The Royal Masonic Benevolent Institution

Cornwallis Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Cornwallis Court provides nursing and residential care for up to 74 older freemasons and their dependants. The service is split into three units, residential, nursing and Geoffrey Dicker House. Geoffrey Dicker House is a separate building which is part of Cornwallis Court and is specifically for people living with dementia.

There were 70 people living in the service when we inspected on 10 and 11 January 2017. This was an unannounced inspection.

There was a registered manager in post. 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 are currently investigating an incident where a person fell on an exposed pipe and sustained burns and will report on this once the investigation is complete.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of this report.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

Not all risks to people living in the service were being identified. Improvements were needed to ensure that all risks in people's daily living were assessed and these assessments provided staff with information about how to effectively manage and minimise these risks. This included environmental risks and those linked to health conditions. Where risk assessments had been carried out they were not always completed fully to include relevant and detailed guidance for staff.

Incidents such as falls had not been consistently reviewed by the provider so that preventative actions could be considered and put into place where needed.

People generally received their medicines safely and had access to healthcare professionals such as GP's, dentists and chiropodists when required. However, improvements were required to provide guidance to staff regarding as and when required medicines.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible; the policies and systems in the service did not always support this practice. There was not always reference to the Mental Capacity Act 2005 (MCA) to promote people's rights and where people were unable to give their consent, best interest decisions were not always recorded as having taken place.

Care plans, as identified by provider's own audits, were contradictory and had not always been updated as people's needs changed.

A complaints procedure was in place, however not all complaints had been recorded.

There was a lack of oversight of the service by the provider to ensure the service delivered was safe. Although the provider had some quality assurance systems in place, these had not been effective in allowing the management team to identify concerns and take the required action. Improvements were required around the effective auditing of health and safety.

Safe and effective recruitment practices were followed to check that staff were of good character, physically and mentally fit for the role and able to meet people's needs.

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.

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 were not always identified or action taken to mitigate the risks. The risks were not continually monitored and systems were not checked to ensure that they were effective in mitigating risk.

People were provided with their medicines when they needed them and in a safe manner. However, guidance for medicines prescribed to be given 'as and when required' was not always in place.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff were trained to meet the needs of the people who used the service.

The provider did not make sure that people's capacity to consent to care and treatment was properly assessed and recorded to determine people's level of understanding in accordance with MCA.

People's fluid intake was not always monitored to reduce the risks associated with dehydration.

People had access to appropriate services which ensured they received ongoing healthcare support.

Is the service caring?

Good

The service was caring.

People were treated with respect and their privacy, independence and dignity was promoted and respected.

People and their relatives were involved in planning their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans were not always up to date and were contradictory in places.

People were provided with the opportunity to participate in meaningful activities.

There was a system in place to manage people's complaints, however not all complaints were logged.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Robust and sustainable audit and monitoring systems were not in place to ensure that the quality of care was consistently assessed, monitored and improved.

Improvements were required by the provider to ensure they had effective oversight of the service and ensure that risks to people's health, safety and welfare had been identified and addressed.

Cornwallis Court

Detailed findings

Background to this inspection

Cornwallis Court provides nursing and residential care for up to 74 older freemasons and their dependants. The service is split into three units, residential, nursing and Geoffrey Dicker House. Geoffrey Dicker House is a separate building which is part of Cornwallis Court and is specifically for people living with dementia.

There were 70 people living in the service when we inspected on 10 and 11 January 2017. This was an unannounced inspection.

There was a registered manager in post. 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 are currently investigating an incident where a person fell on an exposed pipe and sustained burns and will report on this once the investigation is complete.

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Incidents such as falls had not been consistently reviewed by the provider so that preventative actions could be considered and put into place where needed.

People generally received their medicines safely and had access to healthcare professionals such as GP's, dentists and chiropodists when required. However, improvements were required to provide guidance to staff regarding as and when required medicines.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible; the policies and systems in the service did not always support this practice. There was not always reference to the Mental Capacity Act 2005 (MCA) to promote people's rights and where people were unable to give their consent, best interest decisions were not always recorded as having taken place.

Care plans, as identified by provider's own audits, were contradictory and had not always been updated as people's needs changed.

A complaints procedure was in place, however not all complaints had been recorded.

There was a lack of oversight of the service by the provider to ensure the service delivered was safe. Although the provider had some quality assurance systems in place, these had not been effective in allowing the management team to identify concerns and take the required action. Improvements were required around the effective auditing of health and safety.

Safe and effective recruitment practices were followed to check that staff were of good character, physically and mentally fit for the role and able to meet people's needs.

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.

Inadequate

Is the service safe?

Our findings

This inspection was prompted in part by a notification of an incident where a person sustained burns from an exposed hot pipe. This incident is subject to a separate investigation of a potential offence and therefore at this inspection we did not examine the circumstances of the incident. However, the information gathered by CQC indicated potential concerns about the identification and management of health and safety risks. This inspection examined those risks, the action the provider had taken and any lessons learned.

In response to the incident, hot pipes in bedrooms had been lagged and protective covers had been installed for most radiators. However, the risk posed from a heated towel rail and an uncovered radiator had not been identified, assessed or managed accordingly. The risk of people scalding themselves had not been mitigated in these areas. In addition, we saw other environmental risks that had not been robustly assessed to ensure people were protected from the risk of harm. For example, trip hazards from trailing extension cables in people's bedrooms. For people with poor mobility and/or at risk of falls this had not been recognised as a potential risk.

Following the inspection we asked the provider to tell us about the actions they had taken to identify any potential risks to people using the service from the environment and what they had done to minimise those risks. The provider responded and informed us about the assessment of risk they had carried out, the hazards they had identified and the actions they had taken to minimise the risk to people.

An effective system was not in place to properly analyse incidents that resulted in, or had the potential to result in harm to people, to learn from those incidents and where necessary make changes to their care and reduce risks. Records showed 91 falls logged for incidents of falls over a four month period (from September to December 2016). The incidents of falls were not fully analysed to identify trends or themes for individuals or for the service as a whole in order to minimise risks and improve outcomes for people.

All of the above are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they were satisfied with the arrangements for their medicines administration. We saw that medicines were provided to people in a polite and safe manner by staff. Medicines administration records (MAR) were completed and staff had signed the records appropriately to show that people had been given their medicines at the right time. Staff administering medications had received the appropriate training to do so.

Where people were prescribed medicines on a "when required" basis, for example for pain relief or to reduce anxiety, we found there was not sufficient guidance for staff on the circumstances these medicines were to be used. This meant that there was a risk that these medicines could be administered when they were not required or wanted or not given when they were needed.

We recommend that the service explores current guidance from a reputable source, for example The

National Institute for Health and Care Excellence regarding PRN guidance.

People told us that they felt there were enough staff to meet their basic needs but had mixed views about the consistency of staff and their knowledge . The registered manager was in the process of recruiting additional staff to ensure that staff vacancies were filled and told us that they had been using agency staff in the interim. One person said that none of the regular staff were on their unit on the day we visited. One relative said, "Agency staff don't know the residents, this puts pressure on the permanent staff. I worry that the agency staff don't know what the residents can do or what help they need." One person told us that the staff did not have time to just sit and chat although they did check on them fairly regularly. They said, "Staff had time to come and talk to me when I first came, but not now." One staff member said, "It's not very often that we don't have enough people on the shift and it's usually the same agency staff."

Any new agency staff members completed an induction that had recently been introduced to ensure that they were provided with the key information they needed to support people. The registered manager tried to use the same agency staff as much as possible. The service used a dependency tool to determine the staffing levels for the service. We checked the rotas for a four week period and found that the majority of shifts had been fully covered. This was confirmed by the registered manager.

Records showed that checks were made on new staff before they were employed by the service. These checks included if prospective staff members were of good character and suitable to work with the people who used the service. Records also showed that checks on nursing staff were made to ensure that they were allowed to practice in the United Kingdom.

Staff had received safeguarding training and were able to identify different types of abuse and what action they needed to take if they suspected someone was being abused. One staff member said, "I would tell the manager and if manager involved, when go higher up to head office."

Where a safeguarding concern had been raised, the service had taken action to report this to the appropriate organisations. Actions had been taken to reduce the risks of future incidents, which included disciplinary action.

Requires Improvement

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 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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff were provided with training in MCA and DoLS and had understanding of capacity. One staff member said, "We always assume that someone has capacity to make decisions for themselves." However, they had not applied this training effectively. For example, there were limited mental capacity assessments and best interest decisions recorded. Where people lacked capacity to consent to 'as and when required' often referred to as "PRN" medicines, we did not see that this decision had been made and recorded in the person's best interests, in line with the organisation's policy.

Capacity regarding bed rails had not been considered for people living with dementia. There were no formal assessments of capacity for two people who were using bed rails and no evidence of decisions to use bed rails being made in the person's best interests if this was applicable. This meant that the decision for their use may not have been in the individual's best interest and could place them at risk of injury. Staff had not recognised the potential impact on people or explored alternative and more suitable options.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Need for consent

People told us that the staff asked for their consent before providing any care. One person said, "Staff ask my permission before helping me." We saw that staff sought people's consent before they provided any support or care, such as if they needed assistance with their meals and where they wanted to spend their time in the service.

People told us that they enjoyed the food, had sufficient amounts and enjoyed a balanced diet. One person said, "Food is first class." Another person told us, "I am quite happy with the food. I get a choice and I can get a drink when I want." People were encouraged to eat independently and staff promoted independence where possible.

At lunchtime we saw that all the meals were nicely presented and people were offered a choice of what they would like to eat. We heard staff offering assistance and gaining consent before helping people. For

example, "Shall I cut that up for you?" One person was heard saying, "This is delicious."

A member of the catering staff was knowledgeable about people's specific dietary requirements and how people were supported to maintain a healthy diet. They told us how they served pureed food individually on the plate so that it looked appetising and people could taste each flavour. One person said, "I have allergies and the home cater for them all. They really take care to make sure I get the right food. I have not had a problem since I have been here. I must have put on weight."

The needs of people were met by staff that had to support to achieve competencies, knowledge, skills, attitude and behaviours they needed to carry out their role and responsibilities. People told us that the staff had the skills to meet their needs. One person said, "They are a lovely family of staff, very friendly, no issues with the staff." The service had systems in place to ensure that staff were provided with support and the opportunity to achieve relevant qualifications for their role. Staff told us and records confirmed that they had received training in mandatory subjects relevant to their role such as safeguarding, manual handling and first aid.

New staff were provided with an induction course and shadowed other carers as part of their induction. New staff had the opportunity to undertake the Care Certificate. This is a recognised set of standards that staff should be working to. One staff member said, "I am currently shadowing and my training lasts for 12 weeks."

Staff were knowledgeable about their work role, people's individual needs and how they were met. Team meetings were held regularly within each department, staff felt supported and the majority of staff had regular supervision. One staff member said, "I had supervision last month and we talk about what affects me and any problems when you are working. I enjoy it here and we all get on well with each other." Another staff member said, "The shift leaders are brilliant. If you are unsure they will always help you and you don't feel as if you are being a burden."

A staff forum had recently been developed to allow staff to discuss any support they required, how this could be provided and to develop ideas for the service.

People experienced positive outcomes regarding their health. The service made appropriate referrals to other health care professionals when required. One person said, "They [staff] call a Doctor really quickly. I have had marvellous attention since I have been here." Where one person's health deteriorated on the day of inspection, the GP was called and the person was admitted to hospital. One relative told us that "The staff are very effective at picking up on any health related issues and they take action promptly and keep me well informed."

Good

Is the service caring?

Our findings

All staff demonstrated a hands on approach which was compassionate and caring. However, this report identifies areas where despite this positive approach, opportunities had been missed to robustly deal with shortfalls that could potentially mean people were not being protected from risk of harm. The provider therefore needs to consider further how its overall approach demonstrates that it is caring.

People spoken with said that the staff were caring and treated them with respect. All of the relatives we spoke with were complimentary about the approach of the staff. One relative said, "This home surpasses everything. The care is wonderful, the staff are all pleasant with residents and relatives, and they are caring, engaging and patient. They will go out of their way to ensure that they (residents) have everything they need." Another person's relative told us, "They [staff] make sure [relative] has everything they need." One person said, "The staff are so kind and considerate." Another person commented, "There is never any rudeness, they [staff] are very good."

People told us that they were supported to maintain their independence by staff. One person commented, "I dust around and I do my windowsill. It used to be done for me but not now." Staff were attentive and noticed when people required some additional help. Where one person was struggling with their walking frame, a staff member responded by giving verbal prompts such as, "Careful, take it slowly", while allowing the person to continue to use their frame independently.

Staff spoke about people in a compassionate way. There was a relaxed and friendly atmosphere in the service and people and staff clearly shared positive relationships. Staff communicated with people in a caring and respectful manner. They communicated in an effective way by getting down to their level, making eye contact with people and listening to what people said.

People's privacy was respected by staff who communicated with people discreetly, for example when they had asked for assistance with their continence. One person said, "They always knock before coming in." One staff member said, "If we are supporting with personal care, we close the door and cover people with a towel to maintain their dignity." Staff communicated discreetly between themselves when discussing how best to support people.

One person's relative told us how they respected the person's choices, for example where they wanted to spend their time. Another relative told us, "I don't have any worries about my [relative] health here. I know they respect my [relative] because I have seen it." People's views were listened to and their views were taken into account when their care was planned and reviewed. One person said, "I can express my opinion and they listen to me." A second person commented, "I don't argue or complain unnecessarily but they [staff] do listen to me." One relative commented, "The staff listen to us and take our wishes into account."

People told us that they were involved in their care planning. One person said, "I had a chance to input into my care plan and I have an annual review with my carer. If things change the plan is updated and I get a copy. " Another person told us, "Staff refer to my care plan and it is constantly reviewed."

People were supported to maintain contact with others who were important to them and some people chose to attend weekly ladies and gentleman's meetings held at the home. One relative said, "[Person] doesn't like mixing very much although [person] does go to the Gentleman's meetings.

People told us that they could have visitors when they wanted them. This was confirmed by people's visitors and our observations. One relative said, "There are no restrictions on coming or going." One person said, "My daughter visits whenever she wants and she can bring her pets." This meant that the risks of people becoming lonely or isolated were reduced and people's relationships were respected.

Requires Improvement

Is the service responsive?

Our findings

The quality of the care plans, as identified by provider's own audits, was not consistent. While some plans were very detailed and personalised about what was important to people, others had missing information or contained contradictory detail about how to support people. There was a risk that staff may not know which information was the most current. Where changes had been made, the information had not always been updated throughout the care plan. For example, the care plan record for one person stated they were independent and no assistance was required. However, the additional information sheet stated that person required one carer to assist them to get washed and dressed. The care plan record had not been updated when the person's needs changed. One person had a risk assessment to support them to self-administer their medication; however the medication care plan stated, "I wish for staff to administer my medication." The risk assessment had not been removed when the person's needs had changed. Where people's care assessments stated that they needed to receive hourly checks throughout the night, these checks were not documented. This meant that people were at risk of not receiving consistent support that was tailored to their specific needs.

Where people were identified at risk of developing pressure ulcers, actions were not always recorded to demonstrate what was being done to reduce their development or prevent further deterioration. Clear guidance for staff was not included in care records. For example, people who needed help to reposition themselves did not have records that reflected how often they should be repositioned or how they should be re-positioned. The records did not document what support had been given or when. A staff member in charge on one unit could not tell us who needed this kind of support. Despite this, one professional confirmed to us that people's wound care was being provided in a safe way. The management team recognised that the lack of records did not enable them to effectively demonstrate this.

Where people required support to ensure that they had sufficient fluid intake, this was not always clearly documented and staff were unable to demonstrate that this support was being provided according to people's assessed needs.This was because people's fluid intake was not effectively recorded and monitored. Records were not consistently completed by staff and where they were completed, we could not see that they were monitored or checked to see if the person's fluid intake was sufficient to meet their needs.

A new computerised records system was in the process of being introduced to the service but not all staff had been trained to use it and others were unsure of how to use the system and said they needed more support. Because of this, staff were recording information in different places and could not locate information that we requested on the system. As a result, records may not accurately reflect the care needed or the care actually being provided and staff were not able to find the most up to date information to ensure that they provided the care that was required.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Person-centred Care

Despite our findings, people who were able told us their care needs were met. One person said, "I told them

what I wanted when I came here and they took note of it all." Another person commented, "Staff understand my needs." One relative told us, "They [staff] make sure [person] has everything they need." Where people required staff intervention to help them remain well and have their care needs met we found that these were mostly followed. For example, one person was supported to see the GP when they had lost weight. We observed staff handovers and saw that information about people was detailed and changes to people's conditions were shared and discussed.

People told us that they enjoyed the activities that were on offer. One person said, ""I like painting and handicrafts and have attended classes here. There are some sports activities inside and out depending on the weather." Another person said, "I like the keep fit. I also do some crafts. I don't feel bored." A third person said, "There is a list of activities every week and you can choose whether you want to go or not. I like watching my TV."

We saw people participating in activities throughout the day. This included having their hair styled in the service's hairdressers, watching television, singing in a lounge, talking to each other, staff and visitors. The service employed activity co-ordinators and there was an activities programme in place which showed that people were provided with activities to reduce the risks of boredom and isolation. The service received copies of a reminiscence newspaper called 'Weekly sparkle' which talks about events in history and how things used to be. These were used to encourage people to talk and share memories. There was a large communal lounge where activities and social events took place. Recent activities included breakfast club, word games and quizzes. The activity co-ordinators organised group events as well as visiting people in their bedrooms to provide interaction. Feedback included, "Fantastic – really enjoyed it."

There were items in Geoffrey Dicker House that people could use to stimulate their senses and memories People had reminiscence boxes beside their bedroom doors and families had brought in items that were personal to evoke memories. Doors to bedrooms had been made to look like front doors to aid recognition of people's personal space. The environment had been designed to help people orientate themselves and chose activities independently. For example easy read signs and symbols on rooms and drawers so people knew what was inside. People who live with dementia often benefit from being able to touch and feel items which occupy them and/or help provide comfort. We saw these were available and being used by people where appropriate. This included prams, dolls and aprons with items attached which people could touch and feel. .

People told us that they knew how to make a complaint and that their concerns and complaints were listened to. People's relatives told us that they were confident that if they raised concerns or complaints they would be addressed.

There was a complaints policy in the service, which advised people and visitors how they could make a complaint and how this would be managed. The service had not received any written complaints. Verbal concerns had not been recorded in line with the providers policy. The registered manager told us that concerns tended to be minor and that they would meet with the people involved to resolve these. As concerns were not logged, it was not possible for the provider to monitor these for trends and patterns, to ensure that that service learned from these concerns and continually improved.

Residents and relatives meetings that had been held two monthly. Records seen confirmed this and subjects for discussion included the menu, activities and planned improvements to the home. Surveys had been sent out to residents and relatives requesting people's views on the service. The responses received were positive.

Requires Improvement

Is the service well-led?

Our findings

Improvements were required to ensure that there were robust systems in place to monitor the quality of care provided and ensure it was safe and of a consistently good quality. As mentioned in this report, we identified issues with audits, risk assessment, care records and the application of MCA assessment and decision making processes.

Staff from the wider provider organisation also had responsibility for oversight and governance in the service. It was not always clear how each responsible person was able to assure themselves that those they had delegated actions to were completing those tasks robustly and completely. For example, despite an incident that required a full review of environmental risks, whilst a significant amount of work had been done by the facilities team, the assessments completed did not cover all areas, not all risks had been identified or control measures put in place to minimise potential risk to people's health, safety and welfare.

Opportunities were missed to properly analyse all incidents that resulted in, or had the potential to result in harm to people, learn from those incidents and where necessary make changes to their care as covered within this report. For example, falls were not fully analysed to identify trends to minimise risks and improve outcomes for people. In another example, a medication audit identified an issue four months in a row but no action was documented as having been taken to stop its reoccurrence. While some incidents had been investigated by the service and highlighted areas for improvement and learning, this was not applied consistently across the service.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good Governance

Following the inspection, the provider told us that they were using a new system which would allow them to fully analyse falls and would inform a review of the falls policy, associated risk assessments, guidance and training for staff to ensure that the provider was as proactive as possible in reducing the risk of falls within the service.

Despite the gaps described above, the service had a continuous improvement plan which had recently been introduced and identified the issues highlighted from the provider audit. This did identify areas for improvement and showed that these areas were being actively addressed. For example, where it was identified that food temperatures required recording to ensure food was hot enough for people who had food served in their rooms, thermometers had been purchased and temperatures were being recorded. The plan had clear timescales for when the improvements should be made. There were policies and procedures in place to provide guidance to staff and these had been reviewed regularly and guidance was displayed for staff in the staff room and office areas. There was a 'Policy of the month' to ensure that staff refreshed their knowledge. The policy that was on display for the month was whistleblowing.

The service had an awards programme to recognise staff who had done something particularly well and who had displayed the values of the organisation. The values were displayed in the service. This ensured

that staff were motivated and knew what was expected of them.

People, relatives and staff told us that the management team were approachable. One person said, "I would certainly recommend the home. It is friendly, good food, clean and everyone is so approachable." Another person commented, "I am happy here and I would certainly recommend it. I see the manager every few days." One staff member said, "I can raise any concerns, definitely. I can go to [registered manager] and speak to them. We don't have to wait for supervision. "

We saw compliments that had been received which included, "Thank you very much for the loving care that you gave [person]." And, "I see examples of high standards of care every time I visit your home."

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans were not always accurate or detailed enough which put people at risk of not receiving care that met their needs. Records did not always evidence the care that had been provided. Fluid intake was not effectively recorded or monitored. 9 (1) (3) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Mental capacity assessments and best interest decisions were not always in place. 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The assessment of risk was not effective. Risks were not identified or measures taken to reduce the risk in a timely manner. Systems did not properly analyse incidents that occurred and ensure learning from these. 12 (1) (2) (a) (b)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation 17 HSCA RA Regulations 2014 Good governance

Systems were not always effective in identifying and addressing areas of concern. There was a lack of effective oversight and governance within the service.

17 (1) 17 (2) (a) (b) (f)