Woodbridge Lodge Limited

Woodbridge Lodge Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 10 and 11 May 2016 and was unannounced.

Our previous inspection of 23 June 2015 had rated the service as Requires Improvement in the areas of Effective and Responsive. This inspection found that improvement had not taken place and a number of requirements of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were being breached.

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. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The service provides care and support for up to 32 people and is located central to Woodbridge town. On the day of our inspection there were 30 people living in the service. Some people living in the service were living with dementia.

The registered manager of the service had left the service the week prior to our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider had put arrangements in place to cover the management of the service while a new manager was recruited. This included cover by three different people all of whom had responsibilities elsewhere within the organisation that would continue.

Risks to people living in the service were not appropriately managed. Appropriate risk assessments were not always completed. Where they were, staff were not aware of the actions put in place to minimise the risk therefore these were not always followed. Appropriate manual handling practices were not always followed.

There were not sufficient staff to support people with their assessed care and support needs. This resulted in people waiting long periods for their care and support or not receiving the care and support they required. Staff regularly stayed over their contracted hours to provide care and support.

Effective infection control processes were not in place. Poor infection control procedures were observed during the inspection. Infection control audits were not used to improve processes.

The service did not demonstrate an understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) appropriately. Where people who required a referral to the appropriate authority this had not always been carried out and other referrals had been made inappropriately.

Staff did not always receive effective supervision and training. They did not demonstrate the skills required to provide effective care. We observed poor manual handling practices, poor infection control procedures and poor communication with people. We did observe some good interactions although these appeared to be because of the character of the individual rather than training and support they received from the service.

People had mixed views on the quality of the food provided. The lunch meal was not relaxed and enjoyable. People demonstrated challenging behaviour during the meal that was not addressed by staff. People did not always receive the support they needed to eat their meal. People's dietary intake was not effectively monitored.

People were able to express their views at residents and relatives meetings. However, people did not always feel listened or believe their concerns would be acted upon.

People did not always receive personalised care that was responsive to their needs. Care plans were not reviewed regularly to ensure they reflected people's changing needs. People did not always feel involved in their care planning.

The management appeared disconnected from what was happening in the service with a lack of cohesive leadership. The Provider Information Return (PIR) sent to us before the inspection gave examples of what the service was doing. We did not see these demonstrated during our inspection.

Monitoring and auditing was not effective and did not drive improvement. Action plans were not put in place where audits had identified deficiencies.

Medicines were managed safely and appropriately. People received their medicines when they required them. People were safeguarded against the risk of abuse as the staff were trained to recognise abuse. This was supported by appropriate safeguarding and whistleblowing policies.

You can see what action we told the provider to take at the back of the full version of the 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?

Inadequate

The service was not safe.

Risks to people were not adequately managed.

Safe moving and handling practices were not followed.

There were not sufficient staff to meet people's needs.

There were poor infection control procedures in the service.

Is the service effective?

Inadequate

The service was not effective.

Mental Capacity Act 2003 and Deprivation of Liberty Safeguards were not fully understood and applied.

Staff were not appropriately supervised leading to instances of poor practice.

People were not sufficiently supported to maintain an adequate food and fluid intake. Food and fluid intake was not effectively monitored.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff did not always demonstrate caring behaviour, particularly when under pressure to perform tasks in a specified time frame.

People did not always feel their concerns were listened to.

People's privacy and dignity were not always respected.

Is the service responsive?

Inadequate

The service was not responsive.

People did not always receive personalised care that was

responsive to their needs.

People and their relatives were not fully involved in their care planning.

People were not always supported to take part in activities that were meaningful to them.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of cohesive management within the service.

The service did not demonstrate an open and inclusive culture.

Information from monitoring and audits was not used to drive improvement.

Woodbridge Lodge 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 10 and 11 May 2016 and was unannounced. The inspection team consisted of 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. This particular expert had experience of caring for a person with dementia.

Before the inspection we reviewed information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection, we spoke with six people who lived at the service, three relatives, three members of care staff and the cook. We also spoke with the operations manager for the provider and two visiting healthcare professionals.

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 looked at five people's care plan records and other records related to the running of and the quality of the service. Records included staff files, audit reports and questionnaires which had been sent to people who used the service.

After the inspection we asked the provider to send us an urgent action plan as to how they were going to address our immediate concerns. This was received within the timescale given and detailed the actions the provider would be taking to address the concerns we raised.

Inadequate

Is the service safe?

Our findings

Risks to the individuals and the service were not managed so that people were protected and their freedom supported and respected. For example we observed one person walking in the garden in the pouring rain without a coat or an umbrella. Records showed that this person was living with dementia. Their care plan recorded that they would 'walk without purpose'. The care plan also contained a risk assessment for this person accessing the garden which stated '[Person] is independent walking and will walk around the home. [Person] is able to access the garden if [person] wishes but would need supervision.' Care staff were not aware of the contents of the risk assessment. When we drew the attention of a member of care staff to the person in the garden they supported the person back to the service. The risks to this person going out alone into the garden were not appropriately managed putting the person at risk.

Another person had been referred to the dietician due to weight loss. One of the actions recommended by the dietician was weekly recording of the person's weight. This had not been carried out. The care plan recorded that the person was too unwell to sit on weighing scales. The risk of not being able to weigh the person had been highlighted in the care plan, however there was no action recorded as to how this risk could be addressed and reduced through other methods of assessing weight loss.

A visiting professional told us, "They are struggling with manual handling." We observed unsafe moving and handling practices during our inspection. For example one person was supported to move from a chair to a wheelchair with the aid of a walking frame which is not the appropriate equipment to support a person with this manoeuvre. An accident/injury report by a member of staff described an injury to them whilst moving a person. The incident described an unsafe practice.

This was a breach of Regulation 12 (b), (d) and (e) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not ensure that there were sufficient numbers of suitable staff to keep people safe. One person said, "The worst thing is waiting for the toilet. This morning I waited for 20 minutes at least, they [staff] have got lots to look after and for the first time I made a mess." Another person said, "Sometimes you want help and it does not come." A relative said, "We came last night and at tea time where were only three staff and we ended up helping in the kitchen."

We observed the lunch time meal and saw that one member of care staff was supporting three people to eat. During the meal they had to get up from the table on a number of occasions to answer the telephone and answer the front door bell as there were no other staff available to do this.

Staff we spoke with expressed concerns that there were not sufficient staff to meet people's needs. They cited the fact that they regularly stayed over their contracted hours to complete tasks as evidence of lack of staff.

We spoke with the operations manager regarding staffing levels. They told us that a dependency assessment

tool was used to determine staffing levels and that they were currently working to the levels of staffing determined by this tool. They also told us that there were plans to increase the staffing levels in the morning but this had not yet started.

This was a breach of Regulation 18(1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adequate infection control processes were not in place to protect people from the risk of infection. A visiting professional told us, "I sometimes have to prompt hand washing." We observed poor infection control practices. For example, one person in the dining room was given a used discoloured dish cloth to wipe their hands, the person then went on to wipe their nose with the cloth. A member of staff then took the cloth back into the kitchen and put it on to the tray laden with clean tea and coffee cups. We later observed the dish cloth being used to wipe place mats.

The infection control audit for November 2015 had identified areas for improvement such as the cleaning of people's property. There was no action plan demonstrating how this would be addressed. A relative said, "The laundry is behind and things go missing."

This was a breach of Regulation 12(h) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed a senior member of staff dispensing medicines. They were able to describe and demonstrate how the service managed medicines safely, for example ordering and disposal. One person told us, "I am in quite a lot of pain every day and have tablets in the morning, middle of the day and at night and they stay with me and wait by my side until I have taken them." However, a relative told us, "I hope that they are better now but we have had a battle. I came in about a month ago and found tablets on the table."

Medicines records we inspected were appropriately completed. There were appropriate protocols in place for 'as required' medicines so that staff knew when people who could not describe their symptoms should be given this type of medicine.

There were suitable arrangements to safeguard people against the risk of abuse which included reporting procedures and a whistleblowing process. We saw that advice about how to report concerns was displayed in the staff room, including contact details for the relevant authority. Safeguarding incidents were reported and investigated appropriately and reported to the local authority and the CQC. Staff were knowledgeable about the risks of abuse and reporting procedures.

Inadequate

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 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 MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Our inspection of 23 June 2015 had found that the service was not effectively implementing the provisions of the MCA and DoLS. We checked whether the service was now working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that although staff had received training in the MCA and DoLS these were still not being appropriately applied. For example one person's care plan recorded, 'Although we feel a DoLS is needed this has yet to be applied for.' This meant that this person may have had their liberty restricted without legal authorisation. This was brought to the attention of the Operations Manager on the first day of our visit and the service made the appropriate application the next day.

This was a breach of Regulation 11(1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was an inconsistent approach by staff using the principles contained in the MCA when providing care and support. We observed staff offering everybody the same cold drink without offering a choice or telling people what they were giving. We also observed a member of care staff remove a person's gloves without asking if they wanted them removed or telling them what they were doing. However, we also observed some care staff giving people choice of where to sit and checking with people before putting disposable aprons on them to keep their clothes clean.

Staff did not demonstrate the skills to effectively communicate with people living with dementia. For example using closed questions such as, "You don't want any more?" instead of an open question which would have enabled the person to better express their preference. One person became quite frustrated during lunch pointing their finger at another person's face and raising their voice. The person being pointed at kept putting their head in their hands and laying their head on the table. Staff did not intervene to calm the situation. We observed a person living with dementia approach a member of staff and attempt to kiss them. The member of staff did not respond well and appeared to be very uncomfortable with the interaction. Another member of staff was supporting a person to sit down. They gave no verbal instructions to the person so the person did not appear to understand what the staff member wanted them to do.

Supervision of staff was inconsistent. Records showed that one member of staff had not received any

supervision in 2016 and others had only received two supervisions. Supervisions are a method used to ensure staff are supported in their role, monitor their practices and ensure they are putting training into practice. We observed poor moving and handling practice and poor infection control procedures which meant that staff were not implementing their training. Poor practice in these areas could result in the spread of infection and injury to people.

This was a breach of Regulation 18(1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had mixed views on the food provided by the service. They told us that the main meal was acceptable. One person said, "You don't get variety like you would at home. One or two of us would like curry or lasagne but we don't get them. It is just straightforward fare." Another person said, "I never go hungry. Yesterday was liver and bacon and it was a bit bitter, not many people ate it all." People went on to say that while lunch was adequate the tea time meal was poor. One person said, "Tea time is not a good meal, you get two quarters of a sandwich and a piece of cake. I am fed up with sandwiches, there is not a lot of variety."

People did not receive the support they required to maintain their food and fluid intake. A relative said, "Fluids, [relative] is not good at drinking and has to be prompted and this morning when I got here at 11.30 [their] glass was empty and the jug was full of yesterday's squash. This is an on-going problem. I change [their] juice and encourage [them] to drink." Another relative said, "[Relative] is left alone with food and [relative] cannot manage on their own." The lunch meal was not a relaxed enjoyable experience which would encourage people to eat and enjoy their meal. One staff member was supporting two people to eat, there was no conversation and no checking if the people were ready for the next mouthful or telling them what their next mouthful was. One person was becoming frustrated during the meal and was pointing their finger at another person's face and raising their voice. This went on throughout lunch. The person being pointed at kept putting their head in their hands and laying their head on the table. Staff did not intervene until a senior member of staff told them to.

The service did not effectively monitor the food and fluid intake of people who had been assessed as requiring this. For one person their food intake had been recorded in three different places. This made it difficult to monitor their intake to ensure they were receiving sufficient fluid. Fluid intake recording had also been duplicated which could mean that a person appeared to be having more fluid than they were. Food and fluid charts were not monitored to ensure that people received adequate intake each day. Staff we spoke with did not know who was responsible for monitoring this with one person telling us that it was the night staff and another that it was the manager. When we asked to see a person's fluid charts these could not be found and were eventually located in a box containing fluid charts for everybody. The Operations Manager had to search through the box to find the charts for the particular person we had requested. Fluid charts had not been totalled to establish the total fluid intake and output for each day. There was no monitoring of a people's fluid intake to establish what they had consumed each day and ensure it was adequate for their needs.

The service used the Malnutrition Universal Screening Tool (MUST) as part of the assessment process to establish people's nutritional needs. This was incorporated into the computer care planning programme. Where this established that people needed a referral to a dietician this had been made. However, the advice given by the dietician was not always fully implemented. Staff did not have a full understanding of the MUST. We asked the Operations Manager for a copy of the service MUST policy and were given nutrition guidance and the National Institute for Clinical Excellence guidelines. There was no guidance around how to support someone with a low body weight to maintain their weight. This could mean that appropriate

actions were not taken when a person was at risk of losing weight.

This was a breach of Regulation 14(1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's individual needs were not met by the design and decoration of the service. Records showed that 20 people had been assessed as living with some degree of dementia. The service decoration was not dementia friendly. For example chairs were not arranged in clusters to encourage conversation. Signage in the service did not promote people's independence and support them to find their way around the service. For example identification of people's individual rooms and bathrooms by signs and accent colours and artworks.

The service made appropriate referrals to other health care professionals. One person said, "Dentist came last week and gave me some fillings. District nurse and chiropodist come and if you don't feel well or have a pain and you are worried they get a doctor to come." Another person said, "I can see a doctor or dentist if you want to. I speak to staff."

Requires Improvement

Is the service caring?

Our findings

There was an inconsistent approach to caring. Whilst we saw some good practice we also found poor practice which was not identified and acted on robustly by the provider. This included aspects of the running of the service which affected the ability of staff to care for people well. For example not enough staff and skill levels of staff. This was reflected in comments we received about the service. One person said, "Carers are great generally. They are kind and patient but there are not enough of them." Another said, "The little young carers have been excellent, they are good. The carers are a jolly mob." A member of care staff told us that the service had introduce a key worker scheme where a member of care staff was given between three to five people to get to know better. They told us that they had developed more knowledge of the people they had been allocated to be the key worker for.

We observed some staff showing concern for people's wellbeing. For example we observed a member of care staff supporting a person to return to their room after their meal. They showed patience and gave good encouragement to the person to walk independently. However, on occasions where staff were under pressure to perform tasks, such as at meal time, this person-centred approach suffered. A relative told us, "Today [relative] clothes do not match, the cardigan does not go with that shirt and [they have] has got yesterday's socks on. [Relative] has no bra on. Sometimes the night staff get [relative/them] up and they do not have the time to spend on [relative/them]."

A relative told us that as a result of concerns raised they understood from the management team that a designated member of staff would be allocated each shift to look after people who stayed in their bedrooms but this was not happening. We asked the management team if this procedure was taking place but they were not aware of it. This demonstrated poor communication within the service.

People's privacy and dignity was not always respected. We saw some good examples of staff respecting people's privacy for example the maintenance person checked with a person who was eating lunch in the dining room if they could go and fix the toilet in their room and let them know that they would be in their room when they returned. However, we also observed staff supporting one person to sit at the dining table, staff then moved them because another person wanted to sit where they were sitting. The staff member did not check with the person if this was acceptable and did not move the person's drink with them. We observed other members of staff entering people's bedrooms without knocking or asking permission. We also observed staff lifting up the bed clothes of a person being nursed in bed without checking that it was acceptable or telling the person what they were doing.

People were able to express their views at residents meetings. However, they did not always feel their concerns were acted on. When asked about residents meetings and changes made as a result of them one person told us, "Had one three months ago and we said about the lack of towels and flannels in the rooms not being available all the time but there was no change. It was the first meeting I am aware of, there was lots of very open conversations, there was a change of care manager who has now gone. No promised changes were made." Another person said, "I could not get flannels, when I threatened to cut up the towels they did give me flannels." When we checked people's bathrooms at 3.30pm only six out of seven rooms

checked had towels and flannels available.

Inadequate

Is the service responsive?

Our findings

Our inspection of 23 June 2015 found that people were not involved in their care planning. This inspection found that people still did not always feel involved in their care planning. One person said, "I have not been asked my views." A relative told us, I have to go searching for information unless it is an incident. A relative had written in the response to the question 'What we could improve on' in the April quality assurance survey, 'Communication with the family. We feel out of the loop of care/decision making.' Staff were not aware of the service policy regarding reviews of care plans. One member of care staff said, "It is up to the relatives three monthly, six monthly or yearly." A member of the management team told us that the policy was to review care plans every three months. Records did not demonstrate that care plans had been updated regularly. This could mean that the care plans did not reflect people's current needs leading to them receiving inappropriate care or support. Care plans were held on computer they did not always demonstrate that people had been involved in the review of their care and were not easily accessible for people to read. Separate paper folders were kept where documents which required a signature were held but these did not always demonstrate that people had been involved in the reviews of their care.

People did not always receive personalised care that was responsive to their needs. For example one person had had an impacted bowel, the GP was involved and they had been prescribed bowel medicines. The service was not monitoring this person's bowel movements to check if the medicines were effective. Risks to people from an impacted bowel are serious and have resulted in death.

Care plans did not always reflect people's needs and contained contradictory information. For example care plans contained a section on mobility. One question asked about a person's level of mobility and this had been completed as 'unable to move'. There was another question which asked if the person was able to walk and this had been answered 'yes'. Another section in the same care plan had identified this person's skin as 'paper dry' but their tissue viability has been assessed as low need. This information was inconsistent and did not ensure that the person received care which met their needs.

People had mixed views regarding the activities they could be involved with in the service. One person said, "It is a bit dull at times, we do jigsaws, I read and sometimes I can sit here quite a while before anyone notices me." However, another person said, "We have fun days, music groups, good musical times, card games, jigsaws and Church services." We spoke with the service activities co-ordinator. They were enthusiastic about their role and we saw notice boards in the service conservatory which contained some recent art work produced by people living in the service. However, when we discussed with them the type of activities they provided and what training they had received they told us that they had not had any specific training, what they provided was as a result of their experience caring for a relative. Activities we observed were generic, such as bingo and flower arranging. They were not related to people's specific interests and previous experience and were not designed to ensure they felt part of their community.

This was a breach of Regulation 9(1) and (3) (a) and (b) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a complaints policy which was displayed in the service. Formal complaints were recorded on the service computer and dealt with within relevant timescales.

Inadequate

Is the service well-led?

Our findings

The service did not promote a positive culture that was person centred, open, inclusive and empowering. One person said, "We were private and it was homely, now it is purely a business venture. We have just lost another manager and [they were] not here five minutes."

The registered manager had left the service the week before our inspection. We were given different reasons by the provider's management team as to the reason they had left. This did not demonstrate a transparent and open culture.

The provider had put arrangements in place to cover the management of the service while a new manager was recruited. This included cover by three different people all of whom had responsibilities elsewhere within the organisation that would continue. This did not provide people or staff with a consistent support structure. We found a lack of management oversight with a lack of a response when deficiencies were identified. For example a report in early December 2015 had identified a trend regarding falls at night. One of the actions identified had been to monitor people's fluid intake and this would be reviewed at the end of December 2015. There was no evidence that fluid intake had been monitored or that the action plan had been appropriately reviewed.

Monitoring and auditing within the service was not effective and used to drive improvement. For example an accident report showed that an injury to a member of staff had been due to poor manual handling techniques. No action had been taken as a result of this report to ensure that the poor manual handling techniques of the member of staff had been addressed. Our inspection observed further examples of poor manual handling techniques which could have resulted in injury to people or care staff. Another example was the infection control audit for January 2016 which had identified areas for improvement. No action plan had been put in place and our inspection identified poor infection control practices putting people at increased risk of infection..

Information given to us prior to the inspection in the service PIR was not demonstrated in practice. For example the PIR stated that observations charts were in place and checked by management. We found that was not the case, for example as demonstrated earlier the recording and monitoring of fluid intake. The PIR also stated that staff supervisions were carried out regularly. Our inspection found that this was not happening in practice. This demonstrated a disconnect between the management and what was actually happening in the service.

Relatives we spoke with did not feel the service encouraged open communication and did not react appropriately to issues they raised. One relative had been concerned about the inadequate response to concerns they had raised with the service that they contacted us with their experiences.

This was a breach of Regulation 17(1) and (2) (a) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management were not aware of the day to day culture of the service. Some staff demonstrated compassion and respect for people using the service. However, others did not. The management team were not visible and available in the service to demonstrate appropriate values and behaviours. One person said to us, "The care is patchy, some excellent some could vanish. I look out of my door and watch one carer wandering down with my tea. They came slouching along and when they got here there was no cake." We raised the attitude and demeanour of this particular member of staff with the management team at feedback giving them further examples of inappropriate behaviour we had observed which had not been addressed by senior staff or the management team.

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 were not involved in their care planning

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's consent to their care and treatment was not appropriately obtained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment All that was practicable was not done to mitigate risks. Premises were not used in a safe way. Equipment was not used in a safe way. Inadequate infection control procedures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's nutritional needs were not met.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established and effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient competent and skilled staff deployed.