St. Cloud Care Limited

Holmwood Care Centre

Inspection report

30 Chaddesley Road
Kidderminster
DY10 3DJ
Tel: 01562 824496
Website: www.stcloudcare.co.uk

Date of inspection visit: 5 May 2015
Date of publication: 20/07/2015

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**

Overall summary

This inspection took place on 5 May 2015 and was unannounced. The service provides care and support for up to 60 older people some of who may be living with dementia. On the day of our inspection there were 54 people who lived at the service.

There was a registered manager in place. 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.

People were protected from harm because staff knew how to protect them from abuse. We found that when staff reported abuse the registered manager took action. They worked with external agencies to ensure people were kept safe from harm. The provider had learnt from incidents and measures were put in place to reduce the likelihood of these incidents from happening again.

People's individual risks were assessed and monitored. Where action was required to keep people safe from risk, staff were aware of this and what steps were to be taken to reduce the risk.

Summary of findings

However, our findings from this inspection identified that there were insufficient staff to meet people's needs. People did not receive care, treatment and support that was individual to them. We found that people received care and support based on staff's requirement rather than the person's needs. For example, we found three people were distressed and they told us they were frustrated. These people were assisted with getting up, washed and dressed twenty minutes before lunch was being served.

We found that because of staffing levels within the home, some people did not receive their medicines in a timely way, with some people receiving their morning medication 30 minutes before lunch time. The times people received their medication was not recorded to ensure people received their medicines with sufficient time's in-between doses. However, we found the storage and management of medicines was done so in a safe way.

People who we spoke with felt that staff were knowledgeable about how to care for them. Staff told us they received training and this benefitted them in their roles. For example, staff knew why a person who was at risk of dehydration needed their fluid intake to be monitored and recorded. They used this information to ensure the person was drinking enough fluids to keep them healthy.

We found that people and where necessary, their family members, were sought for their consent in line with their care. We found these wishes were respected by staff and staff recognised the importance of this. All staff we spoke with were aware of people's human rights and how this could be affected for people who may lack capacity. We saw that mental capacity assessments had been carried out where people were not able to make decisions themselves. We found that families were involved in making best interest decisions about the person's care. However, we found that while the provider recognised that some people had their freedom restricted; this was not done so in a legal way. As the provider had not submitted the applications to the supervisory body in order to gain the correct permission.

We found people were supported with enough food and fluid to keep them healthy. We found that people had access to healthcare professionals, such as optician, dentist and their doctor when they required them.

People and relatives told us they felt listened to and were an active part in developing their care. However we found this was not always the case. People's views and decisions they had made about their care were not always listened and acted upon. For example, people were not able to have a bath or shower when or as often as they would have liked. People told us that they would have to "book a bath" so that staff were available. One person told us that prior to coming to live in the home they would bathe every day, and now they were only able to bathe once a fortnight. During our inspection we found the communal bathrooms were used as storage areas for equipment and some baths were dusty. Staff told us that nobody had had a bath that day, but did not know why.

People did tell us that staff treated them kindly, with dignity and respect. People told us that staff respected their privacy, for example, staff would knock on their door and wait for a reply before entering. We saw staff interacting with people and they did so in a kind, caring and sensitive manner.

We found that the decision's people had made about their care and support were not always met in a responsive way. Some people had to wait to be assisted to the toilet; others were required to wait to receive personal care in the morning while other people received their morning medication half an hour before lunch time. This was not personal to the individual's choice and did not reflect their wishes.

We found that people knew how to complain and felt comfortable to do this. Where the provider had received complaints, these had been responded to.

The provider did not always demonstrate clear leadership. Staff were not always supported to carry out their roles and responsibilities effectively, which meant that people's care was sometimes compromised. We also found that lack of communication hindered the effective and responsiveness of the care provided to people.

Our findings did not reflect the provider's findings, which were largely task orientated roles, such as cleaning schedules. Where shortfalls were identified, effective systems were not always in place to ensure that lessons were learnt and used to improve staff practice.

Summary of findings

We found three breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. There were not enough staff to keep people safe and meet their needs. However staff had the knowledge and understanding to protect people from harm.	**Requires improvement**
Is the service effective? The service was not always effective. People were potentially deprived of their liberty without permission. People were supported with enough food and drink to keep them healthy. People were cared for by a staff team that were skilled to meet their needs effectively.	**Requires improvement**
Is the service caring? The service was not always caring. People's decisions about their care were not always followed and listened to. People were treated in a respectful way and their privacy and dignity were maintained.	**Requires improvement**
Is the service responsive? The service was not always responsive. People did not always receive care that was responsive to their individual needs. People's concerns and complaints were listened and responded to.	**Requires improvement**
Is the service well-led? The service was not always well-led. A lack of communication and leadership meant people did not always receive high quality care to a good standard. People did not always receive a good experience of care because the provider did not focus on how the service delivered and achieved this.	**Requires improvement**

Holmwood Care Centre

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 5 May 2015 and was unannounced. The inspection team consisted of three inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience on this inspection had experience of caring for older people living with dementia.

As part of the inspection we reviewed information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us by law.

As part of the inspection we spoke with fourteen people who used the service and five visiting relatives. We also spoke with the registered manager, one nurse, seven care staff, the cook and the maintenance person. 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 reviewed nine people's care records. We also looked at staffing rota's, call bell data, nutritional audits, provider audit, staff training schedule, complaints records and maintenance of the home.

Requires improvement

Is the service safe?

Our findings

On our arrival to the home in the morning we found that the call bells rang consistently. Within a 15 minute period, two of these calls went to emergency, which meant that the bell had not been answered for more than 10 minutes. We found that most people were in bed when we arrived. We found some people were distressed waiting for assistance from staff. We spoke with people about staffing levels. Three people were upset about the time in which they were assisted to get up in the morning and told us they had to wait a long period of time before receiving assistance. One person told us, "I am fed up of waiting to get up; they get me up when they are ready". Another person said, "If you ring the bell at two minutes to 12 you have to wait as its lunch time. You have to know when to ring it". Another person said, "It doesn't matter how many times you press it they won't come". The person's relative was present when they said this, who offered reassurance by explaining to them that, "Staff were very busy".

We found these people had been assisted to wash, dress and provided with food twenty minutes prior to midday. We saw one person was eating toast at 11:50, when lunch was served at midday. We were concerned that this person had not received breakfast before this time. Staff were unsure if the person had eaten breakfast prior to this. One staff member said they would have given them a biscuit with their cup of tea. We spoke with the person who said they thought they had had breakfast earlier that morning.

We found that people's requests for assistance to the bathroom were not always prompt. We heard one person ask staff to assist them to the toilet; the person was required to wait 10 minutes before their needs were met. We heard people calling from a communal lounge, when we entered we found three people shouting for staff to assist another person to the bathroom. We used a call bell to alert staff to the area, they arrived promptly, however the person was in a distressed state at this time.

We spoke with staff who told us the home was a busy place to work. One staff member told us, "We meet people's basic needs, but more staff are always needed". On the day of our inspection there were 10 care staff, two senior care staff and one nurse on duty and 54 people lived there. The registered manager explained that two nurses worked on the morning shift. However on the day of our inspection one nurse was on duty and a second nurse had not been scheduled to work, a senior carer had been scheduled to work to assist the nurse.

We spoke with the registered manager about what we saw and what people had told us. The registered manager was aware that staffing levels did not reflect the care needs for the people who lived there. They told us this was hindered by staff moving within the provider's organisation and staff vacancies filled with agency staff. We asked the registered manager how they ensured there were enough staff on duty to meet people needs. We were told that the provider reviewed staffing levels based on the number of people who lived in the home rather than the dependency levels of people who lived there.

All of above evidence supported this was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

We spoke with people about how they felt safe in the home. People told us they felt safe from harm. One person said, "Yes I feel safe here, if I have a problem I tell my son". Another person said, "It was strange at first living here, but I feel safe". Another person spoke of their first experience using a hoist and explained how staff supported them to feel safe in the hoist. A relative told us, "We don't worry about [the person], they are safe, I call in regularly".

Staff were able to tell us what they believed abuse meant and examples of what they would immediately report to the management team. They demonstrated their understanding of the procedures to follow if they witnessed or had an allegation of abuse reported to them. We found that staff had reported an incident of abuse to the registered manager. The registered manager had taken appropriate action to protect people from harm and reduce the likelihood of the incident from happening again. They had worked with the local authority to investigate these concerns. Measures were put into place to reduce the likelihood of these incidents from happening again. For example, staff reported to the registered manager that there were staff who carried out some areas of poor practice during the night time shift. The registered manager investigated these concerns and reported to the external agency. The registered manager told us that spot checks by management were carried out at night to ensure people were safe.

Requires improvement

Is the service safe?

Staff who we spoke with could explain to us about people's individual risks and how they protected them from harm. For example, one person was nursed in bed and was at risk of pressure damage. Staff were able to demonstrate how they reduced the risk of pressure damage, such as regular repositioning and ensuring the person's skin was dry and clean.

People did not express any concern about the management of their medicines, however we found on the day of our inspection that people's medication was not provided in a timely way. One nurse administered medication for 37 people who required nursing care. The nurse told us that usually there were two nurses on duty; however this had not always been the case over the last four weeks, since one nurse had been placed to work at the providers other service. There was no second nurse scheduled to work for the day. Instead a senior carer with medicines training was scheduled to work to ensure medicines were administered to those who required nursing care. The nurse told us that they did not feel comfortable with this arrangement and wanted to ensure people who required nursing care was given medicines by a nurse. One the day of our inspection the medication round took three and a half hours to complete and some people received their morning medication at 11:30am. We found the nurse was distracted with phone calls and questions throughout the medicines round. The nurse told us this always happened. The nurse provided re-assurances that priority had been given to those who required their medicines in a timely way, for example, those who required insulin or who received medicines four times a day to ensure there was appropriate times in-between doses. However it could not be demonstrated that the times the medication was given was recorded. They told us that records had not been written on this occasion, but usually they recorded the times. Therefore assurances could not be made that people had their medication with sufficient time's in-between doses.

Requires improvement

Is the service effective?

Our findings

We spoke with the registered manager about when an application to deprive someone of their liberty should be made. The registered manager showed us they were knowledgeable about the Deprivation of Liberty Safeguards (DoLS). For example, they knew that people who lived in the dementia unit were restricted of their freedom, as the doors within the home were locked with key coded access. They told us they had recently reviewed all the people who lived at the home however had not completed the applications to restrict people's freedom in a legal way. We discussed with the registered manager that there was a need for them to fulfil their responsibility. They told us they had not felt the need to rush due to a delay of applications at the local authority. Therefore, the provider had not fulfilled their legal responsibility and completed applications to the supervisory body to seek standard authorisation to ensure that people were not being unnecessarily deprived of their liberty.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

We spoke with people about the staff that cared for them. One person said, “The [staff] are very good and make you feel comfortable”. Another person said, “I am well looked after”. A relative told us, “The staff are fabulous”.

Staff told us about the courses they had completed and what this meant for people who lived in the home. Staff felt their knowledge had been kept up to date; they attended mandatory training and were able to complete additional relevant training. For example, we found that some people were at risk of dehydration. Staff we spoke with knew who required their fluids to be monitored to prevent dehydration. Staff had personalised information about how much fluid the person required each day to keep them healthy. The staff member could demonstrate how they provided extra encouragement to a person if they had not drunk sufficient amounts of fluids the previous day.

We spoke with two care staff who told us that they felt supported in their role and had supervisions with the nursing staff, which were useful. They told us they felt able to approach the registered manager about any issues. We spoke with the registered manager who told us that smaller meetings happened with staff and they were aware of staffs concerns around staffing levels.

People we spoke with told us that staff always sought consent before carrying out any of their care needs. One person told us that staff always sought consent. They went onto say that they were aware what was in their care plan and regularly discussed this with staff. All staff we spoke with told us they were aware of a person’s right to choose or refuse care. One member of staff said, “It’s their choice”. They told us if they had concerns about a person’s choice that could have a negative impact that they would refer any issues to the registered manager or nursing staff on duty. For example, one care staff member told us about a person who expressed their wishes to stay in bed, not to eat meals and at times drink enough fluids. The staff member told us that this was the person’s choice and staff had respected their decision. However, they monitored the person’s fluid intake to ensure they did not become dehydrated and kept the person’s doctor informed inline with the person’s agreement.

We looked at how the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA). This is a law that provides a system of assessment and decision making to protect people who do not have capacity to give their consent. Relatives we spoke with told us that they were involved in their family members care, and where it was deemed that the person did not have the capacity to make decisions about their care they were involved in making decisions for the person’s best interest. Staff we spoke with understood their roles and responsibilities and what this meant or how it affected the way the person was to be cared for. We saw that people’s capacity was considered when consent was needed or when risk assessments were carried out. We saw that where decisions were made on people’s behalf, best interest meetings had been held in line with the requirements of the MCA.

People who we spoke with told us they enjoyed the food at the home. One person said, “The food is very good”. Lunch time at the home was a variable experience for people. In some areas of the home we found people had a positive experience, the tables were laid and people chose where they wanted to sit. We saw people chatting with each other and staff. People were offered a choice of food and were given time to enjoy this. However, in another area of the home we saw this was not a positive experience for people. For example, when one staff member asked a person if everything was okay with their food, the person replied, “It’s not that nice”. However no alternative was offered.

Requires improvement

Is the service effective?

People were offered hot and cold drinks throughout the day. For those who required assistance to drink, we observed staff support and encourage people. Staff did not rush people and took their time to assist people to enjoy their drink. We saw that where required, staff monitored people's fluid intake to ensure they drank enough to keep them healthy.

People we spoke with told us they had access to health care professionals when they needed to and that visits were arranged in a timely manner when they requested. One person we spoke with said, "The doctor comes when I need them". We saw an example in one care record that following the doctor's visit they prescribed the person antibiotics. People told us they saw the dentist, optician, social workers and other health professionals when they required them and staff were prompt to action this. Staff were able to tell us about people's individual care needs which were confirmed in the care planning records. Nursing staff told us how people were supported with other health conditions and how they were monitored and supported within the home. For example, one person had acquired a pressure sore from outside of the home. A specialist nurse was contacted who advised the nurses of correct dressings to apply and ensured the correct equipment was used, for example an appropriate pressure relieving mattress. The person's care records demonstrated how the pressure damage had begun to heal following the advice of the specialist nurse.

Requires improvement

Is the service caring?

Our findings

We found in busier areas of the home where people's care needs were more complex, people were not always supported to make day to day decisions about their care. We spoke with people about their choice of how often they would like a bath or a shower. One person we spoke with told us that prior to living in the home they would bathe every day. Now they lived in the home, they would bathe once a fortnight. They said, "I have to book a bath to ensure staff and equipment are available". They went onto say they would like a bath more often. Another person told us, "I have a bath or a shower about once a week, you have to tell them in the morning and they book you in". Our observation around the home showed that communal bathrooms were mostly used to store equipment, such as hoists, commodes and linen. We found all the bathrooms were dry and some were dusty. We asked staff how people were supported to have a bath or shower. Staff told us that if the person requested a bath they would provide this. We asked staff how they prepared the bathroom so it was a suitable place for people to use, however staff could not give clear details about where the equipment was stored. We asked if they had offered to bathe anyone on the day of our inspection, all staff told us they had not and no baths had taken place. Staff could not explain why nobody had been offered a bath. We provided feedback of our findings to the registered manager. They told us that storage was an issue in the home and equipment was stored in the bathrooms. However they were not aware that people had to book bath in advance.

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

People told us and we saw that staff were caring towards them. All the people we spoke with told us they liked living at the home, one person said, "The care home is very good". Another person said, "I'm very happy and settled". Relatives we spoke with felt that all staff were approachable, friendly and were good at providing care and support to their family member. One relative said, ""[The person] has been here for two years and we are very happy with it. They love it and the staff are fabulous". Another relative said, "We are very happy with the care here they look after [the person]". They felt the staff supported them well and were kind.

People told us that staff respected their privacy. One person we spoke with said, "They always knock on my door and treat me respectfully". Another person said, "The staff are lovely, very respectful". Another person said, "Staff never assume anything, they always ask me first". Visitors told us they were able to see their relative in private and that there were no restrictions on visiting times.

People told us staff spoke kindly to them and in a respectful way. They told us staff listened to what they had to say and spent time to respond to any questions. We saw how staff treated people with respect and addressed people in a positive and courteous way. They understood people's needs by reducing any concerns. For example, we saw one person became anxious when the wind had blown the parasol over in the garden. Staff listened to the person, secured the parasol and reassured the person that this was now safe. We observed people were assisted in a discreet way and care staff were professional at all times when assisting people.

Requires improvement

Is the service responsive?

Our findings

The registered manager told us that people's needs were assessed before they came to live in the home. And that on their arrival to the home further assessments were used to develop care plans that were personalised to the person support and meet their health needs. People and their relatives told us that their preferences and choices were discussed in detail. One relative we spoke with said, "I am very involved with Dad's care". The registered manager told us that they were in the process of completing full reviews of all people's care plans with the person and their family members. At the time of our inspection, two full reviews had been completed. However our findings did not demonstrate that the decision's people had made about their care and support were always met in a responsive way. Through our conversation with people and our observation around the home we saw examples of how the service offered was not responsive to people's needs. For example, people were required to wait for staff to become available before they received personal care. This was reflected in the times some people were assisted in the morning. In which we found three people were distressed waiting for staff to arrive to assist them and told us that staff came only when they were able to. People told us they were not offered a bath or shower as often as they would have liked and if they did want a bath they had to be booked in, to ensure staff were available to assist them. We also found that people's requests for assistance to the bathroom where also delayed, with one person waiting 10 minutes before they were helped. Staffing levels also reflected delays in people receiving their medication in a timely way.

People told us that they had the opportunity to discuss their interests and social activities and people we spoke with felt that staff supported them with this. One person explained to us how they worked with staff to develop a 'life profile' and that it was a true reflection of their life. They told us that staff supported their wishes and went onto say that they did not like to go out much and staff respected that. We spoke with another person who told us that they were supported to practice their religion with a priest visiting very Sunday. On the day of our visit people attended a communion service held within the home. People told us that they welcomed this service.

People felt they had maintained relationships with their families. Relatives were free to visit at any time and told us staff were friendly, inclusive and made them feel welcomed. One relative said, "I know [the person] is looked after, the service is quite good and the family is pleased". Another relative said, "I call in regularly".

Every person we spoke with said that they felt confident enough to speak with staff or people in management if they had any concerns or complaints. People said that staff listened to them when needed. One person told us, "I have no complaints, if I have I go to the top". Another person told us that they had no complaints with the care and felt they offered everything they needed. They went onto say that they would feel confident if they needed to raise a complaint and that it would be dealt with. Throughout our visit relatives approached staff and the registered manager to talk about the care and treatment of their relative. A relative told us, "We don't worry about [the person], they are safe and there are no complaints". Another relative said, "We are very happy with the care here they look after Mum". All of the staff we spoke with explained what they would do if someone made a complaint to them. Staff told us they would try to sort out the complaint first, but if this was not possible they would speak with the nurse or the registered manager. The provider had a complaints procedure in place, relatives told us this information was clear and easy to understand. The provider had received six complaints since our last inspection. The complaints had been responded through meetings with the registered manager. Agreed actions were put into place to ensure a satisfactory outcome was achieved.

Requires improvement

Is the service well-led?

Our findings

We looked at how staff were supported to carry out their roles and the lines of accountability within the home. We found that staff were not always supported to do this effectively to ensure people received good quality care. This was because there was a lack of active leadership and communication. Decisions had been made over and above the registered manager's decisions without prior discussion. For example, the registered manager had appointed a senior care staff member to assist the nurse with the medication round, as the service was not fully staffed of nurses. The nurse was concerned that people who required nursing care should receive medication from a nurse, and in this instance, a senior care staff member was not appropriate. The nurse had made the decision to complete the medication round, which resulted in a delay of people receiving their medication.

Some people we spoke with told us they had had an accident or incident while they were at the home and felt these had been managed appropriately. We looked at how incidents and accidents were monitored that occurred in the service. Records showed that each incident was recorded however the detail of actions taken were sparse and it was unclear what action had been taken, or what learning could be taken from this. The registered manager recognised that reviewing of accidents and incidents required further work to ensure that emerging risks were anticipated identified and managed correctly.

A provider audit had taken place in December 2014. The audit had not identified the concerns that we found at our inspection. We found that the provider's focus did not demonstrate how the service delivered care, treatment and support to a good standard for all of the people who lived there. The actions following the audit were mainly around cleaning schedule and maintenance of the home. The registered manager was required to complete the shortfalls identified by January 2015 and this would be followed up with another provider audit. However this had not taken place, the registered manager did not know when another audit would take place.

The registered manager told us they made spot checks to ensure people were receiving the right care. We saw the registered manager was completing checks of medicated cream charts to identify any gaps. They showed us a person's medicated cream chart and identified gaps in the record. The registered manager told us they would need to identify which members of staff were on the duty where there was missing information. This was to identify if it was a recording error, or that the person had not received their medicated cream as required. However, we noted that the registered manager did not record these details and as such it was unclear as to how the shortfalls would be followed through. We asked the registered manager how they would follow up the shortfalls found, they replied, "There is too much about writing things down and documentation". Therefore, it could not be demonstrated that the shortfalls were followed through accordingly. So to improve the quality of care for people and drive improvement for staff practices.

Staff told us they liked working at the service even though it was busy at times and felt more staff were needed. Staff told us they did not always have regular opportunities to contribute to the running of the service. They said that staff team meetings did not always happen; they told us these would be useful to discuss smaller issues. Staff told us that they had recently completed a staff survey, however the results of these had not been provided yet.

People made positive comments about the way the home was run. People told us that the registered manager was visible in the home. One person said, "The [registered] manager visits regularly to ask how I am". People told us that seeing the registered manager regularly meant they were able to voice their thoughts and opinions and they were listened too and felt involved. We saw relatives were comfortable approaching them during our visit to discuss any concerns they may have. We spoke with one relative following their discussion with the registered manager, who told us that they were happy with the outcome. Staff told us that the registered manager visited at night and on the weekends to check everything was okay. The registered manager told us this happened through lessons learnt following the outcome of poor staff practice at night.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **People who used the service did not always have their needs met as there were insufficient numbers of staff to meet people's needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **People who used the service were deprived of their liberty for the purpose of receiving care or treatment without lawful authority.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People who used the service did not have the care and treatment that was appropriate, met their needs and reflected their preferences.**