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The Limes Residential Care Home

Inspection report

The Limes Residential Care Home
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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?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This unannounced inspection took place on 6 February 2015. The Limes provides accommodation and personal care to older people. The home is registered to accommodate 26 people. There were 19 people living at the home at the time of the inspection, two of whom were in hospital temporarily.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The last inspection was 6 February 2014 where we found a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2010 due to a failure to implement safe staff recruitment practices to ensure new staff were suitable people to work in a care home.

Summary of findings

We found this had improved at this inspection.

There was mixed feedback from people living in the home. The majority of people said they felt safe and well looked after at The Limes.

Staff were kind and supportive to people. One person told us, “The staff are very pleasant and helpful.” Staff supported people with personal care, to eat and drink enough and helped them to maintain their health. Staff felt supported and received supervision from the registered manager to help them learn and improve in their job. There were some opportunities for people living in the home to take part in activities but these were limited and not always age appropriate. Three people told us there was not enough to do to fill their time.

The service did not protect people enough from the risks of falling over. The layout of the building and the way staff were based in the lounge meant that some people were at high risk of falls when they left the lounge area. The design of the building limited the homeliness of the environment and the choice of places for people to spend their time. Most people sat in a line in a narrow lounge area. Those who preferred to stay in their room were able to do so.

Medicines were not always managed properly as the records did not always give enough detail to prevent unsafe practices, for example there was no up to date written guidance for how frequently one person could have pain medicines. The registered manager did resolve this straightaway when we brought this to his attention after this inspection.

Some equipment such as the cooker, fridge, some shower facilities and first aid kits were not clean and well maintained. Staff had not received all the training they needed and the training records were not up to date.

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

We have also made recommendations about improving the menu, seeking advice on falls prevention and providing training to staff for providing good care to people at the end of their life.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not consistently safe. People were not appropriately protected from the risk of falls in the home. Medicines were not always managed safely which could have an impact on people's health and wellbeing.

People thought there were enough staff to provide care to everyone.

Cleanliness in the home was adequate with the exception of kitchen equipment. Staff had limited knowledge about responding to allegations of abuse.

Is the service effective?

Requires improvement

The service was not consistently effective. Staff did not have all the training they needed.

Staff sought consent from people before providing care and supported those who needed help to eat and drink. People received good support with their health needs.

The building was not designed and adapted to best meet the needs of people living there. The service did not make good use of the space to ensure everybody had a choice of places to sit, could eat their meal at a dining table, move position regularly during the day and move around the building safely.

Is the service caring?

Requires improvement

The service was caring. People told us staff were caring. We saw staff treat people with respect and communicate well with them.

People's rights to privacy and independence were respected. There was a lack of end of life care planning and although staff provided end of life care with support from specialist nurses, we have made a recommendation that staff are trained in end of life care in order to improve and plan for good end of life care.

Is the service responsive?

Requires improvement

The service was not consistently responsive. Everybody had their needs assessed and a written care plan setting out their needs. Most people said they were well looked after at the home. There was not enough stimulation and activity to meet everyone's needs. One person did not have a chair suited to their needs.

The service responded to concerns and complaints.

Summary of findings

Is the service well-led?

The service was not consistently well led. The registered manager knew people's needs well and was supportive to the staff team. The quality of service was regularly monitored by the provider's service manager and people's views were listened to. However there was not enough analysis of accidents to reduce the number of falls in the home.

Requires improvement

The Limes Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 6 February 2015 and was unannounced. The inspection team consisted of two inspectors, a specialist professional advisor who was an occupational therapist, 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.

We took into account the service's inspection history. Before this inspection we reviewed all the information we held about this service, including the notifications sent in by the provider over the past year, complaints, safeguarding alerts, the inspection reports from 2013 and from the last inspection on 6 February 2014, the provider's action plan for improving the service and information provided by the local authority.

We used a number of different methods to help us understand the experiences of people living in the service. We spent time observing care and how staff interacted with people in the communal areas such as the lounge and dining area and we spent time with some people in their rooms. We met all the people who were using the service and spoke with everyone who was able to speak with us about their experience living in the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with four relatives and received information from two others. We spoke with the registered manager, the service manager for the provider who has responsibility for overseeing all of the provider's care homes, and seven staff members. We also received information from two health and social care professionals about the home.

We looked at nine of the nineteen people's care records in detail. We also checked risk assessments, ten staff files, staff duty rosters for a three month period, staff training, supervision and meeting records, accident and incident records, selected policies and procedures, quality checking records, menus and five people's medicine administration record charts.

Inadequate

Is the service safe?

Our findings

People told us they felt safe in the home, and a relative of one person living in the home said, “He has been absolutely safe.”

We spoke with five staff about their understanding of safeguarding people from the risk of abuse. Staff were able to describe the risks that people living in residential care might be exposed to but were unsure when they last had safeguarding training or the precise details of the provider's policy on safeguarding people from abuse. They said that they would report any matters they were concerned about to their team leader or the manager and provider. Only two of the staff knew how to contact external agencies should they feel that any concerns they raised were not taken seriously.

Since 1 January 2014 there had been two safeguarding alerts both finding that there had been a delay in the service seeking medical attention for somebody when they were injured following a fall.

We found that people were not sufficiently protected from the risk of falls. Despite assessing people as being at risk of falls there was insufficient action taken to help them reduce the risk of falling over. There had been five falls resulting in serious injury (for example fractured pelvis and fractured hips) in the last year. We also found sixteen occasions in the last two months where people had been found on the floor by staff where they had fallen, usually without injuring themselves. One person had been found on the floor by staff five times in the last month but no action had been taken to support this person to reduce the number of falls they were having. We asked the staff and manager about this and they said they did not want to restrict the person from their wish to walk around the building. We saw that they walked around including up and down the stairs unsupervised. They told us they were trying to leave. On one occasion we saw this person descending the stairs alone whilst balancing over the stair gate in an attempt to lock it behind them. This person was at risk of falling downstairs. The service had referred the person to the falls clinic but were taking no action within the home to help keep them safe. Staff were not deployed to supervise people at high risk when they were not in the lounge.

A staff member said of another person, “He is only safe in the lounge, where we can watch him. He walks if he is in his room.” Staff did not carry out regular checks on people in their rooms or who were walking around the building or in the garden. When asked, staff said there was no policy to carry out checks on people at specific intervals.

All care plans looked at had a standardised risk assessment for falls included. Those identified as at high risk of falls had this included within their care plans. These had been reviewed on a monthly basis. When we checked the daily log notes for one person it was apparent that information in the care plan did not reflect the number of falls in total. The daily records and accident book showed there had been more falls than indicated in the care plan. This meant some staff may not have been aware of how frequently this person was falling over.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People had appropriate risk assessments to assess their risk of getting pressure ulcers and risks relating to poor nutrition.

The provider had ensured safety checks such as gas, electricity and fire equipment had been carried out and the last report by the Fire Service in November 2014 found the premises to be satisfactory in terms of fire safety.

The staffing level according to the rota was four staff on duty during the day (plus the manager) and three at night. There was one senior and three care workers providing care in the day, and at weekends one of the seniors worked alongside four staff instead of the manager. The manager and staff confirmed this was the usual staffing level. People thought there were enough staff on duty. Comments included: “I never have to wait long for help” and “They have to take me to the toilet, I ask and they take me” and “I don’t have to wait very long.” We saw that there were enough staff if people stayed in the lounge but staff were not deployed to meet the needs of people who were in their bedrooms or moving around the building.

We spoke to the five staff on duty on the day of our visit. On the day of our visit the team also included a new member of staff on induction. Staff told us that there were sufficient numbers of staff to support people in the home enabling each person’s personal care needs to be met. We also found that the registered manager took appropriate disciplinary action against staff when needed.

Inadequate

Is the service safe?

We looked at the files of nine staff working at the home to see if they had been properly recruited.

We saw that each person had filled in an application form as part of the recruitment procedure and had been interviewed. The notes of the interviews undertaken showed that an assessment had been made of each person's suitability to work at the home. For example we saw that one interview record noted an applicant's lack of knowledge on one aspect of care in an otherwise competent interview and a recommendation was made for training on this point. We checked the training records and confirmed that member of staff had attended the recommended training.

We saw that the provider had taken up two references for each member of staff employed. We saw that Disclosure and Barring Service (DBS) checks (to make sure staff do not have a criminal record) had been carried out satisfactorily on all members of staff. Staff confirmed that they had not been allowed to start work until these checks had been completed.

We saw that each file contained valid photographic identification and records of qualifications were available where appropriate. For example we saw NVQ accreditation certificates where staff had these. We looked at the references of those most recently employed. The provider had previously not taken enough care to ensure staff's background was checked through references. We found the provider had taken out appropriate references for three of the four newly recruited staff. They had not taken appropriate references for a fourth person but recognised their errors and informed us that they had decided this person would not be allowed to work again until a suitable employer reference had been received.

People's medicines were not always managed safely. Residents said they got their medicines when they expected them. Comments included, "I have medication and if you wanted painkillers, you can get them", "He gets his medication as he needs it" and "I get pain killers when it's [the person's leg] sore." However we found some concerns relating to people's medicines.

Some people did not receive their morning medicines until 11.45am and the times of administering medicines were not recorded on the charts. This meant there was a risk that medicines given more than once a day could be given at too short an interval. The senior team leader told us they were working all day so knew what time they had given people their morning medicines. However there was still a risk that medicines may not be given at suitable times.

There was one error in the controlled drugs record but this had no negative impact on anyone and staff were aware of the error in recording.

One person had no care plan for pain relief medicines. There was no written guidance for staff to explain when this person could take their pain relief. Staff told us that the specialist nurse had agreed an increase in the person's painkillers by telephone and this had not been recorded. This lack of written guidance meant there was a risk that the person would be in pain and have to wait for their medicines while staff sought advice. We reported this to the manager who said they had resolved this matter shortly after our inspection to ensure the person was not in pain.

We saw that throughout the morning the medicines cabinet was left unlocked. This was a risk as somebody could help themselves to medicines when staff were not looking.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We saw some good practice where staff giving the medicines asked people if they wanted to take it and sat with them while they took it explaining what it was for. One person stated they did not want their medicines, this was respected by the staff member and then recorded in the notes.

We inspected the building and found the following concerns; a stained mattress and pillow in one room, a bedroom with an odour of urine, first aid kits did not contain the recommended contents to deal with medical emergencies, a broken radiator cover in one bedroom, a bedroom door which would not close, and a broken shower. There was no shower chair in one wet room so people who needed to sit in the shower had to sit on the toilet which was unacceptable. In the kitchen some saucepans were greasy and worn, the fridge was not cleaned and the hob had a build-up of grease.

Inadequate

Is the service safe?

This was a breach of Regulation 16 of the Health and Social Care Act of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 15 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Requires improvement

Is the service effective?

Our findings

Staff received supervision. Staff told us that supervision was usually every other month although supervision notes available showed that some staff were supervised less frequently. Staff who had been working in the home for more than a year had an appraisal carried out and recorded in their file. The records showed that issues related to people's work and performance were discussed. Staff said that the meetings with their manager had been helpful allowing them an opportunity to discuss any problems or issues relating to their job. One member of staff told us about the feedback they had received from the manager which had been helpful in improving the way they spoke with people living at the home. This showed that the manager used supervision sessions and appraisals to give feedback to staff in a helpful way to encourage them to improve.

We saw records showing that an induction programme was in place for new staff. This included aspects about general safety, administrative procedures as well as information about how to support people and issues such as safeguarding and moving people safely. In some of the files we looked at there was also an employee competence checklist which had been used in the early months of employment. However it was unclear how much of the induction programme had to be completed before people started to work independently within the home. We noted that one of the care staff on duty of the day of our visit had only been employed for one week and had not yet completed much of the induction programme. They told us that they had shadowed members of staff to learn about how to support individuals within the home and were already providing personal care without supervision although they had not read people's care files at that stage. This was a risk as new staff may provide unsafe or inappropriate care if they do not know people's care needs.

Staff records contained information about the training that staff had received but these records were not comprehensive or up-to-date. We discussed this with the manager who explained that training records were collated by the provider. The training matrix currently in place was last updated in May 2014 by head office. This showed that some courses had been completed by staff but not others.

The provider had not given the registered manager certificates of staff attendance at training and it was not possible to confirm that all staff had been trained to the required level.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

CQC is required by law to monitor the operation of the Mental Capacity Act (MCA) 2005, Deprivation of Liberty Safeguards (DoLS), and to report on what we find. DoLS are a code of practice to supplement the main Mental Capacity Act 2005. These safeguards protect the rights of adults by ensuring that if there are restrictions on their freedom and liberty these are assessed by appropriately trained professionals. The provider was following the requirements of the Deprivation of Liberty Safeguards which require providers to submit applications to a 'Supervisory Body' for

authority to deprive somebody of their liberty. One person had a deprivation of liberty safeguard and it had been applied for another person who was in the home against their wishes. This person did not want to be in this home and said, "I can't understand why I can't leave'. We discussed this with the manager who showed us that the person's responsible local authority knew they did not want to stay there and that a best interests process had taken place and a DoLS was being applied for. The registered manager told us they understood that they needed to apply for DoLS for everybody in the home who was not allowed to leave the home without supervision.

Staff gained consent before providing care. They said they asked people before they supported them and observed people's facial expressions and reactions if they were not able to consent verbally to make sure they were not unhappy or uncomfortable. One member of staff told us that it was important to give people time to reply to questions and to come back and ask again at a later point if a person refused support initially. We saw staff talking appropriately to people, listening to what they were saying and giving them enough time to respond.

People received support to eat and drink but not everybody liked the food.

There was no menu displayed and people told us, "If you get up late you will have a drink and then wait until lunch for food" and "We get no advance warning of the menu" We

Requires improvement

Is the service effective?

saw the four week menu and found that the meals eaten did not always match the menu. There was insufficient choice offered. There were two meals cooked but sometimes these were two chicken meals or two fish meals. The only cultural meals included in the menu was a curry once a week.

People did not have many positive comments about the food. Comments from people living in the home and their relatives included; "The food is not too bad", "I think you can have something different," "The food is okay," "the food is alright, nothing special," "lunch was OK" and, "I don't think the food is very good. The supper is always the same."

During mealtimes staff supported people who needed help to eat. The team leader advised other staff on how to support people. We saw good practice where staff took time to encourage and help people, asking them if they liked the food and cutting it up for them. We saw one example of bad practice where a staff member stood up to support a person with eating rather than sitting so that they could make eye contact. We informed the manager that one member of staff needed guidance on how to best support people with eating.

People were satisfied that their health needs were met. One person said, "I know I can see the chiropodist," another said, "I see the doctor whenever I want to and I have seen the district nurse," and a relative told us, "[my relative] has seen the dentist and chiropodist. His dentures are not in use, it's his choice."

Staff were able to identify which people were diabetic or at risk of falling. We saw appropriate health screening tools such as MUST (to assess if someone was at risk of poor nutrition) and Waterlow, which assesses a person's risk of getting a pressure ulcer, were in all care plans.

There were records of medical appointments and the outcome of the appointments. This included diabetic clinics, the falls clinic and discharge summaries after a person had been in hospital. The staff said that if they thought somebody needed or wanted to see a doctor they would report this to their team leader who would arrange an appointment. We were told that the doctor attended the home twice per week.

The design of the building and the way it was organised did not meet people's needs for a safe and homely environment. One person told us they thought the care was good but the environment was "poor." The lounge area was long and narrow so people had to sit in chairs in a line facing the wall which was not a homelike experience. There were slopes on the first floor with no warning signs and staircases had stair gates at the top which were locked. This was a risk to people's safety. People could go up to the second floor staff area without supervision even when they wer at risk of falling. The home was not dementia friendly as there was a lack of signs and photographs to help people find their way around. When people were in their rooms or walking around the building there was no expectation that staff check on them frequently.

The conservatory was cold and nobody used it during the inspection. There was not enough room for people to eat in the dining room as it only seated 11 people, so some people had to sit in the lounge in the same chair all day including for their meals. This was a lack of choice and a lack of movement increases the risk of people getting discomfort and pressure ulcers.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We discussed the concerns about the environment not being safe and homely with the registered manager who agreed that he would request an assessment of the building by an occupational therapist to ensure it could be used more effectively for people's safety and comfort.

We recommend that the service seek advice to provide a more varied diet to suit people's preferences.

Requires improvement

Is the service caring?

Our findings

People told us that staff were caring. They said, “The staff are very pleasant and helpful” and “They always use my Christian name, they are very polite.” Other comments included; “They are very caring and hardworking” and “These girls are kind and very nice.”

Care plans detailed cultural and religious needs. People said their religious needs were met and one said, “I can see a minister if I want.” They also said their visitors were welcome at any time. Relatives confirmed this and said they did not have to give prior notice of their visits.

We saw staff being gentle to people while supporting them with tasks such as eating, taking medicines, getting changed and checking on their wellbeing. Staff were patient, spoke quietly and did not rush people. We saw that if somebody refused a request to have their medicines or their meal, staff left them and tried again later. This was good evidence of respecting people’s decisions while still encouraging them to do what was in their best interests. Staff communicated effectively with people and took time explaining things and listening to people.

Staff were able to tell us about how they ensured people's privacy and dignity was protected. For example people were able to stay in their own rooms if they preferred including for their meals. We saw staff treating people with dignity throughout the day of the inspection by treating them with respect, allowing them to do things in their own time and explaining what was happening.

We saw two care plans had DNAR (do not attempt resuscitation) forms completed and were up to date. Most care plans seen did not have end of life preferences recorded. One person was receiving end of life treatment but had no written end of life care plan. There were specialist healthcare professionals overseeing the person’s care and there was no evidence that their needs were not being met, but a written plan for staff to follow would ensure all staff knew how best to meet the person’s needs.

We recommend that the service seek training and guidance for staff in end of life care.

Requires improvement

Is the service responsive?

Our findings

People gave mixed feedback about the home, ranging from, “I don’t like it here and would not recommend it to others” to “We get plenty of attention, they do care for my needs” and “We are all looked after well here.” People who made negative comments felt they had a lack of meaningful activity in their daily life.

Each person had a written care plan in place setting out their care needs. All were reviewed and updated on a monthly basis. People told us their care needs were met. Two relatives also said they thought the care was good and focused on people’s needs.

There was not enough for people to do to maintain their interests. There were two televisions mounted on the wall but people said they did not choose what to watch. Staff had not been given training in organising suitable activities for people who have dementia.

One person said they went shopping which they enjoyed and staff supported them with this. Staff encouraged people to engage in activities in the afternoon of the inspection. The activities however were not age appropriate with jigsaw puzzles featuring young children’s TV characters and colouring books. One person said they would not take part in those activities. There was a lack of activity materials designed for adults.

One person said they enjoyed “colouring in” but two others said, “There’s not very much for people to do” and, “I don’t like sitting in the chair all day long.” People said they did not get support to go out. There had been an outing to a park that some people went on four months ago but most people had not left the home for longer than that.

The above issue was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff reviewed people’s care plans regularly to monitor their changing needs and kept basic daily records of care provided.

Two people said they had no complaints but would complain to the manager if necessary. One person told us, “I’ve got no complaints but I know where to go if needed” and “I have done a questionnaire, there were no issues.” We saw somebody raise a concern with staff and staff dealt with the situation well leaving the person satisfied that they had been listened to. The complaints procedure was available and we were able to see the record of complaints and action taken in response.

Requires improvement

Is the service well-led?

Our findings

The registered manager was actively involved with staff and people living in the home and we saw that staff approached him for advice regularly throughout the day. The registered manager also knew and spoke to visitors about their relative's wellbeing. Staff on duty said they found the registered manager helpful. They described the manager as being "supportive" and "sympathetic." We found him to be knowledgeable about people's needs. A relative told us, "The manager is very approachable. He is around all the time." People living in the home did not all know who the manager was but said comments such as, "I think the home is run well" and "I'm as happy as one can be, they [staff] all do their best."

Staff told us the home was managed well and staff worked well as a team. They said they were supported. There were regular staff meetings held.

The provider's service manager visited the home regularly to audit the quality of the service provided. We saw these reports and they included at each visit conversations with people living in the home and staff working there for their views on the service. The service manager visited the home at least monthly and often more frequently and monitored whether the registered manager acted on the recommendations she had made.

The provider visited the home to look at maintenance issues and we saw a record of repairs and redecoration needed and dates the work had been carried out.

There was evidence of some ongoing improvement, both to the building and in response to people's requests. Minutes of quarterly residents' meetings showed that people could raise concerns and make requests and the registered manager agreed to act on them. There was some evidence of acting on people's suggestions. The service manager monitored the number of accidents at their quality monitoring visits but there was no analysis of accidents and incidents that occurred at the service, so that learning could take place with the aim of minimising the risk of harm to people using the service.

We recommend the service seek advice from a reputable source on falls prevention within the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The registered person was not doing all that is reasonably practicable to mitigate the risks to service users' safety by not taking enough action to manage the risks of falls [Regulation 12(2)(b)], not ensuring the premises was safe and used in a safe way for providing care [Regulation 12(2)(d), and, not ensuring the proper and safe management of medicines [Regulation 12(2)(g)].

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The registered person had not ensured staff received appropriate training and professional development as necessary to enable them to carry out their duties. Regulation 18 (2)(a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment How the regulation was not being met: The registered person had not ensured all equipment was clean, suitable for the purpose for which it was being used and properly maintained and appropriate standards of hygiene maintained. Regulation 15 (1)(a)(c)(e) and 15 (2).

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: The registered person was not designing care with a view to achieving service users' preferences (for personal interests and activities) and ensuring their needs are met.