The Orchard Trust

The Orchard Trust - Sevenoaks

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an unannounced inspection which took place over two days on the 25 and 26 August 2016. Orchards Trust – Sevenoaks provides accommodation and personal care for up to 11 people with a complex needs; such as a learning disability and a sensory or physical disability. Accommodation is divided into two distinct houses. People share some communal areas between the houses. The grounds around the houses are accessible and some areas are safe for people to use unsupervised. Additional facilities have been provided for activities and people have a range of play equipment such as swings they can use.

At the time of the inspection the registered manager had been promoted and had removed their registration from this location. 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. A new manager had been appointed and was going through the registration process with CQC.

People did not always have the support of enough staff to meet their needs and to ensure they could participate fully in their lifestyle choices. Staff had not received individual support meetings as scheduled and did not feel supported in their roles and responsibilities. People's care records had not been kept up to date with their changing needs or reviewed as scheduled. During the inspection changes were made in response to our findings in medicines records, employment checks and submitting statutory notifications to CQC.

People's care records were individualised and reflected their preferences and routines important to them. Staff had a good understanding of their needs and supported them with kindness, sensitivity and patience. When people were upset staff responded by offering reassurance or helping them to cope with their emotions by offering them a drink, music or space. Staff understood people's preferred form of communication using sign language, music and objects to give them choices about they day to day lives. People's personal space had been adapted to provide sensory environments which they could interact with. The gardens around their home also provided a stimulating space to spend time. People when able enjoyed going out to day centres, doing voluntary work or day trips. They used the provider's swim gym and trampoline facilities.

People were supported by staff who had access to a range of training to maintain their skills and knowledge. They were able to complete training specific to people's needs such as epilepsy and rebound therapy (trampolining). People's rights were upheld. Staff had a good understanding of how to keep people safe and how to raise concerns. Accidents and incidents were closely monitored to make sure the appropriate action had been taken. A representative attended a Trust Our Voice Board which held managers to account and shared people's experiences. People's views were sought as part of the annual survey and during their reviews.

Quality assurance processes were in place which included feedback from people, relatives and staff. Visits by a representative of the provider had not been recorded and a new audit tool had been introduced to evidence any action being taken in response to their visits. Managers and representatives of the provider attended local networks ensuring they kept up to date with best practice and changes in legislation.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was mostly safe. There were not always sufficient staff employed, to meet people's needs. Improvements made to the recruitment and selection of staff needed to be maintained to ensure people were kept safe.

Improvements had been introduced to make sure medicines were managed and administered safely.

People's rights were upheld and they were kept safe from the risks of harm or injury.

Is the service effective?

Requires Improvement

The service was not always effective. People's experiences were not as good as they could be because staff were not supported in their roles. Morale was low despite staff working conscientiously to meet people's needs.

People's consent was sought in line with the essence of the Mental Capacity Act 2005. People deprived of their liberty had the appropriate authorisations in place.

People were supported to be healthy through a balanced diet. Their nutritional needs had been assessed and reflected their individual dietary requirements.

People's health care needs were promoted and changes to their needs had been responded to by staff.

Is the service caring?

Good

The service was caring. People were supported with kindness, sensitivity and care. They were reassured when upset and shared lighter moments with staff when happy.

People's care was planned with regard to how they responded to the care provided to them.

People were treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service is mostly responsive. People's care was responsive to their changing needs but their care records did not always reflect this. The monitoring and review of people's care records was inconsistent.

People had access to a range of meaningful activities which reflected their lifestyle choices.

Complaints had been investigated and action taken to address issues raised.

Is the service well-led?

Requires Improvement

There were aspects of the service which were not well-led. Managers had not promoted a service which responded to the views of staff and the experiences of people.

Quality assurance systems were being improved to make sure the standard of the service was closely monitored.

The Orchard Trust - Sevenoaks

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.

The inspection took place on 25 and 26 August 2016 and was unannounced. One inspector carried out this inspection. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we have about the service including notifications. A notification is a report about important events which the service is required to send us by law.

As part of this inspection we observed the care being provided to eight people using the service. We spoke with the nominated individual, a representative of the provider, seven care staff and a visitor. We joined staff at a handover between shifts. We reviewed the care records for four people including their medicines records. We also looked at the recruitment records for four staff, staff training records, complaints, accident and incident records and quality assurance systems. We observed the care and support being provided to people because they were unable to give us verbal feedback about the experience of their care. We used the Short Observational Framework (SOFI) for inspection. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We contacted four health and social care professionals and asked them for feedback about this service.

Requires Improvement

Is the service safe?

Our findings

People did not always have sufficient staff input to meet their needs. Staff were observed balancing their time; for example they supported some people to go out on activities and provided care and support to those remaining at home. They said people were unable to go out if staff levels were low or if people did go out those people remaining at home had less individual support. People were observed in one residence following a member of staff around, waiting for their personal time, as staff attended to each person in turn. Staff gave an example of how one person had reacted by going to bed when there were not enough staff on duty. We observed this happening. We discussed these concerns with the nominated individual and representative of the provider who confirmed they would look into the issues raised and take the necessary action. The representative of the provider said staff had been invited to look at the roster and offer their suggestions about how it could be arranged to meet the needs of people and staff.

Staff spoken with could not confirm what the correct staff levels were for each residence. They said there were not enough staff to always meet people's needs. The rota indicated seven staff were allocated to work across the residences with three in each residence and a team leader working across both. Copies of the rosters were provided after the inspection which confirmed the minimum staff working had been five rising to eight at times. The representative of the provider said the minimum staff levels expected would be five rising to seven or eight. Bank and agency staff could be used to cover last minute absences and management had at times been called in to help out over the weekend. In addition staff were supported by a cleaner, maintenance person, deputy manager and manager during the day.

People were supported by staff who had been through a recruitment and selection process to check on their skills, aptitudes and capabilities. Application forms had been completed and any gaps in employment history had been investigated with the applicant providing a full employment history. There was evidence the reason for leaving former employment with adults and children had been clarified. We discussed the recording of this for one applicant which provided the reason for the gaps in employment history but not the dates. This was rectified during the inspection. Prior to starting work a Disclosure and Barring Service (DBS) check had been completed. A DBS check lists spent and unspent convictions, cautions, reprimands, plus any additional information held locally by police forces that is reasonably considered relevant to the post applied for. Although some information had been recorded on a checklist not all the information needed by CQC had been kept. The checklist was amended during the inspection to provide the relevant details of the DBS check.

People's medicines had been safely given to them although care needed to be taken when making recordings on the medicines administration record (MAR). Handwritten entries on the MAR had not been signed or countersigned by staff as a correct record of the prescribed instructions. The representative of the provider said this was contrary to their procedures and addressed this during the inspection. The medicines policy and procedure had been updated to reflect the latest guidance from the National Institute for Clinical Excellence. Staff had completed training in the safe handling of medicines and were observed safely giving medicines to people. Protocols were in place for people having their medicines when needed. This informed staff about the maximum dose and when to contact the GP for advice. Stock levels had been recorded and

monitored; items had been labelled with date of opening and were disposed of within the correct timescales. People had their medicines at times to suit them and staff made sure they took medicines with people when they went out. Records had been kept for logging medicines in and out of the medicines cupboard. Facilities were in place for medicines which needed additional secure storage and records had been well maintained. Emergency medicines were provided for three people and staff had received the relevant training to administer them.

People's rights had been upheld. Records had been kept of their possessions and their finances were robustly managed. They were supported by staff who had a good understanding of their roles and responsibilities with respect to recognising abuse and raising concerns to the appropriate staff. They had completed safeguarding training and had access to information about how to raise concerns. This information was updated during the inspection to ensure staff had the contact details of the relevant authorities to be informed when needed. Staff described how they responded when they observed unexplained bruising, the records they kept and how they escalated their concerns. They were confident team leaders and managers would take the appropriate action to investigate and keep people safe. There was evidence action had been taken in response to unexplained bruising or injuries and incidents involving two people living at the home. The manager had discussed these issues with the local safeguarding team and had noted in their records they had called CQC.

People were kept safe from the risk of harm. Any potential hazards had been assessed and risk assessments described the strategies put in place to minimise these. When people had accidents or incidents records had been kept detailing what had happened, how it had happened and any action taken by staff to keep them safe. Accident and incident records were monitored to look for any developing trends and to make sure the appropriate action had been taken. When needed a full investigation had been carried out to determine the cause of any accidents and whether they could have been prevented. Occasionally emergency services had been called and if necessary people had been taken to hospital for further treatment. There was evidence referrals had been made to the relevant health care professionals to review people's physical health and their medicines to make sure these had been the cause of any accidents such as falls. Staff had also researched equipment which could be provided to keep people safe when having epileptic seizures such as a helmet or alarms for beds or rooms. The representative of the provider said that wherever possible the least restrictive solution was found. For example, one person had a call bell system so they could access staff at any time of the day and night without the need for constant staff supervision.

People were safeguarded against the risks of emergencies. Each person had an individual personal evacuation plan should they need to leave the property quickly. Staff confirmed there was an out of hours emergency call system in place should they need advice or support from management. Checks were in place to monitor health and safety systems such as fire, water temperatures, portable appliances and infection control procedures at the appropriate intervals. Equipment had been serviced in line with manufacturer's guidance.

People benefitted from staff who said they would be confident raising concerns under the whistle blowing procedure if they had any concerns about the practice of their colleagues. Whistle blowing is where a member of staff raises a concern about the organisation. Whistle blowers are protected in law to encourage people to speak out. The representative of the provider shared with us their response to concerns raised and the investigations into the conduct of staff along with the action they planned to carry out.

Requires Improvement

Is the service effective?

Our findings

People's experience of their care was varied because staff providing their care had not received effective individual support to work to the best of their ability. Staff reflected that they were "a hard working staff team", "dedicated to the needs of the people living in the home" but they did not feel supported in their roles and responsibilities. They had not received individual support sessions (supervisions) as scheduled throughout the year. These had been arranged to take place every three months but records showed staff had attended one meeting instead of the planned three. Staff said they felt they could raise issues with the management team, although they did not always feel action had been taken in response to their concerns. For example, they had requested a management presence alongside staff and for staff levels to be maintained so they could ensure people's care was consistent and any shortfalls were managed. They also talked about low morale and the turnover of staff. This meant staff did not feel they were effectively supported in their roles to ensure people's needs were being met.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by staff who had access to a programme of training. A training schedule had been devised which highlighted the training needs of staff and when they needed to complete refresher training. The responsibility for this had been transferred to a training department to oversee the training needs of all staff. Staff confirmed they had been doing a lot of training and the representative of the provider confirmed 85% of mandatory training had been completed which included fire, first aid, moving and handling and infection control. Each member of staff had an individual training profile along with certificates to evidence successful completion. Staff said they had access to training specific to people's needs such as sign language, rebound therapy (trampolining) and epilepsy. New staff had completed the care certificate and then went on to the diploma in health and social care. The care certificate sets out the learning competencies and standards of behaviour expected of care workers. The provider information return stated staff were given key roles such as "Activity Champion, Communication Rep and Challenging Behaviour Champion" to develop their skills and knowledge.

People made choices about their care and lifestyle choices. They were observed being asked by staff to make choices about activities, food and drink. Their care records provided evidence of an assessment of their capacity to consent to their care or aspects of it in line with the Mental Capacity Act 2005 (MCA). The 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. Any decisions made in people's best interests, such as administering their medicines or providing personal care had been recorded in people's care plans. They noted who had been involved in these discussions such as the GP, health care professionals, staff and relatives.

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 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. Applications had been approved by the supervisory body for people to be deprived of their liberty in their best interests to keep them safe from harm. There was evidence wherever possible the least restrictive solution had been found. The DoLS had been reviewed when needed.

People were supported when they occasionally became upset or anxious. Their care records provided clear guidance about how to recognise when they were becoming distressed and how to support them to become calmer. Staff spoken with had a good understanding of how to support people and were observed following people's behaviour support plans. Staff had completed training in positive behaviour support and told us they did not use physical intervention. Monitoring charts confirmed this and indicated people were being effectively supported to become calm by staff using distraction techniques such as offering a drink or snack, putting on music or creating personal space. We discussed with a representative of the provider two incidents where people had assaulted others living in the home. These had been one off incidents with no evident intent to injure or harm. Staff made sure people involved in these incidents were supported afterwards and checked there had been no injuries or psychological harm.

People were supported to maintain a balanced diet. People's specific dietary needs had been explored with them and their relatives. For example one person preferred a gluten free diet and this was provided for them. Another person had lost their appetite and so fortified foods and drinks had been provided resulting in their weight being stabilised. People were observed having access to drinks, snacks and treats when they wanted them. People helped to make drinks and were involved in baking and cooking if they wished. People had access to a speech and language therapist to assess their eating and drinking needs. Care records identified where they were at risk of choking and how their food should be prepared, for example cut up or food of a soft consistency. Equipment had been provided to enable them to feed themselves such as cutlery or plate guards. People's food and fluid intake had been monitored when they were at risk of losing weight or dehydration. People were observed enjoying their meals and indicating to staff when they had eaten enough or wished for more.

People had access to health care professionals to help them stay healthy and well. Each person had a health action plan which described their medical history, medicines they were currently taking and their current health care needs. A hospital assessment had been completed to take with them in emergencies providing a summary of their health care needs and also how to communicate effectively with them. Strategies had been developed to support people at clinics when they might become anxious allowing for private facilities if needed or ensuring appointments were on time. People's changing needs had been responded to appropriately and the care they received reflected this.

Good

Is the service caring?

Our findings

People were observed interacting positively and warmly with staff. They sought their company and were responded to appropriately by staff who treated them patiently, kindly and with sensitivity. People enjoyed light hearted moments with staff, laughing together and appreciating time with each other. Staff showed concern for people reacting in a timely fashion to their mental and physical well-being. They knew people well and understood how to support them if they were showing signs of distress. They reassured people and offered them activities or support they knew people would engage with. A visitor spoke positively about the relationship people had with staff, commenting "Support is very good." Staff told us, "People are really cared for; this is a loving home" and "Staff think the world of service users."

People's preferred form of communication was clearly detailed in their communication passport. This was in an easy to read format which used pictures to describe facial expressions along with a narrative about how to interpret people's behaviours. Staff were observed singing along with one person who used music to communicate and clapping with another person. Other staff used Makaton sign language to reinforce the spoken word when talking with people. Staff also used objects of reference to help people make choices such as showing them objects they related to and which they linked with an activity. For example, a coat would mean they want to go out or a cup would indicate they would like a drink. People's care records listed the objects they would react to with their meanings. Other information had been provided in easy to read formats such as the complaints form and activities schedules which used personalised photographs. A display of staff photographs provided a daily guide to who was working with people.

People's human rights were respected. If they had preferences about the gender of staff supporting them with their personal care this had been recorded in their care plans and had been respected wherever possible. People's religious beliefs had been recognised and their choice about whether to actively participate were noted. People's sensory needs had been considered when designing their individual rooms and their shared areas. Two people had a sensory disability and so shared areas were sparsely furnished so they could move around their home safely and freely. Individual bedrooms had a range of sensory decorations which provided sound and texture or colour and visual stimulation depending on people's individual requirements. People had access to a range of therapeutic services such as reflexology and massage. The therapist said people looked forward to this with great anticipation and were far more relaxed after their sessions.

People had the support of appointees or relatives who were actively involved in their care. They were kept up to date with changes in people's needs. Relatives were able to visit people and people also kept in touch using the telephone and Skype [video or voice calls via the internet]. Staff said, "Staff understand people really well" and interpreted their experience of their care through their body language, verbal feedback and general sense of well-being. The provider information return stated, "Keyworkers for those who cannot communicate put forward ideas and concerns on the individual's behalf." Two people had lay advocates. Advocates are people who provide a service to support people to get their views and wishes heard.

People were treated with dignity and respect. Staff were observed going to help them with personal care,

knocking on their bedroom door and announcing their presence before providing personal care behind a closed door. People were observed being encouraged to be independent around their day to day lives. For example, taking their plates and cups to the kitchen, helping themselves to drinks and putting their coats away. A member of staff enthusiastically related how it had taken one person over 12 months to learn to take their plate to the kitchen after their meal which they now did without prompting.

Requires Improvement

Is the service responsive?

Our findings

People's care records did not reflect their individual needs or any changes which had occurred. Whilst the care people received had been changed to respond to the care and support they required, their care records had not always been updated to reflect these and some care records had not been reviewed since 2014. People had key workers, named members of staff, who had responsibility to review their care and support and keep their records up to date. When handwritten changes had been made to care plans these had not been signed or dated. Some care records had a monthly review record which had not been completed as scheduled. Other care records had a review record which did not state when the review was due. When this form had been completed records had been reviewed annually. We discussed the care needs for one person with a representative of the provider who related different needs to those we had read in their care records. For example, care plans and risk assessments talked about the use of a helmet for protection. This was no longer being used. The records for this person had not been updated with changes in their needs and the support they were currently receiving. There were inconsistencies in record keeping which could potentially have led to people receiving incorrect care.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care records were individualised reflecting their history, likes and dislikes and routines important to them. Each person had a pen picture giving a summary of the way in which they would like to be supported. Clear guidance had been provided about what people could do for themselves and what they needed help with. Staff had a good understanding of people's needs and how to support them. Staff explained how they interpreted people's feelings and well-being interacting with them in their preferred manner whether through music, touch and activities they liked and enjoyed doing.

People's changing needs had been responded to such as loss of weight or depression. The appropriate health care professionals had been contacted for advice and support. Staff reported that people had made positive changes in their health and well-being, stabilising their weight and starting to engage in day to day life again. A person who had moved into the home had made significant progress and staff reported they had settled in well. They said how they needed less support from staff, were happy in the company of other people living in the home and were participating in activities. None of these had been thought to be achievable when they moved into the home.

People had a range of activities scheduled to take place, both inside and outside of their home. People went out to day care, were involved in voluntary work, helped with recycling and went on trips to places of interest. We observed them helping to bake, doing arts and crafts, going swimming, for a picnic and shopping. They also took part in arts and crafts, had sessions of reflexology and listened to music or audio books. Great effort had been taken to make sensory environments which people could engage in. Their rooms had visual stimuli, music and televisions. People enjoyed using YouTube and either listening or watching their favourite videos or shows. The gardens provided safe areas to walk and explore, with a water feature and plants to stimulate smell. They also had access to large swings and an activities outhouse.

Nearby they could help out at an allotment growing their own vegetables. They also had access to other facilities owned by the Trust including a Swim gym and a trampoline.

People's experiences of their care and support were monitored through complaints and concerns. Staff observed people's behaviour and interpreted this to reflect on what was working for them and what might need changing. If people refused personal care or food, staff worked together to ascertain the cause and make adjustments to their care and support until a state of well-being was restored. The provider information return stated, "The health and well-being of individuals is a prime concern of all staff and any issues are quickly raised with the appropriate people." An easy to read complaints form had been provided for each person. Complaints had been made on their behalf by relatives and staff. These had been investigated and action taken to address any issues raised. Feedback, written and verbal, had been provided to the complainants with an apology if needed. Issues ranged from shortage of staff, cancelling activities, staff attitude and performance.

Requires Improvement

Is the service well-led?

Our findings

The manager had been in post since March 2016 and was supported by a deputy manager. The nominated individual and representative of the provider had recognised the management team needed some support and guidance and had appointed a consultant to mentor them through their induction into their new roles. In addition the manager had guidance from the previous registered manager who had been promoted within the Trust. Staff said they had voiced concerns about the management style and the lack of support they felt they had to deliver care and support to people. The nominated individual and representative of the provider discussed with us the impact of staff vacancies and challenges around funding for people whilst trying to maintain the standards of care. All of these issues had clearly impacted on people's experience of care and the outcomes we found during the inspection.

The manager was aware of their responsibilities under the Care Quality Commission (CQC) and had applied for a disclosure and barring service check in preparation for submitting applications to become registered with CQC. She had also submitted statutory notifications and informed CQC of events affecting people and the service. The representative of the provider submitted two outstanding statutory notifications during the inspection with respect to incidents which accident and incident records stated had been notified to CQC but statutory notifications had not been received.

People's views and experiences of their care were sought as part of the quality assurance process. This involved people being supported to respond to annual surveys; "Have your say" questionnaires prompted people to give feedback about activities and meals. Concerns about meals were fed back by a representative from the home to the provider's Trust Our Voice Board. This forum enables people using the services of the Trust to hold managers to account. As a result a member of staff attended a healthy food and nutrition training course and was planning a menu which included fresh vegetables and offered two main meals each day. Feedback from relatives and staff was also part of the quality assurance process. Relatives had regular telephone calls and took part in people's reviews, as well as accessing the complaints process. Staff meetings had been scheduled to take place after other meetings had taken place within the Trust, such as the communications group [staff representatives meeting] and health and safety meetings, so that information could be shared with staff in a timely fashion. Staff meetings also gave staff the opportunity to feedback their views.

Quality assurance processes monitored the standard of care provided to people. A representative from the provider carried out monthly visits to the home and said they had not been formally recording these. They shared with us a new audit form which would be used which would record any issues identified and evidence when these had been actioned by the manager. Monthly reports had been produced for the board of trustees so they could monitor the quality of the service. Improvements being made which included setting up a text messaging service for staff so they could request additional cover without intruding on their personal time. This would also be used to prompt staff about training. New quality assurance systems had been introduced to monitor the health and safety of people and services. Robust records were in place confirming health and safety checks had been completed. Accident and incident records were monitored to make sure no trends had developed without the relevant action being taken. A representative from the

home met with other representatives to ensure the provider had an overview of any issues within the services and to standardise audits and records across the services.

The representative of the provider talked about the challenges of recruiting and keeping staff. In recognition of the challenges of retaining staff several schemes had been introduced. Staff had been reminded about health benefits which were available to them such as covering costs for dentist or optician appointments. A long term service award had also been introduced in recognition of long standing staff. The provider information return also said the provider had recognised the impact of employing new staff and the impact their induction had on existing staff. "We are going to review the time frame for new staff to undertake inductions and the care certificate whilst also being shadowed."

The representative of the provider used their experience of being a review co-ordinator of a national accreditation scheme to benefit the experience of people living with autism. Their knowledge and experience was passed onto staff. The nominated individual was also the chair of a local care provider's association and attended the local safeguarding board enabling them to share best practice and changes in commissioning and legislation with managers and staff. The manager attended a learning exchange and local network groups to maintain their knowledge and skills.

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 17 HSCA RA Regulations 2014 Good governance Systems were not in place to maintain an accurate, complete and contemporaneous record in respect of each service user. Regulation 17(2)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Persons employed by the service provider had not received the appropriate support or supervision necessary to enable them to carry out the duties they are employed to perform. Regulation 18(12)(a)