Mr & Mrs J Fieldhouse

Millfields Residential Care Home

Inspection report

Mill Lane
Nevison
Pontefract
West Yorkshire
WF8 2LS

Tel: 01977690606

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

Summary of findings

Overall summary

This inspection took place on 22 August 2017 and was unannounced.

At the last inspection in November 2017 we rated the service as 'Requires Improvement'. We identified one regulatory breach which related to good governance.

Prior to the inspection we had received some concerns from a relative and a visiting healthcare professional. The concerns related to staffing levels, pressure area care, cleanliness and dignity and respect. As a result of these concerns the inspection was brought forward to check people were receiving the care and support they required, that regulations were being met and to review the ratings.

Millfields Residential Care Home provides accommodation and personal care for up to 38 older people, some of whom are living with dementia. Accommodation is provided over two floors with communal areas, including two lounges and a dining room, on the ground floor. There were 28 people using the service when we visited. This included three people who were in hospital and two people who were in for respite care.

The home had a registered manager however they were not present on the day of the inspection and we were informed the registered manager was leaving on 25 August 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. The area manager told us they would be taking over the management of the home.

People gave mixed feedback about the staffing levels as some said they felt there were enough staff and others told us they often had to wait for assistance. We saw there were times when there were no staff present in communal areas where people did not have access to a call bell. We found there were not always enough staff deployed to meet people's needs.

Risks to people were not always well managed as we found risk assessments were not always up to date or accurate. Staff had received training in safeguarding and understood the reporting systems. The majority of safeguarding incidents had been reported to the local authority safeguarding team, although we found one which had not. However, immediate action had been taken to make sure the person involved in the incident was safe.

Many areas of the home had been refurbished and further improvements were planned. Most areas of the home were clean and odour free although we found isolated areas where there were malodours.

Effective systems were in place to make sure people received their medicines when they needed them.

Safe recruitment processes made sure staff were suitable to work in the care service. Staff received

induction, ongoing training and support through supervision and appraisal systems.

People's care records were variable, some were detailed and person-centred, whereas others were not always accurate or up-to-date. 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 did not support this practice.

A range of activities were provided and people told us they enjoyed these. However, people also told us they wanted more opportunities to go out.

People told us they enjoyed the food. However, we found the dietary needs of people who were nutritionally at risk were not being met. People had access to healthcare services such as GPs and other specialists.

People praised the staff and we observed some kind and caring interactions between staff and people who used the service. However, we also saw occasions where staff showed a lack of respect for people and compromised their privacy and dignity.

We found there was a lack of consistent leadership. Quality assurance systems were not always effective which meant issues were not always identified or resolved.

We found shortfalls in the care and service provided to people. We identified five breaches in regulations – staffing, dignity and respect, consent, nutrition and good governance. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

There were not always sufficient numbers of staff deployed to meet people's needs. Safe recruitment processes were in place.

Medicines management was safe and effective. Risks to people's health, safety and welfare were not always well managed. Staff understood safeguarding and incidents were mainly recognised and reported. Cleanliness of the premises was variable.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received the induction, training and support they required to fulfil their roles and meet people's needs

The service was not always meeting the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were not always met. People's healthcare needs were assessed and staff supported people in accessing a range of health professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff knew people well and most were kind, caring and patient in their interactions with people. However, people were not always treated with respect and their dignity was sometimes compromised.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records varied as some were detailed, person-centred and reflected people's preferences, whereas others were not.

People were offered a variety of activities.

Effective systems were in place to record, investigate and respond to complaints.

Is the service well-led?

Inadequate

The service was not well-led.

Leadership and management of the service was not consistent or effective. Processes in place to assess, monitor and mitigate risks to people's health, safety and wellbeing were not always effective. Quality assurance systems had not identified or addressed the issues we found at this inspection.

Millfields Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, 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 22 August 2017 and was unannounced. The inspection was carried out by two inspectors and an expert by experience with experience of services for older people. 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 looking at information we had received about the service and statutory notifications we had received from the home. We also contacted the local authority commissioners and safeguarding team and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We also spoke with a visiting healthcare professional.

We usually send the provider a Provider Information Return (PIR) before 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. The provider had completed and returned the PIR in April 2016 prior to the last inspection, therefore this information was not requested prior to this inspection.

We spent time observing the care and support delivered in communal areas. We spoke with four people who were using the service, five relatives, one care staff, the cook, two assistant managers, the area manager and both providers. Following the inspection we requested some further information from the provider.

We looked at four people's care records, three staff files, medicine records and the training matrix as well as records relating to the management of the service. We looked round the building and saw people's

bedrooms, bathrooms and communal areas.

Requires Improvement

Is the service safe?

Our findings

Prior to the inspection we had received concerns that there were not enough staff to meet people's needs. People we spoke with at the inspection gave mixed feedback about the staffing levels. Most people told us there were enough staff and said staff provided them with the care and support they needed. However, one person told us they thought there were not enough staff at night and said they often had to wait a long time for assistance. Two relatives said they felt there were not enough staff. One of these relatives told us of a recent incident where their family member had been upset as there were no staff present to assist them to the toilet and there was no means for them to be able to summon assistance if staff were not present in the room.

We saw call bells were accessible to people in their bedrooms. However, although there were call points on the wall in the communal areas, these were not accessible to people as there were no leads attached and people were not able to reach the call points. Staff told us people in the communal areas were not able to use the call bell system. They said they carried out hourly checks on people in communal areas and those who chose to stay in their own rooms to make sure they were all right. However, our observations suggested these checks and the deployment of staff needed to be reviewed to ensure a more person-centred approach. We saw one person who was in the lounge all day. In the morning we saw they had been left a drink which they knocked over onto the floor and the same happened with a drink they were given in the afternoon, although staff came into the room to check people, none noticed this person had spilt their drinks. We saw when staff came in to the lounges their visits were brief and focussed on tasks such as giving out drinks rather than spending quality time with people.

There were five care staff on duty when we inspected which included an assistant manager and two team leaders. Another assistant manager was working in a supernumerary capacity. At night there were three care staff on duty. We reviewed the duty rotas for the four weeks leading up to the inspection which showed on several occasions there were only four staff on duty either for part or all of the day. The area manager told us they kept the staffing levels under review and the week before our inspection they had increased the staffing levels by one care assistant between 8am and 8pm to provide further support. They showed us guidance they used to determine staffing levels which considered people's dependencies but did not take into consideration the layout of the building. During our inspection we saw some people chose to stay in their rooms upstairs while others were in the communal areas which were at opposite ends of the ground floor. We concluded there were not always sufficient staff deployed to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found there were safe systems in place to manage medicines. People told us they received their medicines when they needed them and this was confirmed by our observations. We saw the senior staff member administering medicines to people was kind, caring and patient. They explained what the medicines were and stayed with the person until the medicines had been taken providing assistance where needed.

We looked at the medication administration records (MARs). Most people had printed MARs which had been

supplied by the pharmacist which included a photograph of the person as well as information about each of their medicines and any allergies.

Arrangements were in place to make sure medicines prescribed to be taken at a specific time in relation to food were given correctly. Topical medicines such as creams and lotions were administered and recorded as prescribed. When medicines were prescribed to be taken 'as required' (PRN) there was guidance in place to help make sure they were used consistently. Medicine stocks we checked correctly balanced with the amounts recorded on the MAR. Three people were prescribed a thickening agent to be added to their drinks to reduce the risk of choking. Records gave clear instructions about the amount of thickener to be used.

Some medicines are classified as controlled drugs because there are particular rules about how they are stored and administered. We checked the storage, the records and a random selection of stock and found they were correct.

All medicines were stored securely and temperatures of the storage areas, including the medicines fridges, were checked to make sure they were within the recommended limits. We saw records of monthly medicine audits which showed any issues identified were checked to ensure they had been resolved. Staff involved in medicine management had received medicines training.

Safe recruitment procedures were in place to ensure only staff suitable to work in the caring profession were employed. This included requesting a criminal record check with the Disclosure and Barring Service (DBS) and two written references.

People told us they felt safe in the home. One person said, "Yes I feel safe here." Staff told us they had received training in safeguarding and this was confirmed by the training matrix we reviewed. Staff knew how to report any safeguarding concerns and were confident senior staff would take appropriate action. They were also aware of whistleblowing procedures and said they would have no hesitation in contacting external agencies if they felt concerns had not been addressed. Safeguarding records showed incidents had been investigated and action had been taken to ensure people were protected. We saw referrals had been made to the local authority safeguarding team and notified to CQC. We found one recent safeguarding incident which had not been referred to safeguarding or notified to CQC, however immediate action had been taken to make the person safe.

We found risks to people were not always well managed. We saw risk assessments in people's care files included areas such as falls, skin integrity, nutrition and oral health. Some of the risk assessments were detailed and provided clear information about how risks were minimised. However, we found a lack of detail and inconsistencies in other risk assessments we reviewed. For example, one person's falls risk assessment had not been reviewed or updated following a recent fall which had resulted in the person being taken to hospital. Another person's nutritional risk assessment showed they had lost a significant amount of weight in recent months, yet this was not reflected in their care plan which had not been reviewed or updated since June 2017 when it stated the person was eating well. The area manager told us they had identified some of the risk assessments needed updating and this would be addressed.

We saw personal emergency evacuation plans (PEEPs) in people's care files were detailed and described the support individuals needed from staff in the event of a fire. Staff confirmed they had received fire safety training and told us the fire alarms were tested weekly. We saw evidence of fire training and fire drills in the records we reviewed. We found fire safety records and maintenance certificates for the premises were up to date and compliant.

Prior to the inspection we had received concerns about cleanliness and odours. We looked round the home and found although there were three domestic staff on duty, standards of cleanliness varied. We noted odours in some areas. This was particularly noticeable in the one of the lounges where an unpleasant odour was present throughout the day. We saw the seat of one of the chairs in this room was stained and marked. Although the majority of the rooms which were occupied were clean and smelt fresh, we noted a strong odour of urine in one person's bedroom. We informed the management team who told us this would be addressed straightaway.

The area manager told there was an ongoing refurbishment plan and when we looked round the premises we saw many areas had been redecorated and refurbished. One relative told us their family member's room had been refurbished. Another relative told us their family member had been admitted to the home four months previously and said the carpet smelt. They said they had been told a new carpet would be fitted but they were still waiting for this to happen.

Requires Improvement

Is the service effective?

Our findings

People told us they enjoyed the food. One relative told us their family member rang them every day to tell them what they had eaten and said the food was the highlight of the person's day. Another person told us the meals were nice but said they were fed up with having sandwiches for tea.

The kitchen staff member told us there were choices available at each meal time and this was evidenced in the records we reviewed. Although assorted sandwiches were an option for tea on most days we saw there was also a hot option such as bacon and tomato or beans on toast. We saw homemade cakes had been made for tea which included low sugar cakes for people who were diabetic.

We observed lunch in the dining room. People were consulted about the choice of music. Tables were nicely set with mats, napkins and condiments. People were offered hot and cold drinks. We saw people could choose where to sit and were offered an apron to protect their clothes. Where people required assistance with their meals this was provided by staff. The meals were served ready plated from the kitchen. The plates the food was served on were small and the food covered most of the plate. We saw some people struggled to keep their food on the plate. No seconds of either the main course or dessert were offered to people.

We saw a list of people's dietary needs was displayed in the kitchen which included diabetics, soft diets and those who needed a high calorie diet. However, we found the high calorie diet list did not include all the people who were identified in the monthly weights audit as having lost significant amounts of weight. We asked the kitchen staff member if anything was added to the food to provide extra calories for the people on the high calorie list and the kitchen staff member said, "Not that I know of." The kitchen staff member told us drinks for those on a high calorie diet were made with full fat milk and fortified with milk powder and cream. However, we found this was not happening in practice. We saw the afternoon drinks trolley offered people a choice of tea and coffee, the coffee was made with water and the milk was semi-skimmed. The staff member showed us a tin of Ovaltine but said no one had that in the afternoon. We asked the staff member what snacks were available and they showed us a tin of assorted biscuits and a small bowl of hard boiled sweets.

We saw food and fluid charts were in place to monitor the intake of people who were low weight or had lost weight and were assessed as being at risk of malnutrition. The charts we reviewed recorded poor food and fluid intake, yet there was nothing to show these had been reviewed by senior staff or the action taken in response. There were no fluid targets and the amount of fluid consumed each day had not been totalled and on some charts no fluid output was recorded. One person's fluid charts showed over a four day period their fluid intake had ranged from a daily total of 105mls to a maximum of 750mls. The assistant manager told us the food and fluid charts were reviewed monthly by another assistant manager. We concluded people's nutritional and hydration needs were not being met and therefore the provider was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the inspection the area manager sent us information confirming the action they were taking to ensure people's nutritional needs were met.

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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). 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 assistant manager had a good understanding of DoLS and the provider had made appropriate applications. Three people had conditions on their authorisations and these were being met. We saw a tracker was in place to monitor expiry dates and ensure reviews were requested in a timely way.

The training matrix showed the majority of staff had received training in the MCA and DOLS. However, we found staff lacked understanding around the MCA and in particular capacity assessments and best interest decisions. For example, we saw one person received their medicines covertly (hidden in food or drink). Although there was a letter from the person's GP advising medicines were to be given this way to ensure good health was maintained we saw no other evidence to demonstrate the MCA 2005 was being complied with. There was no evidence of a mental capacity assessment for this decision or a best interest meeting and no evidence of a pharmacist's advice. We saw another person had sensors installed by their bedroom door. The assistant manager told us these were activated at night to alert staff when the person came out of their bedroom. The assistant manager told us the person lacked capacity. They said they had not completed a capacity assessment or best interest meeting for this decision and said they would put this in place. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us the training they received was good. One of the providers took the lead in organising staff training and had completed the Train the Trainer courses. They told us three of the team leaders had completed the Train the Trainer course in moving and handling. We looked at the training matrix which showed staff had received a range of training which included areas such as safeguarding, moving and handling, equality and diversity, dementia, fire safety, health and safety and infection control. Our discussions with the provider showed systems were in place to ensure staff received refresher training and were kept up to date.

All new staff completed an induction which was evidenced in the training matrix. New staff who had no previous care experience completed the care certificate. Staff with previous experience completed a self-assessment to see if they would benefit from completing the care certificate. The care certificate is a set of standards to equip health and social care support workers with the knowledge and skills they needed to provide safe and compassionate care.

Staff told us they received supervision and appraisal and this was reflected in the records we reviewed.

People's care records showed they had been seen by a range of health care professionals including GPs, district nurses, dieticians and opticians.

Requires Improvement

Is the service caring?

Our findings

People we spoke with were happy with the care they received. They spoke positively about the staff who they described as 'lovely', 'great' and 'smashing'.

Feedback from relatives we spoke with was mainly positive. Comments included; "I can't praise the staff enough, nothing is too much trouble. My (family member) is always clean and tidy and very content"; "The care staff were very friendly" and "the staff are fantastic, I know (family member) will be well looked after." One relative was not happy with their family member's care and told us they had arranged a meeting with the registered manager to discuss their concerns.

There was a warm and friendly atmosphere in the home. However, we found a lack of consistency in the way staff approached and engaged with people. We saw some interactions between staff and people who used the service were kind, caring and gentle. We saw staff bent down to talk to people so they were on the same level and encouraged and reassured people. We saw staff assisting one person to transfer using a hoist and they explained what they were going to do and checked throughout that the person was all right.

However, we also witnessed occasions when staff were not caring or considerate in the way they responded to people. For example, we saw two staff who were assisting a person to transfer using a hoist. The staff were giggling and whispering to each other throughout the process and did not speak to the person they were assisting. On another occasion we saw staff came into the lounge where five people were sat. They spoke with three of the people, offered drinks and asked if they were okay. The other two people were ignored and had no staff contact. One relative told us their family member was deaf and had two hearing aids. They said whenever they visited the hearing aids were in the family member's bag. They said although they had raised concerns with staff about this they had not received a satisfactory explanation.

Prior to the inspection concerns had been raised which suggested people's privacy and dignity was not always respected and we found examples of this at the inspection. We saw some good staff practices. For example, staff knocked on doors before entering and ensured any personal care was carried out in private. Most people looked clean, comfortably dressed and well groomed.

However, we also observed times when staff showed a lack of respect for people and their dignity. For example, we saw one person was brought into a communal area by staff and the continence product they used was clearly visible to all. When this was brought to staff attention by the inspector this was addressed. However, the same situation occurred again with the same person in the afternoon. On another occasion staff were transferring someone in a hoist in a communal area and the person's clothing was disturbed by the sling exposing their underwear to other people in the lounge. Staff took no action to preserve the person's dignity and privacy. We saw a further person brought into a communal area by staff the person had dried food around their mouth and their fingernails were dirty. We saw when a staff member offered biscuits to people they picked the biscuit up in their hand and passed it to the person. The biscuit tin was not offered so the person could choose their own, no gloves were worn by the staff member when handling the biscuits and no plates were offered. Two relatives told us they often found clothing belonging to other people in

their family member's drawers and wardrobes. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans contained information which staff could refer to that helped build meaningful relationships with people. This included a 'snapshot' of the person with information about what was important to the person and details of friendships, relationships, hobbies and interests as well as a brief life history.

Requires Improvement

Is the service responsive?

Our findings

Our review of the care plans showed people's needs had been assessed before they were admitted to the home. We saw care plans were in place for all aspects of care and some were detailed and person centred. For example, one person's moving and handling plan incorporated advice given by the physiotherapist. It also had detailed information about the slings to be used with the hoist including pictures.

Yet in contrast other care plans were not up to date or accurate. For example, we saw one person's care records showed they had been seen by the dietician in July 2017 who had recommend a high calorie diet and fortified drinks, yet there was no nutritional care plan in place. Another person's care plan described how the person sometimes presented with behaviour that challenged others yet there was no information to guide staff in how to manage this situation. Another person's nutritional care plan was dated September 2015 and had not been reviewed since June 2017 even though the person had continued to lose weight since the review. The area manager had already identified improvements were needed in relation to care plans and risk assessments and was in the process of addressing this with staff.

The provider employed an activity organiser and we saw a weekly schedule of events was displayed in the home. People told us they enjoyed the activities provided, although some said they would like more opportunities to go out. One person told us how their interest in arts had led to the setting up of a weekly art session which they looked forward to. Another person told us they had been out on a shopping trip with staff eight weeks ago and how much they had enjoyed this and hoped they would be able to go again as they said they missed going out. Other people told us of the activities they liked and joined in with, which included bingo, crafts and making cards. We saw people enjoying a bingo session in the lounge on the afternoon of our inspection.

People and relatives told us if they had any concerns they would speak with staff or one of the managers. The provider's complaints procedure was displayed in the home. The complaint log showed there had been three complaints since the last inspection. One of these was currently under investigation. The other two complaints had been investigated and the outcome had been relayed to the complainant.

Inadequate

Is the service well-led?

Our findings

At our two previous inspections we found governance systems were not effective as issues identified through quality audits had not been addressed. At this inspection we found similar concerns. We also identified shortfalls in relation to staffing, consent, nutrition, dignity and respect and therefore concluded the service was not well-led.

The registered manager had been in post since March 2017. They were not working on the day of the inspection and the area manager told us the registered manager was leaving on 25 August 2017. The area manager said they would be taking over as manager of the service and registering with the Care Quality Commission.

Some relatives and people we spoke with said they did not know the registered manager. One relative who visited every week said they had not seen the registered manager and did not know their name. People and relatives spoke positively about the assistant managers. One person said, "(Name of assistant manager) is excellent. If you ask them something you can rely on them to get things done."

The area manager was open and transparent and their discussions with us showed they recognised some aspects of the service had slipped in recent months. They were taking over the management of the service imminently and assured us improvements would be made. Following the inspection the area manager provided information to show the action they were taking to address the issues we identified at the inspection. Staff spoke positively about the area manager and were supportive of the management changes.

Accidents and incidents were monitored and analysed monthly by the registered manager. This included a falls analysis which looked at the time, location, type of fall, any injury and whether the fall was witnessed or not. The analysis identified people who experienced multiple falls and showed what action had been taken in response. For example, referral to the Enhanced Health in Care Homes (ECHC) Vanguards (vanguards are new models of care working to improve the quality of life, healthcare and health planning for people living in care homes).

However, we found appropriate action was not always taken in response to incidents. For example, one incident resulted in a piece of equipment hitting a person on the head. Two staff were using the equipment when this incident occurred. Although no injury was caused to the person, no action had been taken to investigate this further or review the staff members' practice. We raised this with the area manager who, following the inspection, confirmed they were looking into this matter.

Quality assurance systems were in place. We saw some of these systems were effective and resulted in improvements to the service. For example, medicine audits and those related to the environment. However, other audits had not resulted in improvements. For example, an audit of food and fluid charts in June 2017 had identified gaps in recording and fluid output not recorded. The same issues were identified in the July 2017 audit and this reflected what we found at the inspection. Similarly monthly weigh audits looked at the

amount of weight each person had lost every month and gave actions such as re-weigh or refer to dietician or put on a food chart. However, the audits did not consider the effectiveness of these actions or consider the weight loss a person had accumulated over a number of months. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's feedback was sought on the running of the service. People we spoke with told us there were regular residents and relatives meetings. We saw minutes from meetings held in February and April 2017. The minutes from the April meeting were displayed in the home.

The area manager told us surveys had been sent out recently to people who used the service and relatives and they were awaiting their return. We saw comments made in last year's surveys in November 2016 were included in the service user guide.

We saw minutes from staff meetings held in March, April and August 2017. The area manager had also held a meeting in May 2017 with the registered managers of all the provider's services.

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 10 HSCA RA Regulations 2014 Dignity and respect Service users were not always treated with dignity and respect. Regulation 10(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment of service users was not always provided with the consent of the relevant person Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Service users' nutritional and hydration needs were not always met. Regulation 14(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed to meet people's needs. Regulation 18 (1) (2) (a).