Baytree Community Care (London) Limited

Holmwood

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Holmwood is registered to provide accommodation and personal care for up to 32 people, some of who may be living with mental health support needs. There were 30 people living at the service at the time of the inspection.

This inspection took place on 7 March 2016 and was unannounced.
The service is a large two storey older house with an extension built on to one side. The house is situated on the edge of a main road within an area surrounded by trees. Inside the property there are a number of communal rooms and various staircases leading to individual's bedrooms.

The last registered manager left the service in June 2014. The provider had taken steps to recruit another manager who did not continue in their employment. The current service manager started working at the service in January 2016. They were in the process of completing a CQC registered manager's application at the time of our visit. A registered manager is a person who has registered with the CQC 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.

There were insufficient staff at the service to meet people's needs. This meant that people had to wait to receive the support they needed from staff. Because there were not enough staff people had limited opportunities to take part in activities.

Care plans did not contain all of the relevant information that staff required so that they knew how to meet people's current needs. people did not always receive the care and support that they needed. Where risks were identified there was not always information to show what actions were being taken to reduce these risks.

Staff were recruited safety with criminal record checks in place and references taken up prior to them commencing employment. The staff training matrix included a lot of training which staff could attend, however much of the training was either out of date or had not been undertaken yet.

Staff were aware of the procedure to follow if they thought someone had been harmed in any way. Some concerns raised by staff were not appropriately reported by the manager. A complaints procedure was in place and was being used effectively?.

People had access to healthcare professionals when they needed them; however where necessary, care plans were not always updated as a result. People did not always have their nutritional support needs met. Records were not up to date and staff were not aware of some people's current nutritional needs.

Staff did not always comply with the Mental Capacity Act 2005 (MCA). The MCA provides the legal framework

to assess people's capacity to make certain decisions, at a certain time.

There were procedures in place which were being followed by staff to ensure that people received medication as prescribed. The service manager had made improvements to the medication processes at the service in response to some medication errors which had occurred.

There was a quality assurance audit in place however the system was not always effective because issues identified at the inspection had not been recognised during the monitoring and auditing process.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end of this report.

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.

Insufficient numbers of staff were employed to meet people's care and support needs.

Some risks to people had not been consistently assessed. Action had not been taken to reduce risks to people.

Staff were aware of the procedures to follow if they thought someone had suffered any harm.

Is the service effective?

Requires Improvement

The service was not always effective.

Where people did not have the capacity to consent, the provider had not acted in accordance with the legislation and guidance.

Staff were not always aware of people's nutritional support requirements.

People had access to relevant healthcare professionals when required.

Is the service caring?

Requires Improvement

The service was not always caring.

People's independence was not always supported.

Staff did not always have time to spend with people.

People's dignity was compromised due to a lack of staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Activities for people were infrequent and there were limited opportunities to take part in any.

Care records were not always up to date and accurate.

A complaints policy and procedure was in place and was used to respond to any concerns raised.

People's individual needs were not always being met.

Is the service well-led?

Requires Improvement

The service was not always well led.

The quality monitoring arrangements were not fully effective. They had not identified the concerns and breaches of regulations that we identified at this inspection.

Staff felt supported by the service manager. The service manager felt supported by the provider.

Holmwood

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 7 March 2016 and was unannounced. The inspection was undertaken by two 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.

Before we carried out this inspection we reviewed the information we held about this service including notifications. A notification is information about events that the registered persons are required, by law, to tell us about. We also sought the views of the local authority's quality assurance team to aid with our planning of this inspection.

During our inspection we spoke with six people who lived in the home. Throughout the inspection we observed how the staff interacted with people who lived at the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We also spoke to the service manager, deputy manager, director of quality and systems and four staff who work at the service. These included three care staff and a cook. During the inspection we looked at five people's care records and records in relation to the management of the service including staff recruitment records, staff supervisions, complaints and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

People told us, "The staff are sometimes over stretched and the home is short of staff at times." Another person told us, "I don't get to do any activities as there are never enough staff." A staff member we spoke to told us, "Once staffing gets sorted then we will be able to start doing activities with people."

At the time of our inspection we found that there were not enough staff to meet people's needs. All of the staff we spoke with told us that there were not enough staff and that this was impacting directly on the people who lived at the service. We were told, "Staffing is an issue, and there is a lot of pressure on staff." Staff also told us, "We don't have enough time to spend with people; we can't talk to them or spend time with them." Another staff member told us, "I don't even get a break for lunch, there are not enough staff."

The manager told us that they aimed to have four staff on at all times during the day however at the time of our inspection there were three staff. We looked at the staffing rota and saw that during February 2016 there were mostly two staff on during the afternoon and evening shift. We were told by people living at the service and staff that this was impacting on them.

The manager told us that staffing was based on people's needs but that no assessment tool was used to calculate how many staff were required. We were concerned about the impact that the lack of staff was having on people. This was confirmed by staff who also said, "We are short staffed at the moment. If there are two of us [staff] on and we are helping someone then there is no one there for everyone else. This is when arguments and aggression amongst them [people] can start. It is very risky." Another staff member told us about someone who by choice wanted to be assisted up early in the morning so they could sit in the lounge and watch TV. We were told that this person required two staff to assist them up so they had to wait in bed until staff were available which was often late morning.

The manager told us that the service did not use agency staff and that they were trying to recruit bank staff. We were told the vacant hours were not covered unless existing staff worked them.

The lack of staffing and the impact that this was having on people was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff we spoke with told us that they had received safeguarding training. Staff we spoke with knew the different types of abuse and could describe how they would recognise the signs of abuse and how they would report it. Staff told us that they had reported to the manager concerns about how another staff member was speaking to people and some inappropriate support they had observed. We found that this safeguarding issue had not been reported to the local safeguarding team. We discussed this with the service manager and the provider's director of quality and systems during our inspection. They agreed to report it to the safeguarding team that day.

Where risks were documented in a risk assessment actions were not being taken to prevent these risks. For example, one person's care plan said that staff should monitor their pressure areas and that they needed

regular checks and support to assist them to move in their bed. However, this assessment did not state how often these checks should take place and there were no records to show that these were checks were happening. There was not a risk assessment for pressure care for one person; however staff told us that the same person currently had a pressure ulcer. Staff told us that they check people when assisting them for any areas of concern. Risk assessments were not always updated; we saw that one person's risk assessment referred to them using a 'stand aid' hoist however their more recent care plan referenced that they now used a full hoist. Staff also confirmed that the person used a full hoist.

Although health and safety checks had been carried out, such as the fire alarm tests, we saw from some of the records that it was not clear if the actions had been addressed. For example we saw in a health and safety quarterly maintenance check carried out during November 2015 that the outstanding actions had not been updated so it was not clear if these had been completed. The manager and director of quality and systems told us that the actions had been completed but the paperwork had not been updated. There were a number of health and safety recording sheets for areas such as a weekly hoist inspection and a weekly inspection of hoist slings. We saw that these had been completed during January 2015 however monitoring and recording had since stopped. The manager told us that the provider was 'streamlining' all the paperwork used so the record keeping would improve in the future.

We were already aware, from information sent to us by the manager, that there had been a number of medicine errors at the service. The manager and deputy manager had put in a new system in an attempt to make medicine administration safer and more accurate and this had resulted in less medication errors. The manager told us and staff confirmed that staff completed administration of medication training as part of their induction. After completing the training staff were observed administering medicines to people to ensure they were competent before being allowed to do it on their own. We looked at medicines and how these were stored and administered during our inspection. The room where the medicines were stored was also the staff room. The manager told us about their plans to stop staff that were on a break entering the medicines area to help prevent distraction of staff administering medicines. We saw that the manager had introduced a medicines information board to remind staff of specific information and reminders.

Nobody at the service took control of their own medicines. The manager told us that one person had been asking to have control of their own medicines and this was something that they were supporting the person to achieve. We saw that weekly audits of medicines were carried out and that a pharmacist had completed an audit of the medicines during December 2015. We could see from the audit records that this had identified some gaps in temperature monitoring of the medicines storage. The manager told us that they had improved systems to prevent this happening. We saw that records had been completed since the pharmacist audit.

We checked the stock levels of some of the medicines within the medication trolley. These stock checks were matched against the medicine administration records and were correct. We saw that medicines were dated by staff when opened and that discard dates were included. Some people were taking medicines when required (PRN medicines). We saw that there were protocols in place for people's PRN medicines. This meant that people were given their medicines safely and as they were prescribed.

We saw evidence that new staff were recruited safely. Staff personnel files contained application forms and the references the home had sought before they commenced employment. Staff identification was checked and a criminal records check was carried out prior to them commencing employment.

Requires Improvement

Is the service effective?

Our findings

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 as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made of 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.

Staff member's knowledge of the MCA was variable. While some staff had a good understanding of this and how to support people, not all staff were clear if they had received training on the MCA. Some staff we spoke with were not able to tell us the main principles of the Act or how they would support people to make decisions. Other staff we spoke to demonstrated that they had an understanding of the principles of the MCA, one member of staff told us that they understood the principles of the MCA and would involve people such as health professionals if they felt someone lacked capacity to make decisions. Another person was able to tell us some of the main principles of the Act and how they would support people to make decisions. We were told by one staff member that before people received any care and treatment they were asked for their consent and staff acted in accordance with their wishes. Staff told us, "It's always their [people who use the service] choice."

Where issues were identified with people's capacity to make a decision, capacity assessments were not recorded. For example, we saw that in one person's care plan it said that the person could not manage their own medicines as they had a lack of capacity. There was nothing within the care plan to show why they lacked capacity or whether less restrictive options had been considered in order to support the person to manage their own medicines. Another person's care plan said they lacked capacity to manage their finances and the service was acting as their appointee. There was however, no capacity assessment for finances recorded. In addition to a capacity assessment not taking place, we found that there were also no best interests assessments either. Best interests assessments are about how the decision has been reached in the best interests of the person and who has been involved in making that decision.

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

We looked at five people's care records during our inspection. We saw that risks to people regarding their nutritional status were not always identified and actions were not always taken where people were at risk. One person was admitted to the service with a care plan that showed they ate limited amounts and that they required support to increase their food intake. The person should have been weighed monthly, however between June and October 2015 the person was not weighed at all. The deputy manager told us that this was because the person had refused to be weighed however this was not recorded anywhere.

During this time of not being weighed the person lost more than 10 % of their body weight and was subsequently admitted to hospital. Records showed the weight loss was noted in October 2015 however there was not a plan put in place to address this.

Following admission to hospital a person was discharged with advice to the service to offer a high calorie/protein fortified died and to encourage regular meals with high calorie snacks in between. We saw that the persons care plan regarding nutrition had not been updated and they had not been weighed as often as recommended. We shared our concerns with the deputy and manager. They told us that the person now had a healthy weight and could have a normal diet, which they had discussed with the dietician. However, this advice was not documented in the care records.

We saw another person had been assessed as at high risk of malnutrition, however their nutritional assessment had not been updated since December 2015. The person had also not been weighed since December 2015. We spoke to staff, including the chef, who said they had no knowledge of anyone currently or in the past requiring such a high calorie or fortified diet. One member of staff told us that everything that was provided to people was low fat. We spoke to two other staff that were responsible for meal preparation. They told us that the only dietary needs of people living in the service were those who were diabetic. Records we looked at showed a number of other people who were at high risk of malnutrition. There was nothing in the kitchen to tell staff if people had specific dietary requirements.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff told us the menu had recently been changed to make choices more varied. People were given two choices at mealtimes. Staff said if people didn't like the choices available they would be offered alternatives.

Staff told us that they had the training they needed to do their job. One person told us they had recently started work at the service and had a good induction with support. They told us that they were able to shadow other staff before working on their own. One person said that they completed the basics of learning via an online 'e-learning' package. The service manager told us that training and staff completing it had, "Slipped a bit" due to the service being short staffed. We looked at the training matrix for the service as a whole and saw that there were a number of staff who either had out of date training or training that they had yet to complete. Despite working with people who were living with mental health support needs, we saw that no staff had received training in supporting people with their mental health; staff told us they required this training to support people effectively. Neither had all staff members received training in or understood how to assess people's capacity to make their own decisions or ensure that people were able to make decisions. The service manager told us that this was something that was being addressed.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The manager told us that there had been some gaps in staff supervisions as these had not been happening, however there were plans to make them more consistent. Records we looked at showed that supervision meetings had been intermittent. Staff told us however that they felt supported by the manager.

We saw that people had access to external healthcare support when they needed it; records we viewed had details of appointments that had taken place. One person told us, "I see my psychiatrist every six months."

Requires Improvement

Is the service caring?

Our findings

People's independence was not always supported. One person had a record in their admission assessment, which stated they would have liked to return to their flat. There was no guidance to show how they might be supported to become more independent in order to reach their goal. Another person's care plan showed they should be supported to familiarise themselves with the local environment and supported to develop an ability to go to the local shops on their own. Staff told us there were insufficient staff available for this to happen. The service manager told us that they wanted to use staff supporting people through key working as a tool for promoting independence. They said, for example, people could help staff with cleaning. One person had their own vacuum cleaner and were pleased when the manager suggested they use it and clean their room. The manager told us that the staff team were working towards promoting people's independence at the service. We were told that the plans for the service moving forward were to promote people's involvement in household tasks further.

There was a kitchen that people could use to make drinks. One member of staff told us they promoted people's independence through encouraging people to make their own drinks. We were told that when staffing levels improved, some people would be supported to become more independent by using the kitchen. One member of staff told us they promoted people's dignity and privacy through making sure personal care was carried out in private and that permission was sought before going in to people's rooms.

People told us that they thought staff were caring. One person told us, "I like the staff, I like staying here." Another person told us, "I am quite happy living here and I want to stay here for as long as possible." Staff told us, "I love my job."

We saw some caring interactions between staff and the people they were supporting. For example, one person appeared distressed and the senior carer, who was busy, asked another member of staff to come and speak to them. We observed a member of staff responding to a person who was becoming distressed as they wanted a member of staff to go to the shop for them to buy tobacco. The member of staff offered them some of their own personal tobacco to try and calm them down. They reassured the person that they would go to the shop for them, even if they had to do it in their own time. Another person appeared anxious and was frequently trying to engage staff in conversation; however staff were too busy to engage with the person and relieve their distress.

Some people told us that they had been involved in the development of their care plan. One person told us that they had a care plan and they had helped to write it. Another person told us, "I helped with my care plan." Although another person we spoke with was not aware of their care plan and told us that they had not been involved in the development of it, "I do not know what this is [care plan]. I do not think I have one, I do not know." Records showed people were involved in reviews of their care. One member of staff told us reviews were completed with the person and their family. Care records were stored securely. Information was kept confidentially and there were policies and procedures to protect people's personal information. There was a confidentiality policy which was accessible to all staff. Staff demonstrated they were aware of the importance of protecting people's personal information.

Requires Improvement

Is the service responsive?

Our findings

We were told that some people required two staff to assist them to get up and with their personal care. Staff told us that when there were only two staff working on shift, "They [people who live at the service] have to wait until there are enough of us [staff] or we are free to help." Staff also told us that this could result in a considerable wait for people wanting assistance to get up. One staff member told us, "People can't have their personal preferences at the moment due to staffing. They get basic care and not our full attention as they should. Sometimes they have to wait for their care needs." Another staff member told us, "If they had staff, this place would be great. It's the staffing; there are just not enough bodies [staff] at the moment."

We saw that there was an activities time table displayed in the hallway at the service. However, 'hairdresser' and 'nail painting' were on the timetable and these were the only activities listed for the whole day. On the day of our inspection there was an activity that had been listed as 'relaxing music', however this activity was a CD been played in a hallway and did not involve any of the people living at the service. Staff we spoke with told us it wasn't really an activity however it was all they could do with the number of staff they had available. We were told that every other week an external entertainer visited the service to play music with people. At other times people were not occupied in meaningful activities. We observed on another occasion three people just sat in the dining room and for over an hour, four people sat in the lounge with the TV on but no one appeared to be watching it.

The service manager told us that people were invited to a residents meeting although these were generally not well attended. We looked at records of these meetings and saw that people had made comments about activities. In a number of previous meetings, people had mentioned some of the activities that they wanted to participate in however these had not been facilitated. The meeting minutes made reference to an issue with staffing and when staffing levels were increased there would be a staff member assigned to carry out activities with people.

One member of staff told us people wanted to go out however some people with higher support needs were not always able to go out due to low staff levels. Another person said people could come and go as they pleased, however we saw people who required support to be able to access the community, unable to do so due to a shortage of staff. We viewed activity records for people and saw that these did not document activities; they recorded things like 'smoked' or 'watched tv'. One person's care plan stated that staff members should support their increased access to the community. We saw that although staff agreed to this when the person asked, they were not supported to go out for the duration of our visit and an alternative time was not arranged.

We saw in people's care plans that there was information about their preferences and likes and dislikes as well as their history and what was important to them. We found when we spoke with staff that they did not always have up to date knowledge about people's support needs. Staff did not know enough about people as individuals to be able to provide personalised care. When we spoke to staff about people's specific support needs, there were areas such as nutrition that conflicted what we read the persons care plan.

Care plans had not been updated with recommendations from health care professionals. For example one person's psychologist had given recommendations regarding how to manage the person's behaviour, yet the care plan had not been updated. Another example we saw was that someone had a care plan that said they managed their own finances. However information from the home they had previously lived in said they lacked capacity to manage finances. We asked the manager about this, they told us the care plan in place was not correct and that the home was the person's appointee and managed their finances for them. Care plans are important as they tell staff caring for people how the person liked and chose to be supported as well as any healthcare needs and risks that were identified.

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

Interactions and staff approach in communal areas confirmed that staff promoted a relaxed atmosphere with people. We noted that due to the number of staff available and the layout of the building and the communal rooms there were sometimes long periods of time between interactions. We asked the manager about the service and whether they had any links to the community, We were told that there were none however this is something that they could pursue. We were told that some people went out on their own to the town. We were told that one other person went to a church group as this was their choice to do so.

Each person had a key worker. A key worker is a staff member who focused on an individual and made sure that their care needs were met and reviewed. We saw some people had met with their key worker and were asked if they were happy at the service and if they had concerns. We looked at the records of some of these meetings. Some people had raised concerns, for example one person had said, "No" when asked if they were happy and said they had concerns with staff. However, the records did not show how this had been explored, what the specific issues were and what actions had been taken to respond to the person's concerns. The manager told us that they were unaware of this person's concerns. Some people told us that they did not know they had a key worker. We were told, "I rarely have one to ones with anyone [staff]. I do not have one particular worker who looks after me."

The provider's complaints procedure was current and made freely available in the service. We saw details of complaints that had been made during December 2015 and January 2016. Records showed that the manager had responded in a timely manner to the concerns and had welcomed further feedback. People told us that they would complain to the manager if they had any concerns.

Requires Improvement

Is the service well-led?

Our findings

Although there were systems in place to assess and monitor the way the service was run, we found that they had not identified all of the issues that we found during our visit. The service manager had systems in place to check that staff had received training. Whilst we saw gaps in the training undertaken by staff, the manager was aware of this and stated she was in the process of booking staff onto training. We saw that other record keeping was poor, inaccurate, and out of date.

We found that the manager did not have an adequate system in place to determine accurate staffing levels or to respond adequately when staffing levels dropped.

We asked the manager about whether there was an annual review carried out at the service and whether people's views were sought as a part of this review. The service manager told us that a review was carried out last year. However they were not aware if there was an action plan in place as a result of this review. Completed surveys or responses were not available at the time of our visit.

We saw that staff team meetings had been held infrequently since October 2015. The service manager told us that there were plans to increase the frequency of the team meetings however only one had been held recently which was in January 2016. The meeting minutes identified that four people were at medium risk of poor nutrition. Staff members were not aware of the risks to these people and we found that although the information had been passed on, the meetings were not effective in ensuring care practice changed.

Incident reports showed that investigations were being carried out by the service management team when an accident or incident had occurred. However, preventative action to reduce the likelihood of the incident occurring again were not always considered. We saw on the providers incident forms several incidents where the follow up action to prevent the same or similar incident occurring again had been left blank.

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

The manager commenced employment at the service during January 2016 and was in the process of completing a CQC registered manager's application at the time of our visit.

One person told us, "I think this service delivers high quality care." Another person said, "Since the new manager has been here things have improved a lot." We asked a person what they would do if they wanted to complain about something. They told us, "I would complain to the manager, they [the manager] would take me seriously." One of the staff told us, "The manager has an open office." Another staff member told us, "I can approach the manager anytime and report concerns." All the staff we spoke to said they had found the manager was supportive.

We saw people who live at the service engaging with the staff and the manager when they went to the office to ask a question or access their money. It was evident that both the staff and manager were able to

communicate with people on a personal level.

We were told by staff that they feel confident to raise concerns. One member of staff said, "If there are issues the director comes and they monitor the quality of the service." The service manager told us that the provider's director of quality and systems visited monthly and also carried out a quarterly quality check. We saw a copy of the quality check from January 2016.The audits did not show that action had been taken to address the issues identified. The service manager later told us the actions from the audit had been completed but not recorded. This showed us that documenting actions taken was not always completed.

In the fire safety folder we saw that some staff had signed to say they had read and understood the fire safety policy. This form was however partially signed and we saw that some staff had not signed it. There was a fire risk assessment that had been written in November 2015. We saw that there were a number of actions that were due to have been met but had not been updated on the risk assessment. The service manager later checked and told us that the actions on the health and safety quarterly check and the fire risk assessment had been completed.

We saw that there had been some proactive action to respond to errors in medicines administration and new systems had been put in place to improve practice. We were also told by the manager that there were plans to improve the service's key worker systems and opportunities for people to have regular meetings with their key worker.

Providers are required to send the CQC statutory notifications to inform the CQC of certain incidents, events and changes that happen within the service. The manager had sent in statutory notifications to the CQC for the events that happened at the service. However we found that a potential safeguarding referral in relation to the service had not been submitted. The manager actioned this straight away on the day of our visit.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not have the opportunity to take part in activities according to their interests and wishes.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Where issues were identified with people's mental capacity to make a decision, capacity assessments were not recorded and best interest decisions had not been made.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Risks to people regarding their nutritional status were not always identified and actions were not always taken where people were at risk.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider was not operating effective systems and processes to assess and monitor their service. Regulation The provider did not effectively assess, monitor and mitigate the risks related to the health,

safety and welfare of people who used the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient staff to support people in a person centred and responsive manner.