checks had been carried out.

People and staff said staffing levels were insufficient to ensure people's needs were fully met. However, people said they felt safe living at the home.

Medicines were administered appropriately.

Staff had a good understanding of safeguarding including how to report concerns.

Incidents and accidents were logged, investigated and analysed.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Staff had not received all of the training, supervisions and appraisals they needed.

The provider was not fully compliant with the Mental Capacity Act (2005).

People were supported to meet their nutrition and healthcare needs.

### Is the service caring?

**Good**

The service was caring.

People and relatives told us staff provided good care.

Staff were kind, caring and considerate.

People were treated with dignity and respect and were

supported to be as independent as possible.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Care plans were not personalised or detailed enough. Two people did not have any care plans in place when we inspected.

People did not always have opportunities to access the local community when they wanted.

People had opportunities to take part in activities in the home.

People knew how to complain if they were unhappy with their care. The provider had not received any complaints.

## Is the service well-led?

**Requires Improvement**

The service was not always well led.

The registered manager was absent from the home. The interim management arrangements were unclear and lacked structure.

There was no evidence available to show how the owners of the home monitored quality and safety.

Relatives said the home had a welcoming and friendly atmosphere.

The provider received positive feedback following the most recent consultation with people, staff and health professionals.

# Risedale Rest Home Limited

**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 16 and 23 May 2017 and was unannounced.

One inspector and an expert-by-experience carried out this inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the home. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. We also contacted the local authority commissioners of the service, the clinical commissioning group (CCG) and the local Health Watch.

The provider completed a provider information return (PIR) prior to the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with nine people and two relatives. We also spoke with the owner, the deputy manager, a senior care worker and a care worker. We looked at a range of records which included the care records for five people, medicines records, recruitment records for five care workers and other records relating to the management of the service.

Requires Improvement

# Is the service safe?

## Our findings

The provider did not have an effective approach to the identification and management of risks to people's safety and wellbeing. We reviewed the care records for one person who had recently moved into the home. The information received from the referring agency stated the person had a long history of behaviours that challenged and aggression. We found no evidence that an initial assessment had been completed prior to the person moving into the home to check that staff could meet their needs. The owner told us this had been completed and a phased transition into the home had taken place. However, this was not evidenced in the care records presented to us. There was also no pre-assessment for a second person who moved into the home in March 2017. A staff member commented, "[Person] should have had a pre-assessment but where that is I don't know."

We also found there had been no risk assessments carried out to ensure the person, other people living at the service and staff were safe. Furthermore, the person's mental health care plan stated staff should observe and be aware of signs of a decline in the person's mental health. However, the care plan did not describe what these signs were, the most effective strategies to support the person and when to contact health professionals for assistance. Another person had moved into the home in March 2017 with known care needs relating to skin care. We found the person's care plan contained a blank skin integrity assessment and no care plans had been written at the time of our inspection in May 2017. We also saw blank assessment documents in the person's care records relating to falls, nutrition and moving and handling. This showed the provider had not completed assessments intended to identify and mitigate potential risks to people's wellbeing.

The provider did not have clear guidance in place to help staff make appropriate decisions about when to administer 'when required' medicines. For example, one person had been prescribed a 'when required' medicine to help with managing agitation. We found there was no written guidance to help staff identify the signs and triggers the person may need this medicine.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

Staff told us staffing levels were currently insufficient to ensure people's safety. They said this was due to the registered manager currently being absent from the home. Staff members told us some people required two to one support which meant that when these people required assistance other people were sometimes left unsupervised. They also said that there were fewer opportunities at the moment for people to go out with support. One staff member said, "We could do with another member of staff. [Person] buzzes ten times a day and we have to see to [person]. We need another person on the floor. This has been brought up on a number of occasions. Everybody gets on really well but we do need an extra pair of hands."

We found staffing levels had last been reviewed in October 2016 using a recognised staffing and dependency tool. At this time the tool indicated staffing levels were adequate. However, staff told us that the registered manager would offer support to supervise people when staff were providing personal care or supporting

people in the community. This support was not currently available as the registered manager was absent from the home. We found no evidence to show the owner had reviewed the current staffing levels to ensure there were enough staff on duty to meet people's needs effectively.

Although people and relatives said they were usually enough staff on duty, they gave mixed views about how quickly staff responded to their requests for assistance. One person told us, "Yes quite prompt." Another person said, "They come quickly." A third person commented, "I have used it once accidentally, they came quite quickly." A fourth person said, "I ring the bell, a few minutes, they come in a reasonable amount of time." However, less positive comments included: "Sometimes they are quicker than others"; "Come slowly"; and, "Alarm bells ring a long time before being answered" One relative said, "Yes (enough staff) as they always keep us informed when we come through the door." Another relative told us, "Yes, when we visit and she rings the bell, they come the response is good."

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

People and relatives said the home was safe. They also said they would be happy raising any concerns or worries if required. One person said, "I feel safe here." Another person commented, "Yes (safe), it is very nice and staff are very very helpful." A third person told us, "Everything is alright, I feel safe. I have been here ten years."

Staff also felt people were safe. One staff member commented, "Yes I do (think people are safe). Staff are watching people all the time." Another staff member said, "Yes it is safe. The residents are fine."

Some health and safety checks had been completed in line with the provider's expectations. This included checks of water temperature checks and checks of fire-fighting equipment and emergency lighting.

Medicines were managed appropriately. Medicines administration records (MARs) were completed accurately to account for the medicines people had received from staff. Where medicines had not been administered, a non-administration code had been recorded to explain the reason why. We found medicines were stored appropriately in a locked medicines room. The support people required with managing their prescribed medicines was recorded in people's care plans. Medicines competency assessments were completed every three months to check staff administering medicines had the appropriate skills and knowledge.

People and relatives confirmed they received their medicines when they were due. One person told us, "They are very good (with medicines)." One relative commented, "I have been there when the carer brought a cup with the medication. I said leave it on the corner of the table. The carer said I can't do this, I have to watch [person] take it."

People told us staff treated them equally and fairly. One person commented, "Yes I am (treated equally and fairly), the carers are really nice, if I say I don't want to bother you, they say that's what we here for." Another person told us staff members were "always nice and friendly".

Staff had a good understanding of safeguarding. They could identify various types of abuse and potential warning signs. They also knew how to report any concerns. We viewed the provider's safeguarding log which showed previous safeguarding alerts had been referred to the local authority safeguarding team and investigated. The registered manager had carried out a safeguarding self- assessment of the home to consider any potential risks of abuse occurring in the home. As part of the self- assessment staff competency

assessments had been carried out to check each staff member's understanding of safeguarding.

The provider carried out a range of pre-employment checks before new staff started working with people using the service. This included requesting and receiving references and checks with the disclosure and barring service (DBS). DBS checks are carried out to confirm whether prospective new staff had a criminal record or were barred from working with vulnerable people.

Incidents and accidents were logged and investigated. There had been three accidents recorded in the past 12 months relating to people falling. There had been no serious injuries and appropriate action had been taken in response to these falls. An accident analysis was in place which looked at the type of accident, the nature of any injuries and when they occurred. We saw there were no particular trends or patterns identified from the analysis.

Requires Improvement

# Is the service effective?

## Our findings

Staff had not received the support and training they needed to be effective in their role. For example, moving and handling training was overdue for five out of six staff. Three out of six staff had not completed training on the Mental Capacity Act (MCA) 2005 and a further three staff had not had refresher training on MCA since 2013. One staff member commented, "I have not had that (MCA training). None of the staff employed at the home had completed care plan training.

The provider's 'staff supervision and appraisal policy' dated 1 December 2015 states; 'The care quality commission expect residential care staff have six supervisions, one of which should be an appraisal… Risedale Rest Home will ensure that employees have an annual appraisal of their performance and development needs.' Records confirmed that the provider was not meeting these recommendations. For example, five out eight staff had not had an annual appraisal during 2016. The remaining staff member's appraisal took place on 2 January 2016. Likewise four out of eight staff had not had a formal one to one supervision during 2016. The remaining two staff member's last had a formal supervision in February 2016. Two staff had not received any supervisions or appraisals despite being in post over one year. One staff member told us, "Supervisions were done on a regular basis by [registered manager] but they are off at the moment."

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

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.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The provider had followed the requirements of the MCA in respect of DoLS by ensuring a DoLS authorisation was in place for people lacking capacity to consent to their admission into the home. We also saw MCA assessments and best interest decisions had been made where people were unable to consent to their placement at the home.

However, we found examples of restrictions placed on people without the appropriate documentation to show these decisions had been made in line with the MCA. For example, one person had bedrails in place which prevented them from falling out of bed. Although an assessment considering the potential risks to the

person from having bedrails in place had been completed, there was no evidence that a MCA assessment and best interest decision had been carried out in line with the MCA. For another person the provider was keeping their bank card secure. Although staff told us this was put in place to protect the person's finances, we found there was no record of any assessments involving the person having been completed first.

Although most staff had not completed recent MCA training they demonstrated a good understanding of the individual support each person needed to promote choice and decision making. They told us most people could communicate daily living choices to staff. They described how they would show people items of clothing to choose from based on their preferences. For example, one staff member said, "If I know they like trousers, I hold up trousers. It does sometimes take a while but [person] will point out what they want to wear." Another staff member commented, "We ask people or show them a picture of something (to make a choice).

We recommend the provider researches and follows the Mental Capacity Act code of practice and takes action to update their practice accordingly to ensure decisions for people lacking capacity are only taken following a documented MCA assessment and best interest decision.

Relatives told us they felt staff had the appropriate skills and knowledge. One relative commented, "I have confidence in them."

We observed staff got consent from people before undertaking and care and support. People we spoke with confirmed this was usually the case. One person said, "Oh yes always ask if they have to lift me."

Some people using the service displayed behaviours that challenged others. Although staff members could tell us about the strategies they used to support people when they were agitated, care plans were not detailed enough to describe the most effective strategies for each person.

We observed over lunchtime to help us understand people's dining experience. We saw the menu was displayed on the wall in both written and pictorial formats. People were served their meal without delay. Tables were nicely presented with clean table linen, napkins and flowers. Staff put music on in the background to create a calm and relaxed atmosphere. Most people were independent with eating and drinking. However, where people required assistance this was provided appropriately. Staff ensured people had sufficient to eat. For example, we observed staff asking people if they would like anything more to eat.

We received mixed views about the quality of the meals provided at the home. One person told us, "I have it in my room, it is very nice. I have a menu and they give me a choice. They adjust as I don't like raw onion or gravy. If I say I won't eat that they bring me something else. There is plenty of it" However, one person described the meals as a "basic survival diet". Another person commented there was, "Enough to eat. I never ask for more. It's not the amount of food, it's the variety. Outside of the set mealtimes, we observed people and relatives were offered a choice of tea and coffee during the day.

People and relatives told us they were supported to manage their health care needs. They also told us staff responded quickly and appropriately when they were unwell. Relatives told us they were kept informed about their family member's health. One person commented, "I have seen a dentist here, I have not needed a doctor. I have also seen a podiatrist." Another person said, "They (staff) call the district nurse and the doctor if they are worried about me." A third person told us, "I had a virus. A nurse came and checked my heart and lungs." One relative commented, "The staff keep us informed when we come through the door." [Family member] has seen a doctor and district nurse more times since she has been here. She had changed her GP. The manager organised the transfer."

Good

# Is the service caring?

## Our findings

People told us staff were kind and caring. They went on to confirm staff listened to them and were respectful of their needs and choices. One person said, "No problem with this (being listened to) and pleasant enough staff." Another person told us, "Yes (staff listen) it is good. They are really nice people, they look after me. I feel all relaxed here." A third person commented, "They are really nice. If I say I hope I am not a bother the carers say don't worry that's what we are here for", and, "They are lovely girls I am being well looked after."

People told us they could have one to one time with staff if they wanted it. They also said they did not feel rushed by staff when being supported. We observed throughout our inspection staff chatted and engaged with people. One staff member said, "It is a small home, we can do more one to one with people. We have more time for them. We sit down and have a conversation with people. People are engaged

People told us they were supported to maintain as much independence as possible. One person told us, "I say I will do (wash) my top and they let me do this." One relative said, "They (staff) let [family member] wash herself." Staff told us they aimed to promote people's independence as much as possible. One staff member said, "We give [person] a face cloth and encourage [person]. We encourage [person] to use the handrails to weight bear."

All people we spoke with felt staff respected their dignity and privacy. We saw knocked on people's bedroom doors and requested access before entering. Staff described to us how they adapted their approach to maintain dignity and respect. For example, talking through with people what they were going to do.

Staff had a good understanding of people's needs. The staff we spoke with had worked at the home for a long time and had cared for some people for a number of years. One staff member commented, "The home is small, we know all the residents."

Information was available in most people's care files about any preferences people had. For example, a 'religious preferences sheet' was used to document people's religious preferences and whether they required support to access church or to attend a religious service held in the home. Likewise a 'care preferences sheet' was in place to record people's wishes in respect of their personal care, such as a preferred gender for staff providing their personal care.

Requires Improvement

# Is the service responsive?

## Our findings

Most people using the service had care plans in place. The exception to this was two people who moved into the home in March 2017. For these two people care plans had not been written. When we visited the home for a second day the deputy manager had started writing the care plans. We found care plans generally were not personalised and lacked detailed information about the individual care and support people required. For example, one person was known to experience mental health issues including depression and low mood. We viewed the person's relevant care plan. The only strategy referred to was the use of 'when required' medicine. However, this should be used as a last resort when all other strategies have proven to be ineffective. The care plan lacked details of the most appropriate strategies to support and when it would be appropriate to administer medicine to the person.

Another person's activities care plan stated 'staff to plan suitable activities for [person]. Staff to cater for [person's] dislikes.' The care plan did not go on to identify the best way to engage the person, such as their preferences for activities and any dislikes the person had. Their personal care plan also stated 'staff to encourage [person] to be as independent as possible. Again the care plan did not go on to describe how staff would achieve this aim.

People told us opportunities to access the local community were limited at the moment. Staff we spoke with also confirmed this was the case. Some people needed to access the community to maintain their mental and emotional wellbeing. For example, one person liked to go out with support on a daily basis. Activity records showed that until 21 April 2017 the person went out most days. However, between 22 April 2017 and 12 May 2017 the person had been out on six separate days out of a total of 21 possible days.

One person said, "I play some cards. I would like some magazines. I would like to do more things and I would like to go our more." Another person told us, "There is nothing much to do. I very much like books, only one or two books here. I would like to get out more." One relative said, "The carers do take them out. We saw the carers taking some residents up the road to the shops to get some sweets." We saw staff members playing dominoes and later cards with a person. Staff also told us people were not getting out as often as they would like. One staff member commented, "[Person] will come and tell you he is not getting out as often as can." Another staff member said, "They (people) don't go out as much as they should be. A lot have been complaining about not getting out at the minute. We could probably do with another member of staff during the day for that sort of thing."

This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

There were opportunities available for people to take part in activities in the home. A white board displayed information about the activities planned for each day. Activities included bingo, cards, dominoes, quizzes, exercise sessions, sing-alongs and a Sunday church service. During our inspection we saw some people taking part in activities. One person said, "I like to watch [favourite programme] under the hammer." They were watching this programme at the time. Another person commented, "I do colouring books. We did

painting of Easter eggs and they brought clothes in for me to choose." We observed the person enjoyed knitting and they pointed out their craft box behind the chair. We observed a member of staff showing interest in the knitting and encouraging the person. A third person told us, "I watch TV in the room and the carers ask me if I want to play bingo. A friend from church comes. My [family member's] come in every day. They (carers) bring my visitors a cup of tea." One relative told us, "The lady from the church visits every day."

People and relatives said they would feel comfortable in raising a concern or complaint if necessary. One person said, "There is no need to make a complaint, I would tell them straight if necessary." Another person commented, "Yes I know what to do. I have not made a complaint." There had been no complaints made about the home.

Requires Improvement

# Is the service well-led?

## Our findings

At the time of our inspection the registered manager was absent from their post and had been since April 2017. The interim arrangements at the home were insufficient to provide effective management and leadership. The deputy manager was doing some additional hours. However, this was ad hoc and unstructured. For example, when we arrived at the home the deputy manager was not present at the home and staff were unsure whether they were due in that day. One staff member said, "(Deputy) is supposed to be in doing regular shifts but is never in. There should be somebody else in at the moment."

Due to the absence of a management presence in the home important areas had lapsed. These included essential training and appraisals for staff. We were also unable to locate important information linked to our inspection. For example, the provider was unable to provide us with evidence that some health and safety checks had been completed to ensure the building was a safe for people to live. We asked the provider for compliance certificates to show the electric and gas supplies to the home had been checked and were satisfactory. The owner told us these checks had been carried out but the records were not available to us. We also found the most recent fire risk assessment was dated September 2014. This recommended the next review should be in September 2015. However, the owner was unable to provide us with a more recent assessment.

We found the provider had been pro-active in submitting the required statutory notifications to the Care Quality Commission. However, since the registered manager's absence this had not been the case. For example, notifications in respect of a safeguarding concern and the registered manager's absence had not been submitted. We are dealing with this matter separately outside of the inspection process.

We found no evidence that the owner of the home carried out regular checks of the home to ensure people received safe care. The owners told us they visited the home every day. However, there were no records of the checks that had been undertaken or of the findings from these checks. We viewed a file called 'visits from the provider.' This stated 'all visits are marked on the calendar when the provider has visited the home and has been active in the home, ie interacted with the service users, staff and not office based.' We saw these visits had been marked on a calendar but there were no associated records of what was looked at during the visits. The last documented visit was 29 April 16.

We found the registered manager had been carrying out a range of quality assurance checks prior to their absence from the home. However, some of these had since lapsed. For example, audits looking at health and safety, risk management and infection control due in March 2016 had not been completed.

Meetings for both people using the service and staff had lapsed. These were usually held monthly for people using the service and bi-monthly for staff. However, none had taken place since December 2016.

This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

We discussed management of the home with the owner. They acknowledged our findings and were actively in the process of looking for an interim manager to oversee the home. Following our inspection the owner advised that an experienced registered manager had been employed until permanent management arrangements could be finalised.

The deputy manager had continued with other audits and these were up to date when we inspected. For example, medicines audits and checks of the environment. Medicines audits had been effective in identifying and addressing minor concerns. For instance, cleanliness of the medicines room. An external pharmacy audit had found the home to be compliant with medicines management. This included a review of training, storage, homely remedies and audits.

Relatives described the home as welcoming and friendly. One relative said, "Feels like a family atmosphere." Another relative commented, "It is a small home, we get on with the staff and all are really nice. It is small and friendly." A third relative told us, "They are really nice and welcoming and we know most of the residents."

The provider had carried out a consultation in 2016 to gather views about the home from people, staff and health professionals. Mostly positive feedback had been given. For example, six out of six people said they 'always' felt safe, were treated respectfully, given choices and given the privacy they needed. Where negative feedback was given action had been taken to resolve the issue. For example, one staff member was 'not satisfied' with approaching management with issues relating to the home. The registered manager had spoken with the staff member and provided reassurance.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>People's care was not planned in such a way as to ensure their needs and preferences were met. Some people's needs had not been assessed to determine their needs and preferences.<br>Regulation 9(1)(a), 9(1)(b) and 9(3)(a). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider did not ensure that risks to people's health and safety were assessed and mitigated.<br>Regulation 12(2)(a) and 12(2)(b). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider did not have effective systems in place to monitor and improve the quality of people's care. Systems were also not in place to assess and mitigate risks to people's safety and welfare.<br>Regulation 17(2)(a) and 17(2)(b). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider was unable to evidence there were sufficient numbers of suitable staff |

deployed to meet people's needs fully. Staff did not receive the training, supervision and appraisal they needed to carry out their duties. Regulation 18(1) and 18(2)(a).