Ms Mary Mundy

Towerhouse Residential Home

Inspection report

11 - 12 Tower Road
Willesden
London
NW10 2HP

Tel: 02089337203

Date of inspection visit:
25 July 2017
26 July 2017

Date of publication:
04 December 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Our inspection of Towerhouse Residential Home took place on 25 and 26 July 2017. At our last comprehensive inspection of the home on 20, 24 and 25 October 2016 we found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to safety, staff training and supervision, compliance with the Mental Capacity Act, care planning and quality assurance. We also found one breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following this inspection we imposed conditions of registration on this provider to stop new admissions and to provide us with quality audit information each month.

Towerhouse Residential Home is a care home situated in Willesden which is registered to provide care to up to eight older people. There were five people living at the home, the majority of whom were living with dementia.

The manager at the home is the registered provider. Registered providers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We carried out this inspection to check whether the provider had made improvements to quality of care provided. We found that the provider had made some improvements. Staff training was up to date and in accordance with national training standards for staff working in health and social care services. Staff members were receiving regular supervision from a manager to ensure that they were supported in their roles. Improvements had been made to the environment of the home to ensure that people were safe. A range of quality monitoring processes had been put in place. However these had failed to identify and address some issues in relation to the quality of care and support to people living at the home.

At our previous inspection of the home in October 2016 we found that that the provider had failed to take action to ensure that people were always safe. The safety of the home environment had not been assessed and we found a number of trip hazards that had that had not been identified and remedied. Window restrictors did not meet the Health and Safety Executive's (HSE) guidance on window restrictors in care homes. A fire exit had not been alarmed or otherwise secured to ensure that staff members were alerted when a vulnerable person tried to leave the home.

During this inspection we found that a health and safety risk assessment had been put in place. Improvements to the home environment had been made. New flooring had been put in place to reduce the risk of trips and falls. New window restrictors had been put in place which met HSE guidance. The provider showed us a copy of a recent independent fire risk assessment. However, when we examined the fire exit we found that the locks had been changed but no alarm or other security system had been installed. This meant that people could still leave the home undetected by staff and therefore be put at risk.

At our inspection in October 2016 we found that two people did not have care plans or risk assessments in place. Other people's care plans and risk assessments had not always been updated to reflect changes in their needs. During this inspection we saw that care plans and risk assessments were in place for all five people living at the home. However, these did not always contain any information for staff members about how they should provide care or manage risk to people. Actions to reduce risks in relation to likelihood of pressure ulcers were not always being followed or recorded.

Staff members supported people in a caring and respectful way. They were able to describe their roles and responsibilities in ensuring that the people whom they supported were safe from harm.
At our inspection of the home in October 2016 we had found that there were no formal records of recent safeguarding concerns and these had not been notified to CQC. During this inspection we looked again at the provider's system for notifying us of events such as safeguarding matters. We found that no safeguarding concerns had arisen since October 2016. However, the provider had failed to notify CQC about the death of a person living at the home. It is a legal requirement that notifications are made to CQC in relation to incidents such as safeguarding concerns, injuries or deaths. .

The majority of people at the home were living with dementia and subject to the requirements of the Mental Capacity Act 2005 (MCA). During our last inspection we found that applications for authorisations under the Deprivation of Liberty Safeguards (DoLS) which are part of the MCA had not been made for three people who met the DoLS criteria of being under constant supervision and unable to leave the home unaccompanied. At this inspection we found that DoLS applications had been made for all people living at the home. However, we found that mental capacity assessments were generalised to all activities and not specific activities as required by the MCA.

Staff members told us that they were well supported by the provider/manager. Regular training, supervision and spot checks in relation to competency had been put in place.

We did not see any structured activities taking place during our inspection. However the activities record book and people's care notes showed that activities such as walks, bingo and exercise sessions took place at the home. Three people had recently started to attend a local day service on three days each week.

People's religious, cultural and relationship needs were supported. Faith representatives visited the home on a weekly basis and family members were welcomed when they visited.

Staff managed people's medicines effectively. We saw that the home liaised with healthcare professionals. However, the records that we viewed failed to show that guidance from healthcare professionals was always followed or recorded.

People and staff members told us that they were happy with the management of the home. However, at our previous inspection we had found that there had been limited action in relation to quality assurance and management monitoring of the care and support provided to people. Monitoring and audit processes were incomplete or out of date, and we were not shown how the provider had used these to assess and improve the quality of care.

During this inspection we found that a range of quality assurance processes had been put in place. However, these did not always identify or address potential concerns in relation to people's care and support. We found failings in relation to infection control. Mould in a communal bathroom had not been identified, Exposed chipboard in the kitchen had not been corrected four weeks after it was identified by an independent consultant engaged by the home. There was no regular monitoring of hot water temperature

valves which meant that people were at risk of scalding.

Our concerns in relation to the lack of guidance for staff contained in risk assessments and care plans had not been identified by the provider.. We also found that there had been a failure to record some information, for example in relation to people's nutrition and hydration and significant appointments.

The overall rating for this service is 'Inadequate' and the service is therefore 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.

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.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering what action to take. 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?

Inadequate

Aspects of the service were not safe. Risk management plans had not been put in place to reduce identified risks to people.

Although improvements had been made to the home's environment action had not been taken to ensure that people were unable to leave the home without staff members being alerted.

Medicines were well managed and recorded but there was limited evidence that a person's health needs were being effectively met.

Is the service effective?

Requires Improvement

Aspects of the service were not effective. The home had made improvements in relation to compliance with the Mental Capacity Act (MCA) but capacity assessments were not related to specific decisions.

Information about people's food and drink intake was not always recorded.

Health professionals were involved with people but there were no records showing why a recommended hospital appointment for a person was not made.

Is the service caring?

Good

The service was caring. Staff members supported people in a respectful and dignified way.

People told us that they were happy with the staff at the home and did not have to wait for support when they required it.

People's confidentiality was maintained.

Is the service responsive?

Requires Improvement

Aspects of the service were not responsive. Care plans did not always include information about how care and support should be provided.

Where guidance on care and support was contained in people's care plans this was not always followed.

People told us they knew how to complain if they were unhappy.

Is the service well-led?

Inadequate

Aspects of the service were not well led. Quality assurance processes were in place but these had not always identified issues in relation to the quality of people's care and support.

The service had failed to record important information in relation to people's care and support.

People and staff members spoke positively about the manager.

Towerhouse Residential 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 25 and 26 July 2017 and was unannounced. The inspection was carried out by two inspectors.

During our inspection we spoke with two people who lived at Towerhouse Residential Home. We also spoke with two care staff, the registered manager and deputy manager. We made telephone contact with a representative from the local authority commissioning and safeguarding teams.

We spent time observing care and support being delivered in the main communal areas We looked at records, which included five care records, three staff records and records relating to the management of the service.

Some people communication difficulties associated with dementia so we used the Short Observational Framework for Inspection (SOFI) to observe the way they were cared for and supported. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

Before the inspection we reviewed information that we held about the home. This included Correspondence, enquiries, records of previous inspections and information received from the local authority.

Inadequate

Is the service safe?

Our findings

At our last inspection on 20, 24 and 25 October 2016 we found that there had been a failure to assess risks associated with the environment of the home. Window restrictors had been put in place following an incident but these were not compliant with Health and Safety Executive (HSE) guidance on window restrictors in care homes. We also found a number of trip hazards to people that had not been assessed or managed in relation to risk. We also found that a fire exit door through which a vulnerable person had left the home had not been secured to or alarmed in order to address the risk of a person attempting to leave the home un-noticed in the future. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that there were no trip hazards and that flooring had been replaced in the communal lounge and in people's bedrooms. Window restrictors had also been replaced. These met HSE guidance and were checked on a monthly basis. We saw that an independent fire safety risk assessment had taken place which had identified that security of the fire exit door that was a concern at our previous was unsuitable. The provider told us that the lock had been changed as a result of the assessment. However, we observed that a chair was placed in front of the door which was a breach of fire regulations in relation to external fire exits. There was no system to alert staff if a person left the building without support.

This demonstrated a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the provider about this. They said that they would make arrangements to ensure that a keypad linked to the fire alarms system was put in place for this door.

During our previous inspection in October 2016 we had also identified that risk assessments had not been completed for two people who lived at the home. In addition the risk assessments for other people had not been updated for more than a year. During this inspection we found that new risk assessments had been put in place for people. We found, however, that some risk assessments did not include information about how risks were managed. For example falls risk assessments were in place. These consisted of checklists that identified if people were at risk of falls, but there was no information or guidance for staff about how risks should be managed. One person at the home had a significant visual impairment, but there was no risk assessment in place in relation to this. Another person's risk assessment showed that they had a high risk of developing pressure ulcers. There was no risk management plan in relation to this. We looked at turning and repositioning charts for the person and saw that these had been completed until 7 July 2017. The provider told us that this was because there was no further need to do so as the person no longer had ulcers. We looked at the records of subsequent district nursing visits to the person and saw these showed that the person was being treated for pressure ulcers.

This demonstrated a further continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection of Towerhouse Residential Home during October 2016 we found that people's medicines were not managed safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Medicines were left unattended on two occasions and prescribed creams were found in a communal bathroom. Medicines administration records (MAR) charts had not been signed where prescribed creams and laxatives had been administered. The MAR chart for one person indicated that a medicine had not been administered as prescribed. There was no guidance for staff in relation to the administration of pain relieving medicines. Regular medicines audits were not in place.

During this inspection we found that the provider had taken action to meet the regulation. We observed people being supported with their medicines and saw that medicines were stored and administered safely in accordance with people's prescriptions. Information in relation to when pain relief medicines should be administered had been recorded. MAR charts showed that all medicines including prescribed creams and laxatives were signed for when administered. People living at the home had received medicines assessments by a GP and changes in relation to these assessments had been implemented. Regular weekly and monthly medicines audits had been put in place.

During our inspection we identified that there was sufficient staffing to support people living at the home. We saw that people living at the home did not have to wait for support when they required it. At our inspection of the home in October 2016 we had found that the call bell system was not working and that arrangements were not in place to monitor this. At this inspection we found that the system had been replaced and there were records to show that it was regularly tested on a monthly basis.

At our previous inspection of the home during October 2016 we found that the staffing rota did not reflect the staffing arrangements in operation. At his inspection we looked at the current and most recent staffing rotas. The staff members on shift during our visit corresponded with the names on the rota. However, we noted that a staff member who had been on long term sick leave had been rostered to work during the weeks when they were off. No amendment had been made to show if another staff member had worked in their place. Some shifts on the rota had been allocated to 'agency'. The rotas had not been amended to identify names of agency staff working during these shifts. This meant that we could not be confident from the home's records whether there were always enough staff members available to support the people living there. The provider told us that these shifts had been covered and acknowledged that she had failed to amend the rotas to reflect the names of the staff members who were working at the home.

We looked at the recruitment records for four members of staff. We saw that for three staff members two references had been received and that criminal record and barring checks had also been completed to establish that they were suitable to care for people living at the home. However the record for a fourth staff member did not include this information. The deputy manager told us that these documents had been obtained prior to the staff member commencing work. However they had been misplaced and a risk assessment had been put in place when this was discovered. We saw the risk assessment. However this did not provide sufficient information to assure us that the staff member was of good character and suitable for the work they were undertaking. This staff member was on an extended period of leave at the time of our inspection. The deputy manager told us that they would seek new references and criminal records checks immediately so that these would be in place prior to their return to work.

People told us that they felt safe with the staff. One person said, "I feel safe here," and another person told us, "The staff help me to be safe."

Requires Improvement

Is the service effective?

Our findings

One person said, "They are very good here." Another person told us, "This is my home and I am happy here."

At our inspection of 20, 24 and 25 October 2016, and our previous focused inspection during June 2016 we found that there were gaps in the training records for staff and that regular supervision by a manager had not taken place. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We had served a warning notice to the provider about this. .

During this inspection we looked at the training certificates for the staff members working at Towerhouse Residential Home. These showed they had received training that met national standards for staff working in health and social care services. The deputy manager showed us a training matrix. This identified when training was due to be 'refreshed' for staff. We also looked at the supervision records for staff members working at the home and found that regular monthly supervision by a manager was now taking place. In addition, monthly recorded observations of care practice were in place. These included competency assessments of medicines administration and moving and handling of people who required this support.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

At our previous inspection of the home during October 2016 we found that DoLS applications had not been made to the relevant local authority for three people who were under continuous supervision and unable to leave the home unaccompanied due to risks associated with lack of capacity to make decisions. We also found that information about people's capacity to make decisions was not recorded for two people. Staff members had not received training in relation to MCA and DOLS. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that DoLS applications had been made to the local authority for people living at the home. These included applications for renewals of DoLS authorisations that were coming to an end. We saw that some staff members had now received training in relation to MCA and DoLS. The deputy manager told us that they would ensure that this training would be provided to all staff members.

We found that capacity assessments were in place for people who lived at the home. The forms that were

being used met the guidance associated with the MCA. However, the assessments were generalised to all decisions and not developed in relation to specific decisions as required by the guidance. We discussed this with the deputy manager and provider. They assured us that there had been no recent need to undertake an assessment in relation to a decision about care or treatment and that they would follow the guidance if such a need were to occur in the future.

We recommend that the provider seeks guidance from a reputable source about working with the Mental Capacity Act (2005).

The care records that we viewed showed that they were signed by the person receiving care. Where people were unable to give consent a family member or other representative had been involved. There had been regular meetings with people living at the home. The records of these showed that people had indicated that they were satisfied with their support.

People's individual dietary and nutritional needs were met. There was a menu board on the dining room wall although this had not been updated to reflect the menus that were offered to people. We saw, however, that people were offered at least two choices at mealtimes, and that alternatives were provided if they chose to refuse these. We observed a staff member supporting a person to eat and saw that the staff member spoke with them in a kindly way and waited for them to digest their food. People were offered hot and cold drinks and snacks throughout the day. People appeared to enjoy the food that they were offered and we saw that they ate well. One person that we spoke with told us that, "I like the food," and another person said, "I always get something I like."'

The home maintained a nutrition and hydration record for each person, and we saw that these contained details of all food and drink that had been taken on each day. However' we found that some records had not been completed since 22 October 2017. This meant that we could not be sure that people always received the food and drink that they required. We asked the provider about this. They told us that they were waiting for new record books to be printed.

Monthly assessments of people's weight were carried out. The records that we saw showed that people's weights were stable and within a healthy range. The provider told us that if people gained or lost weight, an immediate referral to a GP for further assessment would be made.

People's care records showed that they regularly received health checks. They had access to a range of health professionals including; GPs, dieticians, opticians, chiropodists, psychiatrists, and dentists. However we found that a recommended hospital appointment for a person had not been made. The provider told us that this was not followed up on the advice of the person's GP but there was no record of this advice. This meant that we could not be sure that the home always addressed people's healthcare needs.

Good

Is the service caring?

Our findings

People told us they were satisfied with the care provided at the home. Comments from people included; "The staff are good to me," and, "They are very nice and treat me well." We observed that people appeared comfortable with their care staff and interacted with them in a positive manner.

.We heard staff ask people how they were, and saw that they checked on people's needs regularly. Staff members appeared knowledgeable about people's care needs. A staff member told us that, "I am learning about people all the time. This helps me to work with them better."

People were supported to maintain the relationships that they wanted to have with friends, family and others important to them. The care plans t we saw included information about the relationships that were important to them.

We saw that, where people required personal support, this was provided in a timely and dignified manner. One person said, "They come quickly when I want them."

The provider / manager and staff members spoke positively about the people whom they supported. A staff member said, "I really enjoy working here. I sometimes come in on my days off to see if I can help someone with an activity."

People told us their privacy and dignity was respected. We saw that staff members offered people choices in relation to the food that they ate and spoke with them about the support that they were being given.

At our previous inspection during October 2016 we found that care documents for people were not stored in a secure place. During this inspection we saw that a secure, lockable cupboard had been purchased and care files were safely stored in this.

Some people's care files contained documented information about people's end of life preferences and needs. This included information about whether people wished to remain at the home rather than being admitted to hospital. We saw that family members had been involved in supporting people with these decisions where required. The provider told us that these had not all been fully completed as some people did not wish to discuss their end of life preferences.

Requires Improvement

Is the service responsive?

Our findings

A person who lived at the home told us that, "I don't wait if I need help." Another person said, "They come when I call for them."

At our previous inspection of the home on 20, 24 and 25 October 2016 we found that care plans were not in place for two people and that other people's care plans had not been updated to reflect their current needs. We also found that there no daily notes of care for two people had been recorded during the week prior to our inspection. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that people living at the home had care plans. These had been recently updated. However, we found that, although these included lists of tasks in relation to care, there was limited information in relation to how such tasks should be carried out by staff. One person's care plan stated that staff should "minimise the risk of [person] wandering from home." However there was no information about what staff should do in order to ensure this. We looked at another person's plan where some guidance was in place in relation to fluid retention. This stated that they should, "lift her legs up when sitting into chair." During our inspection we saw that this person was active and that no action was taken by staff to ensure that they raised their legs when seated.

We looked at the notes of daily care for people living at the home. These were up to date and included information about personal care delivered to people. However, there was little information in relation to, for example, mood, behaviour, activities and engagement with other professionals. For example, some people had been involved in best interest's assessments in relation to DoLS but this was not recorded. This meant that we could not be sure that the provider always took action or recorded information in relation to people's care

The above is evidence of a continuing breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked about activities for people living at the home. The provider told us that three people were now attending a local day service on three days each week. We were shown an activities record. This showed that activities such as reading, watching television, walks, bingo and exercises had taken place. During our inspection people spent their time sitting in the communal lounge with the television on. Although staff members chatted with people we did not see any structured activities taking place. There were books and DVDs available at the home, but these were not easily accessible to people unless they were taken out of storage by staff. At our last inspection we noted that a person who liked music did not have a radio or music player that they could listen to. During this inspection we asked about this. The provider showed us a recently purchased radio/cd player. However, this was not yet in the person's room. We were told that this was because staff needed to familiarise the person with it as they had a visual impairment. The provider told us that they planned to do this immediately.

We noted that most people's rooms were sparsely furnished and did not include many personal items. We asked the provider about this. She told us that two people had destroyed items such as pictures and televisions that had been place in their rooms as they did not like them being there. However, there was no information about this in people's care plans or risk assessments.

At our inspection of the home during October 2016 we found there were no records showing that people were consulted about or involved in making decisions about the home. There were no records of resident's meetings during 2016. During this inspection we saw records showing that monthly resident's meetings had taken place since March 2017. These showed that, for example, safeguarding, day activities, menus and complaints had been discussed with people. .

The home had a complaints procedure. One person said, "I tell the manager if I am unhappy." We looked at the register of complaints maintained by the home and saw that there had been no complaints.

Inadequate

Is the service well-led?

Our findings

The registered manager for the home was also the provider. We saw that she worked shifts at the home and that people and staff members were familiar with her. One person told us, "She is very good to me," and another said, "I like her. She looks after me very well."

During our inspections of November 2015 and October 2016 we found that the provider had failed to report notifiable incidents to CQC. We looked at the matter again during this inspection and found that the provider had not notified us about the death of a service user in May 2017. When asked, the provider told us that she thought she did not have to notify CQC because she had informed that local authority. We are looking at this matter in more detail.

During our inspection in October 2016 we reviewed the quality assurance records maintained by the home. We found that there were no recent completed internal audits in relation to medicines, health and safety and infection control. Two people did not have care plans and risk assessments in place. Other people's care plans and risk assessments had been reviewed on a monthly basis, but they had not been updated to reflect changes in people's needs. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we found that some improvements had been made. The provider had commissioned a consultancy organisation to undertake monthly reviews of service provision. We saw that regular audits were in place in relation to medicines management, health and safety, infection control, water temperatures and call bells systems at the home. However we identified issues that had not been identified through these audits. For example exposed chipboard in the kitchen had not been identified and actions had not been taken to address this. Mould in the downstairs communal bathroom had not been identified nor dealt with. Hot water temperature checks had not included regular monitoring of all outlets to ensure that temperature control valves were in working order. In addition, there were no regular audits of care plans, risk assessments and daily care records, and our concerns in relation to the content and quality of these had not been identified by the provider. We also found that there were gaps in people's records in relation to, for example, nutrition and hydration and appointments. This meant that the provider's systems had failed to identify and address concerns in relation to the quality of the service to people living at Towerhouse Residential Home..

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

During the time of our inspection the provider and deputy manager were covering staff shifts. We saw that they worked effectively with other staff members on the shift and communicated in a positive manner with the people living at the home. Staff members told us that they felt supported by the provider. We were told that, "She's so good. She is always there if I need help or advice." At our previous inspection during October 2016 we had found that there had been no staff team meetings during the past year. At this inspection we saw records of monthly team meetings where issues relating to the service were discussed. A staff member

confirmed that they had attended these meetings and had found them valuable.

We reviewed the policies and procedures.in place at the home. These were up to date and reflected good practice guidance and regulatory requirements. There was a process in place to ensure that staff members were required to sign when they had read the policies.

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 People's care plans did not include information \bout how care should be provided to meet their needs and preferences. 9(1)(3)(b)