Healthcare Trust Ltd

# Penbownder House

## Inspection report

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Date of inspection visit:
22 November 2022

Date of publication:
03 January 2023

## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

About the service
Pendownder House is a residential care home providing personal care to up to 34 people. The service provides support to younger adults, people with mental health needs, older people and people living with dementia. At the time of our inspection there were 34 people using the service. The service was separated in to two units one for people living with dementia and one for people with mental health needs.

People's experience of using this service and what we found
Medicines were not always managed safely. Some medicines information provided in the care plans was not accurate. Medicines that required stricter controls were not always recorded correctly.

Risks were not always identified or safely managed. An open sharps bin containing used needles and syringes was kept on top of a cupboard in the dining room. People who were living with dementia had easy access to this bin.

Staff did not always have the necessary guidance in care plans to help them support people to reduce the risk of avoidable harm. One person, had assaulted staff and other people living at the service. However, their care plan did not contain any risk assessments to guide and direct staff on how to reduce this identified risk, such as noting specific triggers to the behaviour or detailing what worked to de-escalate the situation.

Everyone in the service had an electronic care plan. However, some information provided on the profile page was not accurate. There was a lack of detail in all the care plans we reviewed. Some guidance provided was not good practice.

Infection control processes and procedures were not always robust. Prior to this inspection the registered manager had agreed to all staff dispensing with the wearing of face masks. Staff were guided to wear a mask when working closely with people such as during personal care. This was not in line with the current guidance. The registered manager took advice and re-instated the wearing of masks.

Visitors were still being asked to make arrangements in advance before visiting loved ones. This was not in accordance with current guidance and we advised the provider that visiting should be entirely open and unrestricted.

The Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DOLS) were not always implemented effectively at the service. The registered manager did not have an accurate record showing which people had authorisations in place for restrictive care plans.

Some people had been assessed as requiring pressure relieving mattresses to help ensure they did not develop pressure damage to their skin. These mattresses were not always set correctly for the person using them.

There was very little activity provided for people. There was a 'magic table' (the Magic Table is an interactive light projector designed to increase physical and social interactions for people living with dementia) and several headsets to enable people to listen to their choice of entertainment, however, staff confirmed to us, "They are hardly ever used."

The staff mostly provided task-based interaction with people. On the day of our inspection everyone in the dining room was given the same meal in the same quantities, with no comment made by the staff.

Comments from people about the food where mixed and included, "No choice," "The food is good, very good, I like it. I just eat what is put in front of me" and "The food is alright sometimes. Not really a choice."

The registered manager and the provider shared the audit programme providing an overview of the service provided. However, the audit process was not effective and had not identified concerns found at this inspection.

New staff were recruited safely. There were sufficient numbers of staff on shift to meet people's needs.

Staff were provided with training to ensure they had the knowledge and skills to meet people's needs. Staff were provided with supervision.

People and their families were provided with information about how to make a complaint and details of the complaint's procedure were displayed at the service.

People were asked for their views in a survey. The registered manager communicated with families when they visited, or by email.

There was a registered manager at the service at the time of this inspection. The provider supported the registered manager at the time of the inspection.

For more information, please read the detailed findings section of this report. If you are reading this as a separate summary, the full report can be found on the Care Quality Commission (CQC) website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (Published 20 September 2018). At this inspection the rating has changed to requires improvement

Why we inspected
We received concerns in relation to the care provided by staff. We carried out a focused inspection covering Safe, Effective and Well led.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection. We found breaches of the regulations relating to safe care and treatment, consent, person-centred care and good governance.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for

Penbownder House on our website at www.cqc.org.uk

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

Requires Improvement

The service was not always safe.

Details are in our safe findings below

**Is the service effective?**

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

**Is the service well-led?**

Requires Improvement

The service was not well-led.

Details are in our well-led findings below.

# Penbownder House

**Detailed findings**

## Background to this inspection

Inspection team
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Penbownder House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and we looked at both during this inspection.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Before the inspection, we reviewed information we held about the service and the provider which included any statutory notifications sent to the CQC. A notification is information about important events which the service is required to send us by law. We used the information the provider sent us in the provider information return. This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

We used all of this information to plan our inspection.

During the inspection
We reviewed four people's care plans and risk assessments. We reviewed staff training and supervision. We also reviewed other records relating to the management of the service. We spoke with nine people and six staff including the registered manager and the provider. We spoke with one visiting healthcare professional. We spoke with five relatives on the phone.

Requires Improvement

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection we have rated this key question requires improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

- Medicines that required stricter controls were not always recorded accurately. A number of medicines, which are controlled by legislation, were showing as held at the service, but were missing. Staff told us they had been returned to the pharmacy but there was no record to state this in the logbook. We advised the service to urgently identify where these medicines had gone and correct the records.
- Some people were prescribed pain-relieving patches. The site where these patches were placed on the body should be rotated, to avoid skin sensitivity or local reactions. Staff were not recording where these patches were being applied on the person's body. This meant staff would not know where to apply the next patch using a different position. This is especially important should the earlier patch have become detached.

The failure of the provider to ensure safe medicines administration and management is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2009 (Regulated Activities) 2014.

- Every person's electronic care plan had a profile page which contained a section on care related information and medications, including 'when required medicines' (PRN). The information provided regarding PRN medicines was not always accurate. For example, three people had medicines stated on their profile as being PRN which were not recorded on the MAR. This meant there was no authority for care staff to administer them.
- When a person was prescribed a PRN medicine there was no accompanying care plan or protocol for these medicines. This document should provide information and guidance for staff on when it would be indicated to administer this medicine. This meant staff could not make consistent decisions about when to give these medicines.
- Prescribed liquids and creams were not dated when opened. This meant staff were not aware when the prescribed item would no longer be as effective and need replacing.
- The registered manager and care staff carried out regular medicine audits. None of these concerns had been effectively identified and addressed.

The failure of the provider to ensure medicines were managed in a safe way is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2009 (Regulated Activities) 2014

Assessing risk, safety monitoring and management

● Risks were not always safely managed. An open sharps bin containing used needles and syringes was being stored on top of a cupboard in the dining room. People, who were living with dementia and walking around independently, had easy access to this bin. The registered manager told us they had advised staff to keep it locked away. This meant the action taken had not been effective, and people remained at potential risk.
● Care plans did not always provide the necessary guidance to help staff support people to reduce the risk of avoidable harm. One person had been assaulting staff and other people living at the service. Their care plan did not contain any risk assessment or any guidance and direction for staff on how to reduce this identified risk, such as specific triggers to the behaviour or what worked to de-escalate the situation. This meant staff could not provide a consistent approach and staff and people remained at risk of assault.
● One person had lost weight recently. The CQC had been contacted by their family about this. The person had been assessed as being at high risk from not eating and drinking. The action for staff, provided in the risk assessment stated, "Staff to monitor (Persons' name) intake. Try to fortify their drinks and food where possible to avoid weight loss." There was no mention of the actual support that staff were providing. Staff were providing the person with a food supplement at regular times each day and it had been identified that when a family member supported them it encouraged the person to eat more. This person had recently gained a little weight, so we found no impact on the person as a result of the lack of information provided in their care plan.
● Accidents and incidents were recorded by staff and passed to the registered manager. The record of events was only held in the person's care plan. It was not clear what action had been taken as a result of the incident. There was no overview held by the registered manager showing any patterns or trends of events and the opportunity to reduce a reoccurrence may have been missed.
● Some people living at the service had been assessed as requiring pressure relieving mattresses to help ensure they did not develop pressure damage to their skin. These mattresses were not always set correctly. There was no system in place to ensure the mattresses were regularly checked to ensure they were correct for the person. One member of staff told us, "We don't do anything with the mattresses, it is all done by the district nurses." This meant that people may be at risk of using a mattress that was not set according to their weight and their skin may not be protected effectively from pressure damage. We saw no impact on people as a result of this concern.

The failure of the provider to ensure that risks are effectively assessed, monitored and mitigated is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2009 (Regulated Activities) 2014.

Preventing and controlling infection
● On arrival at the service for this inspection no staff were wearing face masks. The registered manager told us they had stopped wearing masks in the summer 2022. We were told staff wore masks when working closely with people such as when carrying out personal care. However, we saw staff work closely with people without a mask or one was worn but they had it under their nose. This was not in accordance with current guidance and best practice. The registered manager had made the decision to stop wearing masks without any risk assessment in place. This meant there was a potential risk of COVID-19 infection being spread throughout the service. The registered manager was advised, and the wearing of face masks was reinstated throughout the service.
● We were not assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were not assured that the provider was using PPE effectively and safely. However, this was reinstated at the time of this inspection.

● We were assured that the provider was accessing testing for people using the service and staff. Staff and people were being tested if they presented with symptoms.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were somewhat assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

The provider had been asking all visitors to make arrangements before visiting, by calling the service ahead of their arrival. People confirmed to us that they could only visit by pre-arrangement. The provider needed to be advised that there was no longer government guidance supporting any pre-arrangements on visiting. The registered manager assured us that this arrangement would be stopped, and they would formally inform all families and friends that they could visit whenever they wished without prior notice.

Learning lessons when things go wrong
● There were some areas of the service where oversight was not robust, such as risk management, medicine management and DoLS records. This meant opportunities to improve the service may have been missed.
● The registered manager accepted the concerns identified at this inspection and took immediate action to address areas for improvement.
● The registered manager told us they would be aware of any complaints or concerns raised. No complaints were in process at this time.

Staffing and recruitment
● We asked people if they felt there were enough staff and if staff came in a timely manner when they called for assistance. Comments were mixed. They told us, "Oh yes, there's enough staff", "No, the staff are always busy," "I hardly see any staff," "Oh yes, staff look after me well" and "I don't think they rush but they don't have time to sit and chat."
● Relatives told us, "I visit very regularly and I have no problem with the care provided. I do however have concerns with the little time staff seem to have to spend time with people who have dementia. (Persons' name) needs clear communication and a lot of reassurance" and "The staff tend not to engage with people in the course of their work. Many don't speak to them at all" and " I don't think there are enough staff related to the challenge that some people pose to them. We had to lock Mum's bedroom door to stop one person coming into our room. (Persons' name) needs calm. Staff have no time for chatting. I don't think some staff have the skills or experience to deal with people with dementia so they don't interact with them at all really in my experience."
● The layout of the building meant that there were often periods of time when no staff were visible to people. We spent time in a dining room where one person sat alone from 9.45 till lunch arrived at 12.10. There were long periods of time with no staff present in the room.

We recommend the provider seek advice and guidance from a reputable source regarding the deployment and skills of staff who are supporting people living with dementia.

● According to the dependency assessment used by the registered manager, there were sufficient staff employed to meet people's needs.
● The staff said they covered any sickness or annual leave and worked additional hours where possible, so people had staff they knew and trusted. However, the service had used agency staff to cover vacant posts and to provide specific one to one support. The agency staff were not always shown on the rota. We discussed this with the registered manager, and they took immediate action to include agency staff on the rota.
● There were appropriate recruitment processes and procedures in place for new staff.

Systems and processes to safeguard people from the risk of abuse
● The registered manager was fully aware of their responsibilities to raise safeguarding concerns with the local authority to protect people.
● The service had systems in place to protect people from abuse.
● People told us they felt safe. Healthcare professionals were confident people were safe.
● Staff had received training in safeguarding and whistleblowing. Staff understood to report any concerns they had to the registered manager.

Requires Improvement

# Is the service effective?

## Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection we have rated this key question requires improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA.

● The Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DOLS) were not always implemented effectively at the service. The registered manager did not have an accurate overview relating to which people had authorisations in place for restrictive care plans. We were told at the inspection that two people had authorisations in place for restrictive care plans. The registered manager was contacted following the inspection visit to clarify the dates of these authorisations. At this point the registered manager identified that one of the two people named at the inspection visit did not in fact have an authorisation in place. The dates authorised for the second person were not known to the registered manager. We contacted the DOLS team at the local authority to clarify the information provided. Their records showed neither previously named people had an authorisation in place. However, a further person did have an authorisation in place, which the registered manager was not aware of. We informed the service of this concern and asked them to work with the DOLS team in order to ensure they held accurate records.

The failure of the provider to act in accordance with the requirements of the Mental Capacity Act 2005 is a breach of Regulation 11 (Consent) of the Health and Social Care Act 2009 (Regulated Activities) 2014

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The service was using an electronic care plan system. The care plans lacked specific information and

direction for staff. For example, what action staff should take to support a person who had lost weight. Staff did not always follow the guidance in people's care plans. For example, one person required to be re-positioned regularly to avoid pressure damage to their skin. Their care plan stated this should be carried out four hourly. Records stated, on 19 November 2022, staff re-positioned the person at 02.21 and then not till 22.41 and on 20 November 2022 only at 02.03 and 06.34. We did not find any impact on the person as a result of this concern. Staff confirmed they often 'forgot' to record care provided.

● Some guidance provided in care plans was not good practice. For example, one care plan guided staff to 'double pad' a person at night to avoid disturbing them. This is against the best practice guidance provided to staff when they are given training in the use of continence products. Continence products are not designed to be used one on top of another and this practice compromises their efficacy.

● There was very little activity provided for people on the day of this inspection. Staff were in the position of providing activities. We saw some people were colouring in a book. There was a 'Magic Table' (the Magic Table is an interactive light projector designed to increase physical and social interactions for people living with dementia) and several audio headsets were seen hung on the wall, that could enable people to listen to their choice of entertainment. However, staff confirmed to us, "They are hardly ever used." Staff told us, "We just don't have time." There was a display board in a corridor which advertised 'activities today' and the date and day. However, this information was inaccurate, and staff confirmed this was not updated. Some people told us they were bored. Comments included, "Sometimes I get bored. I don't get the chance to go outside" and "I used to do laundry folding but that's now stopped." The provider told us the Magic Table had developed a fault recently but was now repaired. They added that staff did have time to provide activities but that people often declined.

● The service had a mini-bus and a smaller vehicle, but these were not often used to take people living with dementia out to enjoy the local community.

● The service had a task-based culture. The registered manager checked her watch and told us it was "toileting time," when we asked to speak with staff. Some staff had little or no interaction with people when providing meals and drinks or going about their work. There was a rota which set when people were provided with baths or showers. People told us, "I'm told when to have a bath or shower," "They tell me when I have to have a shower and "I'm told when to shower. I can do my own personal care." Drinks were provided at the same time each day. On the day of our inspection everyone in the dining room was given the same meal in the same quantities, with no comment made by the staff present. There was a large amount of waste at the end of the meal.

● The laundry at the service did not always ensure people received their own clothes back. Comments included, "I've been wearing other people's clothing," "I've lost some clothing" and "Laundry is not as good now. I've had stuff go missing. I've had other people's clothing." This did not respect people possessions. One relative told us, "(Person's name) did not even have the necessary underwear on. They would have been horrified to be seen this way. The staff do seem to have lost a lot of their socks and things."

The failure of the provider to ensure care or treatment is always provided with a view to achieving service user's preference and ensuring their needs are met is a breach of Regulation 9 (Person-Centred Care) of the Health and Social Care Act 2009 (Regulated Activities) 2014.

Staff support: induction, training, skills and experience

● Staff were provided with training. Updates were provided to help ensure staff could meet people's specific needs. Penbownder House was separated into two units, one for people with dementia and one for people with mental health needs. The registered manager told us all staff had received training in caring for people with mental health needs so they could work across both units.

● Staff confirmed they received an induction when they started working at the service.

● Staff received one to one supervision. Staff were very positive about the good standard of support they

received from the registered manager.
● Staff meetings were held. The registered manager made a point of seeing all the staff together at each change of shift, to share information.

Supporting people to eat and drink enough to maintain a balanced diet
● Everyone living at Penbownder House was having their food and drink intake monitored. The care plan system provided staff with helpful visual graphics to show if a persons' weight was increasing or decreasing.
● There were two dining rooms at the service. People congregated in a dining room for long periods. We observed 7 people sitting in the dining room at 11.00 am until 14.45 pm with minimal interaction from staff.
● People's view on the food was mixed, "No choice," "The food is good, very good, I like it. I just eat what is put in front of me" and "The food is alright sometimes. Not really a choice."
● Care plans stated the support each person required with their food and drink.
● People were supported with their dietary needs where this was part of their plan of care. We saw staff sitting with people supporting them to eat and drink.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff referred people to other professionals when their needs changed. This helped ensure people could get support as required from health or social care professionals.
● Care records showed records of visiting healthcare professionals' advice and guidance.

Adapting service, design, decoration to meet people's needs
● Rooms were spacious, and corridors uncluttered. There were no malodours. There was clear pictorial signage throughout the service to support people's independence and orientation around the building.
● Access to the building was suitable for people with reduced mobility and wheelchairs. Access to the upper floors was via a passenger lift.
● The service had toilets and bathrooms with fitted equipment such as grab rails for people to use in support of their independence.
● People's rooms were personalised to their individual requirements. Rooms were full of items that were important to the person such as pictures and ornaments.

Requires Improvement

# Is the service well-led?

## Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection we have rated this key question requires improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- As reported in the Safe section of this report, the registered manager had agreed for all staff to stop wearing masks unless they were providing close care. This was not in line with current guidance. The registered manager was not aware of current guidance. When staff were wearing masks, they were not wearing them appropriately and were seen constantly touching them and putting them back in their pocket. This was not in line with good infection control guidance.
- Visitors were being asked to make arrangements in advance with the service before visiting loved ones. This is not in accordance with current guidance and the registered manager and provider were advised that people should not be restricted to agreed visiting times.
- As reported in the Effective section of this report the registered manager did not have effective oversight and processes in place to manage DOLS applications and authorisations. Information held by the provider was not accurate.
- Concerns found at this inspection with medicine records, care plans and DOLS records had not been identified by the registered manager or the provider, prior to this inspection.

The failure of the provider to ensure that there was robust and effective oversight of the service provided is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Continuous learning and improving care

- The registered manager and the provider met regularly and shared the oversight and audit programme between them. The audits completed were not always effective and had not identified the concerns found at this inspection.
- The task driven culture at the service was embedded. This was confirmed by the registered manager who referred to 'toileting time' as an example of the institutionalised practices in place. Staff, people and relatives confirmed there was a bathing rota which was adhered to.

The failure of the provider to evaluate and improve their service is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● The registered manager accepted the concerns that were identified during this inspection. They took immediate action to address many of the urgent issues such as the DoLS assessments.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The registered manager was very keen to make improvements. Some concerns identified during this inspection were responded to immediately.

● Staff were positive about the management support provided to them. Comments included, "(Registered managers' name) is always there for us. She is a nice person; she cares and wants the best for people" and "(Registered managers' name) was very kind to me when I was going through a bad patch, she is a friend as much as a manager."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager understood the duty of candour requirements and had ensured that information was shared with the CQC when concerns were identified, as is required. For example, DoLS authorisations and safeguarding concerns.

● The registered manager had notified CQC of any deaths in line with the regulations.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People had been asked for their views on the service. People's feedback was positive. People told us, "I think they do well as it is. We all get on quite well together," "I'm happy with the way things are. It's very good" and "I'm comfortable here, I wouldn't change anything. They look after me."

● Information on how to raise a complaint was displayed at the service. During the inspection people commented, "I've never found it difficult to speak to anyone" "Staff check on me regularly" and "Staff are nice, no problem."

● Relatives told us they had raised any concerns with the registered manager and action had been taken. Comments included, "They are good people, I am delighted with Penbownder."

● Staff told us that they felt valued and supported by the management team. They told us they enjoyed working at the service.

Working in partnership with others

● The service had established working relationships with professionals including health and social care professionals and commissioners of care to ensure good outcomes for people.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>The provider had failed to ensure care or treatment is always provided with a view to achieving service user's preference and ensuring their needs are met |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider had failed to act in accordance with the requirements of the Mental Capacity Act 2005. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider had failed to ensure safe medicines administration and management. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had failed to ensure risks were effectively assessed and mitigated, records were managed effectively, and ensure robust and effective oversight of the service provided. |