Derbyshire County Council

Florence Shipley Residential and Community Care Centre

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: Florence Shipley Residential and Community Care Centre is a residential care home that was registered to provide accommodation for up to 32 people. At the time of our inspection there were 22 people living there. The care home has eight intermediate care beds in the 'Bailey' unit. The aim is to facilitate discharge from acute settings, and to support people to return home, prevent hospital admission, or long-term care. It also has sixteen spaces for longer term care across two units called 'Woodside' and 'Coppice' which are on different floors. They specialise in providing care to people living with dementia. Each of these units has separate communal facilities. A fourth short stay unit which accommodates a further eight people was not open on the day of the inspection visit.

People's experience of using this service:
The overall rating for the service is inadequate and the service will be placed in special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

After the last inspection the provider had provided us with an action plan to manage staffing levels more effectively. At this inspection we found ongoing concerns about the numbers of suitably qualified staff available to meet people's needs during the day and night. Therefore this plan had not been effective.

Risks associated with people's care and support were not always managed safely. This put people at risk of harm from falling, choking and from other people's behaviours. These risks were not always identified or reported to the relevant authorities to safeguard people from abuse.

Staff did not have sufficient training to enable them to provide safe and effective care. People did not always receive enough to drink to maintain their health and specialist diets were not always provided correctly. Relationships with healthcare professionals required improvement to ensure staff in the home were

following established guidelines to support people. People's capacity to make decisions was not always clear. This meant people were not always supported to have maximum choice and control of their lives and staff didn't always support them in the least restrictive way possible.

Staff did not always protect people's privacy and dignity when supporting them. People were not always included in making choices in a meaningful way. They did not consistently receive personalised care that met their needs. People were not always provided with opportunities for meaningful activity.

The provider did not review records regularly or listen effectively to staff to ensure that risks to people's wellbeing were recognised and timely action taken to protect them. Records of people's care and support were not accurate or up to date.

People received their medicines as prescribed. The systems in place to manage risks associated with them were effective. The home was clean and well maintained. There was good signage and accessibility throughout to support people living with dementia. Safe recruitment practices were followed. There were systems in place to respond to complaints.
Rating at last inspection: Rated as Requires Improvement, report published 28 February 2018.

Why we inspected: This was a scheduled inspection based on the rating at the last inspection.

Enforcement: There are six breaches in regulatory requirements. You can see the action we asked the provider to take at the end of the report.

Follow up: Immediately after our inspection, we wrote to the provider and asked them to take urgent action to address the most serious risks outlined in this report . In response, the provider developed an action plan detailing actions taken and planned, to make improvements and reduce risk. Additional resources were also immediately deployed to the service. We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not Safe.

Details are in our Safe findings below.

Is the service effective?

Inadequate

The service was not Effective.

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always Caring.

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always Responsive.

Details are in our Responsive findings below.

Is the service well-led?

Inadequate

The service was not Well Led.

Florence Shipley Residential and Community Care Centre

Detailed findings

Background to this inspection

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

Inspection team:
The inspection was completed by three inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type:
Florence Shipley Residential and Community Care Centre is a care home. People in care homes receive accommodation and personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
The inspection was unannounced.

What we did:
We used information we held about the home which included notifications the provider sent us to plan this

inspection. We also used the completed Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. However, the provider had completed this nine months previously and we therefore gave opportunities for them to update us throughout the inspection.

We used a range of different methods to help us understand people's experiences. We spoke with four people who lived at the home about the support they received. As some people found verbal communication more difficult, we also observed the interaction between people and the staff who supported them in communal areas throughout the inspection visit. We completed a Short Observational Framework for Inspection (SOFI) to gain an understanding of this interaction. We also spoke with four people's relatives to gain their feedback on the quality of care received.

We spoke with the registered manager, two deputy managers, one senior care staff, six care staff, and a trainee care staff. We spoke with two visiting health and social care professionals to gain their feedback. We also spoke with another healthcare professional after the inspection visit. We reviewed care plans for six people to check they were accurate and up to date. We also looked at medicines administration records and reviewed systems the provider had in place to ensure the quality of the service was continuously monitored and reviewed to drive improvement. These included accidents and incidents analysis, complaints management and meetings minutes.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Staffing and recruitment

- At our last inspection in January 2018 we found that there were not always enough staff deployed to meet people's needs safely. This was a breach in the legal regulations. At this inspection we found that this continued to require improvement.
- People were not always supported by sufficient numbers of suitably trained staff.
- During the inspection some people who were at risk of harm from falls or from other people's behaviour were not supported in communal areas by staff. For example, when some people required assistance with personal care both staff working on one floor needed to assist them which left no other staff available. One member of staff we spoke with said, "When two staff are needed to support some people you can't watch the others who are at risk of falling. I do feel it is unsafe".
- At night there was sometimes only one member of staff working on each of the units. If a member of staff needed to assist colleagues on another floor they were required to leave their unit, leaving it unsupervised. Some people had assistive technology in place to alert staff if they were getting up from bed because of their high risk of falls. Although staff would receive the alert through an electronic pager on another floor they would not be in the vicinity to react promptly to protect people from recognised risk of harm.
- Staff we spoke with told us this arrangement worried them. One member of staff said, "There is a lack of staff, only one at night and if you need to leave to go and assist on the other units that means the floor is unattended. It's very stressful and lonely on your own."
- When we spoke with the registered manager they told us that they had recently increased staffing levels at night to four so that one member of staff was available to 'float' between floors. However, they said when the fourth floor opened in the next week this would revert to one member of staff per floor.
- At the time of our inspection the majority of staff working at night had not had full training and competency assessment in administering medicines. This meant that if people required additional medicines such as pain relief they may not be able to receive it in a timely manner.
- This was an ongoing breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Safe recruitment procedures had been followed when employing new staff.

Systems and processes to safeguard people from the risk of abuse

- People were not always protected from harm and improper treatment because staff and the registered manager did not always take action to safeguard them.
- There were several incidents of actual or threatened physical harm from one person who lived at the home to others. We spoke with staff who confirmed that there were ongoing difficulties between some people who lived at the home. They also said that they couldn't always be in the same room as the

individuals to intervene.
•□Records showed us that on at least one occasion one person disclosed to staff that they had been hit when staff were not present to witness it.
•□On another occasion an incident between two people contributed to one person becoming distressed and falling in the night.
•□No action had been taken to protect these people to reduce the risk of recurrence. On the day of our inspection we saw that two of the people were in the same communal room without staff support on three occasions.
•□No referrals had been placed with the local safeguarding authority and when we spoke with staff they did not recognise their responsibility to report these incidents. Therefore, they did not take the action required to safeguard people.
•□In addition, after the inspection we were informed of concerns a member of staff had raised with the registered manager, about harm to a person who lived at the home. When we spoke with the registered manager they informed us that they had investigated the disclosure. However, they had not reported it to the safeguarding authority in line with their responsibilities.
•□This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
•□People were placed at risk of avoidable harm because risk assessments were not always completed. When they were the guidance was not always followed.
•□One trainee member of staff was asked to assist with supporting people in one communal area. When two other staff were supporting another individual in their bedroom they were the only member of staff in the communal area. We saw that when one person asked for support this member of staff asked which walking frame was theirs and on their response, took a frame to them. At this point another member of staff entered the room and stopped the support and informed the trainee member of staff that the person required support with a different piece of equipment.
•□Despite this near miss the trainee member of staff was asked to support the same person on their own in the afternoon to move with the equipment. We also saw another member of staff move the person on their own with this equipment. When we checked the person's risk assessment it stated that they should have two staff supporting them with this equipment. The trainee member of staff had not seen the risk assessment, nor received a handover and told us that they were unfamiliar with the needs of the people living on this unit.
•□This person was assessed as being of high risk of falls due to frequent accidents, including one which had resulted in a serious, significant injury six month previously. This person had not been protected from further harm because risk management strategies were not known by all staff.
•□Another person was recently identified as being at risk of harm from choking after two recent episodes. These had resulted in a referral to a health professional who instructed a specific dietary consistency for the person's meals, to reduce the risk. The information about this was difficult to locate and was not clear in the person's care plan.
•□They did not have the specialist meal they should have received on the day of inspection. Staff we spoke with also confirmed that they did not have this diet on the previous day. Records confirmed this.
•□When we spoke with staff they had some understanding of the recommendations made by the health professional but also demonstrated they did not fully understand when they gave us examples of the kind of food the person could have.
•□This meant that the person was at continued risk of harm because the recommendations made to reduce this were not being followed.
•□Other people behaved in ways which could cause themselves and others harm. These were recorded on

incident reports which were in people's care plans or daily files and hadn't always been reviewed by senior staff. This meant that the risks of the behaviour being repeated was not regularly reviewed.
•□Staff we spoke with were unclear and worried about how to support some people. One member of staff shared they were frightened to work alone with someone after a physical incident. Another member of staff shared they had been threatened by someone when supporting them. They said, "It is becoming difficult. We could do with two staff but can't really if there isn't enough".
•□There was limited guidance for staff to manage these behaviours. This resulted in staff not being able to effectively support people living with dementia when they became agitated.
•□Staff told us they completed forms about the behaviour but didn't receive a response or guidance as a consequence. One member of staff said, "We fill out the charts and don't know what happens with them and don't hear anything".
•□This meant that the provider was not assessing the cause of the risk to learn lessons from when things went wrong to avoid repetition. It put people at continued risk of avoidable harm.
•□This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
•□Medicines systems were organised and people were receiving their medicines as prescribed. The provider was following safe protocols for the receipt, storage, administration and disposal of medicines.
•□We observed medicines being administered and saw that the staff took time with people and explained what the medicines were. One relative we spoke with said, "It's a bit difficult to get [Name] to take their medicine when they don't want to take it, but the staff are really good. They will come and say, 'come on' and pat them on their arm. If they don't want it the staff will try later".
•□Some people were prescribed medicines to take 'as required'. There was guidance in place to support staff to know when this was needed.

Preventing and controlling infection
•□The home was clean and hygienic which reduced the risk of infection.
•□Staff understood the importance of correct use of personal protective equipment in managing cross - infection. We saw staff wearing protective equipment and that it was readily available.
•□There was a five-star rating from the food standards agency, which is the highest possible rating. The food standards agency is responsible for protecting public health in relation to food.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

Staff support: induction, training, skills and experience

- Staff did not always have the skills to support people well. Although they received regular training in topics such as moving people safely we saw that this learning was not always applied in line with people's risk assessments.
- Some of the people living at the home were living with dementia. Staff did not always have up to date or adequate training in understanding dementia.
- One member of staff said to one person who was living with dementia, "I've told you my name and you've forgotten already". This didn't demonstrate an understanding of the condition.
- We observed people in a communal area. When one person was distressed the staff interaction with them caused additional agitation. However, the staff member continued to interact in the same way. This demonstrated to us that they were not trained to reflect what people's nonverbal communication could be telling them..
- People's records also evidenced a lack of understanding or effective guidance for people's mental health or emotional needs. For example, one person's vocalisation was described as being intentional to seek staff attention. When somebody had been agitated during the night it was recorded by staff that this was not fair as it was waking up other people and staff were trying their best to help them.
- Staff we spoke with identified that they had not had training in understanding dementia recently. One member of staff said, "I did do training in dementia a few years ago but it would be good to have a refresher".
- This was a breach of regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People did not always have effective responses by the staff supporting them to their healthcare needs to maintain their wellbeing.
- Healthcare professionals we spoke with told us the frequency and appropriateness of referrals to them were a concern. They stated they were often asked to assess people before adequate action had been taken by staff to review their condition.
- At the inspection visit we saw that a referral had been made to healthcare professionals, to review one person who was presenting as unwell and refusing their medicines. The person had been assessed and prescribed medicines the previous day. By the time the healthcare professional attended the person was less unwell and had taken their medicines. Healthcare professionals told us that this was not unusual and in

addition to three scheduled visits per week they received daily calls which could result in up to three further visits in one day.
•□Records we reviewed evidenced the frequency of calls made. When we spoke with the registered manager and some staff about people, their response to concerns was to assure us that referrals had been made to other professionals. We needed to ask what the staff in the home were going to do to support people and promote their wellbeing. For example, in response to a discussion about one person's behaviour the response from the registered manager was to make a referral for them to psychiatric services. We had to explain that we needed immediate responses from the staff team on the premises to protect them and others.

Supporting people to eat and drink enough to maintain a balanced diet
•□People's dietary needs were not always met.
•□People did not always have enough to drink. On one unit we observed people were not offered or supported with drinks from 10am until lunch at 12pm. There were some glasses of cold drinks in the room but no one was supported to drink them.
•□There was a mixed experience at mealtimes. For example, on one unit it was pleasant and well organised and people ate well. On another there was little interaction with people and the staff just spoke with each other.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
•□Assessments were completed but were not always clear and at times contained contradictory information.
•□Staff did not always work to national guidelines. For example, if people had a suspected urinary tract infection staff did not always follow national guidance to manage this.

Ensuring consent to care and treatment in line with law and guidance
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 to receive care and treatment with appropriate legal authority. In care homes this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
•□Assessments had been completed when people lacked capacity to make decisions. However, the information was often difficult to ascertain how the assessment was made. For example, one person was living with dementia and had been assessed as requiring a DoLS because they didn't have capacity to consent to living at the home. However, one of their risk assessment's stated, '[Name] is able to identify the risks associated with mobilising without support, advising that they will fall if they do this; however, this does not prevent them placing themselves at risk as they continue to mobilise independently resulting in continued falls'. This demonstrated a lack of understanding around their capacity and ability to make safe decisions.
•□DoLS authorisations were in place when some people had restrictions in place that they couldn't consent to and we saw further applications were in progress.

Adapting service, design, decoration to meet people's needs
•□The environment was well designed to meet people's needs.

- There were several communal rooms and bedrooms were large with en-suite facilities.
- Signage was designed to assist people living with dementia and included pictures and symbols.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; equality and diversity

- People did not always have their privacy and dignity respected.
- People were sometimes spoken about in a task orientated way in communal areas. For example, one member of staff who had supported one person with personal care told other staff, "They are done now, waiting in their wheelchair".
- Staff were busy throughout the inspection visit and there were times they were unable to give people time and attention; for example, to reassure them when they were distressed.
- When staff did have time, we did see some kind and caring interaction with people. Some staff were knowledgeable about people and knew their preferences well. One person told us, "The staff are kind and caring". However, some people also commented, when agency staff who didn't know them well worked with them, the care wasn't as good. One said, "Staff know what they're doing; but sometimes the agency staff forget to be gentle with you".
- Relatives we spoke with told us that they felt welcomed. One relative said, "They always welcome us when we come and offer us a drink".

Supporting people to express their views and be involved in making decisions about their care

- People could make some decisions about their care but some people told us their ability to do this was impeded by the staffing levels. One person said, "You can get up and go to bed when you like; there are no restrictions". However, another person told us that they often couldn't have a cigarette when they chose because staff were not available to support them. This was confirmed by one member of staff.
- Similarly, when people were less able to verbally communicate we saw different approaches. For example, on one unit there was little interaction during mealtimes and people were not offered a meaningful choice of meals. On a second unit they were shown two meals on a plate so that they could choose which one they would like.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
•□People were not given enough opportunity to engage in activities and pursue interests.
•□One person told us, "We could do with a few more activities; it can get a bit boring. The staff haven't got the time. We have activities only now and then; it depends what staff are here. They did my nails for me and the entertainment room is lovely; it's where we go to watch films. We went on a trip to Chatsworth and MacArthur Glen I really enjoyed it. I like to go out and get some fresh air".
•□On the day of inspection, we only saw one short activity on one unit. On another unit people were occupied with other health care professionals throughout the day and told us that this kept them busy. However, on the third there was very little interaction as staff were busy and task focused.
•□Staff confirmed they had little time to spend doing activities with people and this included being able to support them to use the garden.
•□Staff we spoke with told us they had little time to look at care plans and they relied on senior staff to handover information about people in meetings. They said these meetings were detailed and thorough. However, on the day of our inspection a trainee member of staff who was not familiar with people was not given a handover and was unable to identify who was the senior staff.
•□Care plans contained conflicting information and the guidance was not always clear. One person's plan stated one type of specialist diet and then a different type was written in their daily notes. Another person's was unclear how they should be moved safely and had different information in different plans.
•□Some important records about changes in people's wellbeing was contained in daily records, or incident and accident forms. For example, one person had a month of records detailing incidents in their daily files which had not been reviewed. This meant senior staff who were responsible for planning care and staffing levels may not be fully aware of people's current needs so that personalised care could be planned.
•□This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support
•□There was no-one receiving end of life care at the time of our inspection.
•□Advance planning to capture how people wanted to be supported at the end of their life had been completed with some people.

Improving care quality in response to complaints or concerns
•□People knew how to make complaints and were confident that they would be listened to. However, there was no information for people in an accessible format if they were no longer able to read.
•□When complaints were received they had been recorded and reviewed in line with the provider's

procedure. Concerns or 'grumbles' were not managed as complaints but the registered manager said they would consider doing this.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- There was a lack of leadership, coordination and oversight which failed to drive the necessary improvement. At the last inspection we found a regulatory breach in staffing levels and stated that the tool the provider used to plan this was not effective because it did not take into account the layout of the home. The provider had continued to use the same tool despite staff saying it was not effective.
- There was not a systematic approach to reviewing people's care, particularly in line with accidents and incidents. We found records of these in different places and some had not been reviewed or reported to senior staff. This meant that people's care was not reviewed in line with risk management. It also meant that staffing levels were not planned around risk; for example, night time staffing levels in line with people who used assistive technology.
- Some audits were completed but they failed to identify the scale and extent of the concerns found at the home. Some were incomplete or not followed up; for example, falls monitoring was not completed every month in line with the provider's policy.
- Care plans did not always contain accurate, up to date information. They were conflicting and confusing for the staff supporting people which also raised the potential risk of harm for people. People did not have clear and specific plans to support them to manage behaviour which may cause harm to themselves or others. This had led to inconsistent support and increased potential harm to people.
- Staff were not regularly consulted with and there was poor communication with them from the management team. One member of staff told us that they heard that the fourth unit would be opening from a member of domestic staff and this had not been formally communicated. Another said that they thought there had been a meeting before Christmas to discuss working shift patterns but they had not received any information about this.
- We reviewed records and saw that the last team meeting had been in June 2018. At this meeting staff had raised concerns about safety at night, staffing levels and staff trained to administer medicines not being available at night. These were all still concerns at this inspection and had not been sufficiently responded to.
- This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Staff did not feel well supported in their roles. Some staff told us about incidents of aggression towards

them and that they had not received any follow up or relevant support from the leadership team in the home.

- Staff told us there were high levels of stress and they found it difficult because they felt they were not meeting people's needs well.
- Risks and incidents were not always reported or managed to ensure that people were safe. Some staff had not recognised risk for certain people they supported. The registered manager had not met their responsibility to report allegations of abuse to the local safeguarding authority.
- Notifications of incidents were sent to CQC in line with the registered manager's registration. However, because incidents were not routinely reported in the home we identified further concerns which we should have been notified of; for example, safeguarding incidents were not recognised. The registered manager made the referrals after the inspection.
- The provider was displaying their rating as required.

Working in partnership with others

- Relationships with partnership organisations were not always collaborative and difficulties were not always resolved.

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 The care that people received did not always meet their needs or reflect their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always protected from abuse and improper treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not effectively established or operated to ensure that the home was well led.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing 18 (1) There were not always sufficient numbers of suitably qualified, competent,

skilled and experienced staff deployed to meet people's needs.
18 (2) Staff did not always receive the training and support required for them to support people effectively.