

Your Health Limited

Cedar Court Nursing Home (Dementia Unit)

Inspection report

Cedar Court Care Home
Bretby Park
Bretby
Derbyshire
DE15 0QX

Tel: 01283229523

Website: www.yourhealthgroup.co.uk

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22 June 2017

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

We inspected Cedar Court Nursing Home (Dementia Unit) on 22 June 2017 and it was an unannounced inspection. The home provides accommodation and nursing care for up to 50 people who are living with dementia. There were 36 people living at the service when we visited. There was separate all male accommodation upstairs in Bretby View and at the time of our inspection 15 men were living there.

The overall rating for this service is 'Requires improvement' and the service remains in special measures. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services 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.

After the last inspection on 24 January 2017 we put positive conditions on the provider's registration with us. This meant that they were required to report to us what improvements they had made every two weeks. The provider complied with this requirement and at this inspection we saw that some improvements had been made as the provider had reported. However, they had not completed all of the actions that were detailed in their improvement plan and this impacted on the safety and wellbeing of people who lived at the home. Therefore, we will retain the positive conditions on the provider's registration until we are satisfied that significant improvements have been completed.

The home did not have a registered manager in place; however, they did have a manager who was in the process of applying for their registration. 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.

We found that risk was not managed sufficiently to ensure that people were kept safe. This was an issue at the two previous inspections. People were not always supported to move safely and the plans in place to protect people's skin were not always followed to be effective. In the provider's action plan they had addressed staff understanding of managing behaviour which could be challenging. They had also reviewed risk around people's eating and drinking. However, the improvements did not address all risk management.

At the previous inspection we found that the provider ensured that there were enough staff deployed but because a lot of them were from an agency they did not always know people well enough to meet their needs. Although this had improved because there were more permanent staff it was still a concern around the leadership team and for nurses. It meant that there was not always sufficient senior staff to support staff or the manager. It also meant that improvements were not progressed quickly because they were all dependent on the manager completing them. Quality improvement systems were not fully embedded and actions from audits were not all completed.

At the previous two inspections we found that the Mental Capacity Act 2005 (MCA) was not fully embedded and we found that this was still the case at this inspection. Capacity assessments were out of date and some DoLS had also expired without the provider re-applying for them. Best interest decisions were not always completed when required.

Similarly, care plans were not always up to date or regularly reviewed for people to ensure that staff had relevant information to assist them to support people. This had been an issue at the previous two inspections. The manager had devised a new care plan and those that had been reviewed were detailed. However, the progress in completing this was slow and over half of the people at the home still did not have an up to date plan.

We found that the provider did not always respond to complaints in a timely and open fashion in line with their procedure.

Some improvements were evident at this inspection. Staff now had an understanding of how to recognise and report safeguarding concerns. The provider had reviewed systems in line with safeguarding recommendations. Medicines were administered at the correct time to ensure that people received them as required. Records were maintained and management systems had been introduced.

Staff had positive relationships with people and respected their privacy and dignity. People were encouraged to participate in activities and important relationships with friends and relatives were encouraged. People and their relatives were communicated with so that their feedback could contribute to the development of the service.

Staff supported people to see healthcare professionals regularly to maintain good health. Mealtimes were well planned to ensure that people received the support they needed, including specialist diets.

We found breaches of the Health and Social Care Act 2008 (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.

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 consistently safe. People were not always supported safely or in line with their assessed risk. There was a reliance on agency staff in some posts and there were not always the required mix of skills and experience to keep people safe. Safe recruitment procedures had been followed when employing new staff. People were protected by staff who knew how to keep them safe from harm and how to report any concerns. They received medicines at the time that they needed them and records were maintained.

Requires Improvement ●

Is the service effective?

The service was not consistently effective. People's capacity to make their own decisions was not always assessed and reviewed. Legal safeguards were not always up to date. Staff received the training and support required to support people well. People were supported to maintain a balanced diet and to access healthcare professionals when required.

Requires Improvement ●

Is the service caring?

The service was caring. Staff had developed caring, respectful relationships with the people they supported. People were supported to make choices about their care and their privacy and dignity were respected and upheld. Relatives and friends were welcomed to visit freely.

Good ●

Is the service responsive?

The service was not consistently responsive. People's care plans were not up to date to be able to guide staff in how to support them. Complaints were not always responded to openly. Hobbies and interests were encouraged and activities organised.

Requires Improvement ●

Is the service well-led?

The service was not well led. The provider had not ensured that all of the improvements in their action plan had been made. This meant that people did not always receive a safe service. Staff felt supported and told us that the manager was approachable.

Inadequate ●

Cedar Court Nursing Home (Dementia Unit)

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.

Two inspectors and an expert by experience completed this unannounced inspection on 22 June 2017. An expert by experience is someone who has personal experience of using or caring for someone who used a health and social care service. On this occasion we had not asked the provider to complete 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. We gave the manager the opportunity to share this information with us during the inspection.

We used a range of different methods to help us understand people's experiences. We spoke with twelve people who lived at the home to ask if they were happy with the care they received. People had varying levels of communication and so we observed the interaction between people and the staff who supported them throughout the inspection visit. We also spoke with four people's relatives about their experience of the care that the people who lived at the home received.

We spoke with the registered manager, a nurse and eight care staff. We contacted three healthcare professionals who worked closely with the home. We reviewed care plans for eight people to check that they were accurate and up to date. We also looked at the systems the provider had in place to ensure the quality of the service was continuously monitored and reviewed to drive improvement.

Is the service safe?

Our findings

At our last inspection we found that risk was not always managed to protect people from harm and there was a breach of Regulation 12 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. At this inspection we found that some improvements had been made but that further improvements were required.

When some people were supported to move this was not always completed in safe way to avoid the risk of harm to them. For example, we saw that one person was assisted to stand from a chair by two staff who lifted the person from under their arms. This does not follow best practise guidance and may cause harm to the person, or to the staff. Another person was supported to walk by one member of staff who pulled their arm to direct them which could cause harm to the person. We also saw that when one further person was assisted to move using a hoist that the equipment was not used correctly and the person was at risk of falling. When we looked at the risk assessments for these people we saw that they had not been reviewed recently and did not give sufficient guidance to staff; for example, the plan for one person did not include the use of the hoist that they required.

Accidents had not always been reviewed to ensure that action could be taken to avoid future harm. For example, one record showed that a person had fallen in the shower because a chair had moved as they sat down resulting in injury to the person. This had not been reviewed to ensure that the equipment was not faulty nor addressed with the member of staff to ensure that they understood how to use the equipment safely.

The plans in place to manage people's skin were not always followed to ensure that the damage to it was minimised. One member of staff we spoke with said, "When [name] is in the communal area we do try to reposition them with pillows". When we reviewed the plan in place for this person we saw that they should be moved every two hours. We saw that there was a period of four hours when this hadn't happened. We also could not be sure that it had happened as it should in the two days before the inspection visit because records had not been completed. Staff told us that the pressure wound had got worse. We saw that another person who should have been repositioned on a regular basis had also not been moved as regularly as planned. This meant that we could not be sure that the plans put in place to manage people's skin were effective.

Some people received their medicines covertly, this means without their knowledge. Medicines can be given covertly if the person does not understand that they are essential to maintain their health and wellbeing. We saw that the person's capacity to make this decision had not been assessed and that the decision to administer their medicines in this way had not been made in their best interest with guidance from relevant healthcare professionals. There was no plan in place to describe in what circumstances medicine should be given covertly, how to administer it and when this should be reviewed. This meant that medicines were administered covertly without following best practise guidance.

This evidence represents an ongoing breach in Regulation 12 (1) of the Health and Safety Care Act 2008.

(Regulated Activities) Regulations 2014.

At the last inspection we saw that a lot of staff were not permanent and were from an agency and that they did not always know people well enough to meet their needs promptly. At this inspection some new staff had been employed and the agency staff were familiar to people. However, some situations had not been risk assessed to ensure that there were adequate staff. For example, we saw that there was one member of staff in the communal area in the morning supporting people with their meal while other people were supported to get up. There were periods of up to fifteen minutes at a time over an hour long period when they were on their own with eight people. They were unable to respond to each person's needs and some people became anxious during this time. This meant that the member of staff had to attend to them and people's meals were delayed. When we asked them about this they said, "I don't know what the maximum number I should support on my own is. I think other staff will be here soon but I am not sure". They told us that there was a senior member of staff working but that they were not on that floor to give direction. One health professional we spoke with said, "The consistency of nursing staff is still our biggest concern. Information is not always shared and we can be consulted about the same concern on more than one occasion". When we reviewed staffing levels and spoke with the manager we saw that there were still vacancies within the management team of the home and for permanent nurses. This meant that the provider had not ensured that there were sufficient staff who had the right mix of skills and experience to meet people's needs safely.

At our last inspection we found that staff were not given guidance to understand how to support some people who behaved in a way that could cause them or others harm. At this inspection we saw that improvements had been made and staff were knowledgeable about the signs of people's anxiety and took action to reduce it. For example, we saw one person become agitated and vocalised this by shouting. Staff responded to the person and offered comfort and suggested different things which might be what the person wanted. We saw that the person responded to this interaction and calmed down. When we looked at the plan that was in place to support them we saw that staff had followed the guidance suggested. We also saw that plans had been reviewed to support people more effectively. For example, at the last inspection one person received additional support on a one to one basis in their room. At this inspection we saw that they spent planned time in the communal area and staff were knowledgeable about how to support them if they became anxious.

People were protected from harm and abuse by staff who understood their responsibilities to report safeguarding concerns. At our last inspection they did not always recognise what could be considered a concern and we found that this had improved. They were able to describe situations which they would report; for example, if they saw that someone had a bruise. We looked at safeguarding investigations and found that the provider had reviewed staff competency, care plans and the environment to put measures in place to protect people. The manager told us that the number of unexplained bruising and incidents of aggression between people had reduced since these actions had been taken. This demonstrated to us that the provider understood their safeguarding responsibilities.

Medicines were administered to people to ensure that they received them as prescribed. This had improved since our last inspection. We saw that people received their medicines at the time they were needed and that staff were patient and took time with people to ensure that they took them. When people took medicines as required, there was guidance in place to support staff to understand when it should be administered. Records were maintained and there were systems in place to ensure that they were stored safely.

The provider followed recruitment procedures which included police checks and taking references to ensure

that staff were safe to work with people. We looked at recruitment files and saw evidence that this was completed.

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 or 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. At our last inspection we found that improvements were needed to fully embed the MCA and at this inspection improvements were still required. Staff were able to tell us about people's capacity to make decisions and we saw that they supported some people to; for example, to consent to being supported to move. However, best interest decisions had not been considered for all instances; for example, when someone had bedrails put onto their bed. Mental capacity assessments had not been reviewed recently or when people's capacity to make decisions changed. For example, one person's capacity assessment had been completed in 2014 and since then their capacity had reduced due to the progress of their dementia condition.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Since our last inspection some DoLS applications had been made to address restrictions that we highlighted. However, all of the staff we spoke with were unable to tell us who had a DoLS in place.

We recommend that you review all of the capacity assessments to ensure that the information is current and reflects people's abilities to make their own decisions. These should be decision specific and ensure that any decisions made on people's behalf are in their best interest.

At our last inspection we found that people were not always supported by staff who had the skills and knowledge to meet their needs. At this inspection staff told us and we saw that they had received training and support to do their job well. For example, we had highlighted that staff were not knowledgeable about supporting people who sometimes behaved in a way that could be challenging. Staff we spoke with told us that they had attended training in this and that it had helped their understanding. One member of staff said, "It helps you to think about what the behaviour might mean and how to help the person". One relative told us, "Most of the staff do seem to understand dementia and its challenges and appear trained to care for my relative well." One member of staff told us, "When you are supporting someone who has dementia it is important to know them. For example, one person behaves in a certain way which made sense when we found out what they used to be employed as". When we spoke with the manager they told us that they had spent time mentoring the staff. They said, "We needed to change the culture of the home and that included the basics; for example, how staff speak to people". The manager and one other member of staff had completed a dementia course and they told us about their plans to embed it in the home.

New staff were supported through an induction. One member of staff we spoke with said, "Before I started I had to attend various training days and was not allowed to support people until these were completed." Another member of staff told us, "When I started working here with the agency I had an induction to make

sure I was safe; but when I started permanently I was given a more detailed one. I am also working on the care certificate". The Care Certificate sets out common induction standards for social care staff. It has been introduced to help new care workers develop and demonstrate key skills, knowledge, values and behaviours which should enable them to provide people with safe, effective, compassionate and high quality care. The manager said, "We have had a lot of new staff and so we have had to concentrate on getting the induction right and making sure all new staff are competent to support people".

Staff understood people's dietary needs and when they needed a specialised diet. This had improved since our last inspection. One member of staff told us, "We are conscious about people's diet and nutrition. We weigh them regularly to make sure they are not losing weight or anything". The manager told us that they had reviewed every person's diets and made referrals to healthcare professionals for people whose needs had changed. We saw that the kitchen staff had up to date information about people's requirements to ensure that they were given the correct food.

The mealtime experience had also improved and people enjoyed their meals. One relative told us, "[Name] eats very well and they are always offering them drinks and snacks." We saw that people were offered a choice of meals and that consideration had been given to how it was served; for example, there were serving dishes in the middle of the table. When people required assistance to eat this was done in a patient manner. We saw staff taking time to reassure and encourage people throughout the meal.

At our last inspection we found that people were not always supported with their health care when needed. At this inspection we saw that this had improved. The manager told us, "Since the last inspection we have received a lot of support from healthcare professionals to review people's support. We made referrals for some people to receive additional support and ensured that others attended appointments". We saw that healthcare professional visited on the day of the inspection to monitor each person's general health and to review their medicines. This showed us that the provider was ensuring that people had their healthcare needs met.

Is the service caring?

Our findings

At our last inspection we found that people were not always supported in a manner that was caring or promoted their dignity. At this inspection we saw that this had improved. We saw kind, caring relationships between staff and the people they supported. One relative said, "The staff are all really kind and caring and do a good job." We saw that staff were kind to people and reassured them if they were distressed. For example, one person was given a hug and spoken with when they were distressed and we saw this comforted them. One member of staff we spoke with said, "I am confident that the care is good here. It's not always an easy job but I am proud of how we look after people".

People's privacy was respected and their dignity upheld. One relative told us, "My relative is always properly dressed and their privacy is maintained". We saw that when people were supported to move staff ensured that they were covered up. One member of staff we spoke with said, "People's appearance is really important so we do our best to match clothes. We help them with their hair and paint nails as well so that people feel good about themselves".

People were encouraged to make choices about their care. For example, they were asked where they wanted to sit and if they wanted to join in with activities. A lot of the people who lived at the home were not able to verbalise choices but we saw staff showing them different things so that they could indicate which one they wanted. Staff were also aware that some behaviours from people may mean that they didn't want to do something and so they intervened.

People were made to feel important and special occasions were celebrated. We saw that the home had received a card from one person's family thanking them for organising a special birthday party. People's religious and cultural needs were also considered. We saw that one person was supported to attend a religious service on the morning of the inspection. Another person's cultural foods were provided sometimes and staff told us that one member of staff was able to speak with them in their first language which they responded to.

People's visitors were welcomed at any time. One relative told us, "I come very day and I am always welcomed". We saw that relatives visited their families and had familiar relationships with staff; for example, they were offered a drink and a space to visit quietly if preferred.

Is the service responsive?

Our findings

At our last inspection we saw that staff were not always responsive to people's needs and that care plans were not always up to date. At this inspection we saw that some improvements had been made but that further improvements were still required. Staff had a better understanding of people's needs and their preferences. When care plans had been reviewed they were detailed and clear. The manager was continuing to update the care plans and had a plan to complete them within two months. However, over half of the care plans had not been changed to the new format and the information in them was out of date and did not relate to people's current requirements. For example, when we saw that one person did not look safe in the sling that was used to hoist them. When we reviewed their care plan to see what size they should use there was no record of this and the recommendation from the healthcare professional had not been recorded. One member of staff said, "I know that the healthcare professional did an assessment but I am not sure if that is the sling that they recommended".

We recommend that you prioritise updating all of the care plans for people who live at the home to ensure that staff have the information they need to support people effectively.

The provider had a complaints procedure in place and relatives told us that they knew how to complain. Relatives that we spoke with were confident that if they raised a concern with the manager it would be responded to. However, one relative had contacted us prior to the inspection to tell us about a complaint they had made. They told us that they were not satisfied with the detail of an internal investigation. We discussed this with the manager who said that this complaint was being managed away from the home by the provider. They asked the provider to update us and the relative on the outcome immediately after the inspection. This was not completed and when we spoke with the relative they told us, "We have not received a response to this complaint". We have not had an apology or an explanation."

This evidence represents a breach in Regulation 16 of the Health and Safety Care Act 2008. (Regulated Activities) Regulations 2014.

People were encouraged to participate in activities. We saw that some people played games with staff and others enjoyed some one to one time with sensory objects. One relative told us, "They have improved their understanding about people by sending out questionnaires to relatives about life stories etc." When we spoke with staff they were able to tell us about people's previous lives, including jobs and families. This was an improvement on the last inspection and meant that they were able to engage people in conversations and provide them with activities that they might recognise. One member of staff said, "We don't have an activities co-ordinator at the moment and so we do try to spend time doing individual activities".

Is the service well-led?

Our findings

At the last inspection we saw that the systems in place to measure and drive improvement were not fully effective and required improvement. We set positive conditions against the provider's registration which meant that they were required to give us regular updates on their progress towards improvements detailed on their action plan. At this inspection we saw that some improvements had been made but that the provider had not completed all of the actions to ensure that the home was well managed. This continued to have an impact on the people who lived at the home. For example, this was the third inspection that the provider was found to be in breach of regulation 12 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014. This meant that they had not demonstrated that they could make the improvements required to ensure that people were kept safe. They also continued to require improvement for the third inspection in embedding the MCA and providing person centred care by ensuring that care plans were up to date.

There was a manager in post who was in the process of completing their registration with us. One of the actions that the provider had agreed to after our previous inspection was that a leadership team should be recruited in the home, including a deputy manager. This had not been completed and meant that the manager was responsible for completing improvements without the required support. It also had an impact on the day to day management of the home. For example, accidents and incidents had not been reviewed and audited when the manager needed to take some unexpected leave because this responsibility was not delegated to any other member of staff. There were also improvements which were highlighted through audits which had not been completed. For example, a review of medicines management had been completed two months previously by healthcare professionals. They highlighted that the home did not have the required documentation in place to record the administration of covert medicines. The manager told us that they were aware that this needed to be completed but had not had capacity to complete it by the time of the inspection. This meant that when the provider had been informed that recording of medicines was not sufficient they had not ensured that it was improved.

We also asked the provider to prioritise the recruitment of permanent nurses. We saw that slow progress had been made and that there was one part time nurse on the day of inspection and one new nurse had started during the previous week. This meant that several vacancies remained. Healthcare professionals who worked closely with the home told us that this had an impact on the safety of the people who lived at the home. One said, "We are rung for advice and support daily because the agency staff do not know people well and are not confident to make judgements."

Since the last inspection the home had received ongoing support and guidance from partner organisations to help them to make improvements. When we spoke with the healthcare professionals from those organisations, they stated that the work that had been completed was done to a satisfactory standard; for example, starting to write the new care plans. However, they also said that they thought progress was slow and that the majority of the responsibility was held by the manager who did not seem to have capacity to complete it all. When we reviewed additional support given to the home by the provider we saw it had targeted specific improvements. For example one member of the provider's operational team had

completed some environmental audits in response to safeguarding investigations. Another member had completed an audit of care plans which included a review of nutritional records. Although we saw that this did have a positive impact on the quality of the service it was not consistent to ensure that all of the improvements which were required were made in a timely manner.

This evidence represents an ongoing breach in Regulation 17 (1) of the Health and Safety Care Act 2008. (Regulated Activities) Regulations 2014.

We will retain the positive conditions on the provider's registration until we are satisfied that significant improvements have been completed.

Relatives told us that the manager was approachable and had been in contact with them. One said, "I think the manager is very good and all the staff seem to respond well to them. They are trying to improve care and understanding about the people who live here. They always make an effort to talk to us when we are here and listen to what we have to say." The manager told us that they had recently introduced surveys for relatives and arranged to have a regular open forum for families to drop in to see them. This showed us that they were taking action to ensure that they responded to feedback from relatives.

Staff felt supported and that they could raise any concerns that they had. One member of staff said, "The manager is very good. We have staff meetings and they are very approachable and listen to us." They told us that they received supervision and support. We saw that the manager was visible throughout the inspection and knew people well. They intervened on two occasions to ask staff to consider a different way of approaching people. Staff told us that they the manager reinforced values and how to support people.

At the last inspection the provider had not complied with their registration requirements to send us notifications about important events which happen in or affect the running of the home. This had improved and the manager had notified us as required.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service where a rating has been given. It is also a requirement that the latest CQC report is published on the provider's website. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed their rating in the home and on their website.

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 12 HSCA RA Regulations 2014 Safe care and treatment
Diagnostic and screening procedures	The provider had not ensured that the care and treatment of people was provided in a safe way.
Treatment of disease, disorder or injury	
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints
Diagnostic and screening procedures	The provider had not ensured that all complaints were investigated and responded to within the timescales stated in their policy.
Treatment of disease, disorder or injury	
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Diagnostic and screening procedures	The provider had not ensured that there were sufficient systems in place to assess, monitor and improve the quality of the services provided to people.
Treatment of disease, disorder or injury	