Ordinary Life Project Association(The)

Ordinary Life Project Association - 67a St George's Road

Inspection report

67a St George's Road
Semington
Wiltshire
BA14 6JQ

Tel: 01380870168

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
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 inspection took place on the 27 July and 3 August 2016 and was unannounced. At the previous inspection visit which occurred on 12 June 2014 we found breaches of regulations. The provider took action to meet the requirements of the regulations made at the previous inspection. This included adapting the environment to provide people with suitable bathing facilities.

This service is registered to provide accommodation and personal care for up to three people with learning disabilities. At the time of the inspection there were three people living at the service.

A registered manager was in post on the first afternoon of the inspection but on the second day we were informed the registered manager was no longer in post. We were told the registered manager was leaving their post on 31 August 2016. The provider had made arrangements to cover the day to day management of the home. 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.

There was a lack understanding from staff on the principles of the Mental Capacity Act 2005 (MCA). MCA assessments were not always carried out for specific decisions such as bed rails and administering covert medicines. Staff had asked relatives without legal powers to give their consent for male staff to deliver personal care.

Support plans lacked detail and were not person centred. Support plans were inconsistent with Person Centred Plans (PCP) and risk assessments. Guidance from healthcare professionals was not used to develop detailed support plans. This included helping people to develop meaningful activities and for eating and drinking. While support plans were dated to indicate a review had taken place for some people, the plans had not been updated for a significant period of time. Action plans were not developed. This meant support plans described how people liked their care to be delivered but they did not incorporate guidance from healthcare professionals and the effectiveness of the support plans was not evident.

Assessments were developed to ensure people were able to take risk safely and to minimise the risks to people's health and welfare. Staff knew the actions needed to minimise the identified risks. However, some assessments were inconsistent with people's support and PCP plans.

Quality assurance systems were in place. However, the internal self- assessment was not consistent with the findings of this inspection. For example, all standards assessed were shown as met including care planning and MCA.

The person we asked said they felt safe with staff. Members of staff we spoke with were aware of the

safeguarding of vulnerable adults from abuse procedures. These staff knew the expectations placed on them to report allegations of abuse.

Two staff were on duty on both days of the inspection. Staff said two staff were needed to assist with moving and handling manoeuvres. The rotas in place confirmed there was a minimum of two staff during the day. We saw there were three staff on duty during the week to enable people to go out. For example, shopping, swimming and for meals out. At night one member of staff was awake in the premises.

People were supported with their ongoing healthcare needs. Reports from healthcare professionals showed people had input from specialists and they had regular check-ups for example dentists.

People told us they approached staff with concerns. One person said the staff were kind and caring. This person also told us their rights were respected by staff.

Medicine systems were safe. The person we asked said the staff administered their medicines. They said at times they refused to take their medicines and the staff gave them time and returned to check they had changed their decisions.

The range of fresh fruit and vegetables, frozen and dried foods ensured people had a varied diet. Staff followed the advice of healthcare professionals on how to serve meals to minimise the risk of choking.

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 this 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?

Good

The service was safe

Staff showed a good understanding of the actions needed to minimise the risk to people. Sufficient levels of staff were deployed to meet people's needs.

Safe systems of medicine management were in place. Staff signed medication administration charts to show they had administered the medicines. Protocols were developed for administering "when required" medicines.

The person we asked said they felt safe living at the service. Staff knew the procedures for the safeguarding of vulnerable adults from abuse.

Is the service effective?

Requires Improvement

The service was not effective.

People were assisted by staff to make day to day decisions. People's capacity to make specific decisions was not always assessed. Consent was gained from relatives without legal powers for care and treatment.

The legal framework to deprive people of their liberty was not in place for bed rails and covert medicines.

Staff had access to a range of training to ensure they had the correct knowledge and skills to provide people with care and support to meet their needs.

People had a choice of food and drink and they received sufficient to meet their needs. People spoke positively about the food choices available to them.

Is the service caring?

Good

One person said the staff were caring. We observed good interaction between staff and people.

Members of staff were seen spending time with people in shared

spaces. We saw them discuss with people the tasks they were about to undertake.

People's rights were respected.

Is the service responsive?

Requires Improvement

The service was not responsive.

Support plans were not person centred as they did not give staff guidance of people's preferences about the delivery of their care. While support plans were dated as reviewed the guidance received from healthcare professionals was not used to develop detailed support plans.

There was an activities programme in place but activities for people were limited.

Is the service well-led?

Requires Improvement

The service was not well led.

The provider did not have effective systems in place to assess, monitor and improve the quality of care.

Systems were in place to gather the views of people and their relatives.

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Members of staff worked well together to provide a person centred approach to meeting people's needs

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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

This inspection took place on 27 July and 3 August 2016 and was unannounced.

The inspection was completed by one inspector. 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 hold about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

During the visit we spoke with one person, two staff and the registered manager. 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 spent time observing the way staff interacted with people who use the service and looked at the records relating to support and decision making for two people. We also looked at records about the management of the service.

Good

Is the service safe?

Our findings

The person we spoke with said they felt safe living at the service. They said it was the staff that made them feel safe. During the inspection, we saw one person seeking staff's attention to undertake activities with them. They were comfortable sitting together with staff.

Staff were aware of how to keep people safe. A member of staff told us protecting people was the principle of the safeguarding vulnerable adult's procedure. They told us about the types of abuse and the responsibilities placed on them to report allegations of abuse. This member of staff gave us an example of how they would address poor practice from other staff. They said in the first instance they would approach the member of staff. If this poor practice continued they would report it to their line manager. Another member of staff listed the types of abuse and stated "abuse must be reported and if it's not taken seriously continue to report concerns to more senior managers or to the local authority."

One person told us their bed was too small. Members of staff told us the bed was a standard "hospital" type bed and the person's view was being considered. A member of staff said "everything is risk assessed. Risk assessments are devised for the equipment needed to undertake tasks. For example hoists." They said general risk assessments were in place for wheelchairs. Another member of staff described the actions taken to minimise risk. For example, textured meals and positioning for people at risk of choking.

Risk assessments were developed where risks were identified and to ensure people took risks safely. For example swimming and for the use of a "peanut/swiss" ball.[exercise ball] The action plans for using equipment safely such as "peanut/swiss" ball instructed staff to supervise the person. Photographs and detailed instructions on the correct use of the "peanut" ball were provided by the Occupational Therapist (OT).

Moving and handling risk assessments were devised for overhead hoists and for tilting chairs to be used in showers. The action plan included the instructions on the safe use of the equipment, the number of staff needed and that staff needed to be trained before assisting the person with moving and handling. For another person the action plan for the falls risk assessment was to provide a low rise bed to minimise the risk.

A member of staff said accidents and incidents were documented to ensure staff were aware of the event. They said body map forms were used to specify the location of the injury on the person's body. Another member of staff said they recorded accidents and they discussed the events. We saw two accident reports which had recently occurred. The accident from July 2016 was for malfunction of equipment and the emergency services were contacted. On the day of the inspection, staff had noted a red area on a person during personal care. An accident form was completed and a body map form was used by staff to show the location of the red area.

Emergency Contingency Plans included fire risk assessments and personal emergency evacuation plan (PEEP). The fire risk assessments were reviewed in 2016 and included the report of a visit from the fire safety

services. We saw fire safety recommendations were actioned and appropriate means of escape were provided. PEEP's were in place giving staff guidance on the support needed by the person to evacuate safely from the premises. A member of staff described the evacuation procedures for people. They said the procedure was to evacuate from the point of the fire.

One person told us the staff were always the same and they had the help they needed from the staff. A member of staff said two staff were always on duty and often there were three on duty to support people with activities. They said one waking staff was on duty at night. Another member of staff said two staff had to be on duty to support people with moving and handling. The staff rota in place confirmed two staff were on duty from 8am to 8pm and twice weekly a third member of staff was rotered. At night one member of staff was on duty.

The person we spoke with said staff administered their medicines. Staff said they were trained to administer medicines. A member of staff said there was plenty of guidance available for the safe handling of medicines.

Medication Administration Record (MAR) charts were signed by staff to show they had administered the medicine. Protocols on administering "when required" (PRN) protocols were in place. For example, pain relief and for agitation. Protocols for pain relief gave instructions of administration which included the maximum dose that can be administered within a 24 hour period. The protocol for one person who at times became agitated, directed to staff on the distraction techniques to be attempted before administering medicines.

A record of medicines no longer required was maintained which the pharmacist or their representative signed to evidence their receipt of the medicines for disposal.

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's capacity to make specific decisions was not always assessed. MCA assessments were not completed for all decisions made by staff and relatives. The making decisions support plan for one person stated "likes to be in control of everyday life. XX likes to be control and liked to be informed of any decision made concerning him." However, the action plan lacked detail on the person's capacity to made decisions, the person's ability to make decisions and how staff were to support the person with decision making. The health action plan for this person stated that medicines were to be administered in food, the staff were to inform the person their medicine was in their food and that the GP had authorised staff to administer covert medicine. However, the person's capacity to make decisions about their medicines was not undertaken.

Staff had documented in the decision support plan for another person that they lacked capacity to make informed choices which included who to provide personal care such as male staff. Within the plan it was recorded that a relative had given their permission for staff to act on the person's best interest. Other support plans which included the dignity and personal care support plans also included information that a relative had given their consent for male staff to assist with personal care. . However, staff had gained consent from a relative without legal power for male staff to deliver personal care. Staff told us a female urinary device was used. However a support plan and accompanying MCA assessments were not in place.

People can only be deprived of their liberty so that they can 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 told us DoLS applications for continuous supervision were in progress for the people living at the service. A member of staff told us appointments had been made by the local authority to assess people for continuous supervision. We saw bed rails were used for one person. The action plan for the bed rails risk assessment dated 24 April 2015 and reviewed July 2016 stated "always ensure bed rails are used." an MCA assessment and application to restrict this person's liberty was not in place

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The person we asked said they made day to day decisions. They told us the GP made decisions about them

having a flu vaccine and about having blood tests. Another person
MCA assessment and best interest decisions were made for one person to have a hospital procedure. The best interest decision was made by medical staff and in consultation with the registered and area manager. Decision making support plans for another person described how the person made decisions. For example, body language, hand gestures and will remove themselves from the activity or place which they use to express a wish to discontinue.

Staff were aware that people's capacity to make decisions was assessed and MCA assessments for specific decisions were completed and regularly reviewed. They described the decisions people were able to make and how people made staff understand the decisions made. For example, one person was able to express verbally to staff their decisions and another person made decisions by refusing including pushing meals away. Another member of staff said one person was able to make decisions without staff support and another person was able to respond with "yes and no" to the decisions. For example, "we give [the person] as much information as possible to help them make decisions."

One person told us they sometimes refused to take their medicines. They said "the staff say if you won't take them [medicine] then I won't give them to you." This person said the staff returned later to check if they were willing to take their medicines. A member of staff confirmed one person at times refused their medicines and the person was not forced to take them. They said the person was given time and staff then returned and asked the person to take their medicines. Giving people time and space was also used to manage behaviours when some people became frustrated. Staff said they asked the person not to throw items and they were given time and space. Another member of staff said one person at times could become vocal and throw items. They said guidelines were in place on how staff were to respond to people that exhibited behaviours that challenged. Regular meetings took place and concerns about people were discussed.

The positive behaviour plan for one person dated 6 February 2016 listed the triggers and included the reactive and proactive approaches to take. For example, the reactive approach was for staff to use distraction techniques such as offering refreshments and to give the person time and space. For a proactive approach staff were to speak to the person in a calm way and were to act in a manner that empowered the person.

People's dietary requirements were catered for at the home. The person we spoke with told us their preferred meals were served. They said when cheese was served they were provided with an alternative. The menus in place were for the evening meals and a pictures and words format was used. Staff were knowledgeable about people's dietary likes and dislikes. A member of staff said people would have cereals, porridge or eggs for breakfast. They said some people enjoyed "spicy foods" and when these meals were on the menu alternatives were provided to those people who disliked these meals.

The range of food and refreshment were consistent with the menus in place. We saw a good range of fresh fruit and vegetables, dried, tinned and frozen foods. People were offered a variety of refreshments. We also saw fruit juices, squashes, tea and coffee.

We saw staff supporting people to eat their lunch. People were served with a meal of their choice. Staff assisted two people to eat textured meals served following guidance from Speech and Language therapist (SaLT).

The person we spoke with said they saw their GP regularly at the home. A member of staff said the registered manager arranged healthcare appointments and the staff on duty accompanied people on appointments. They said outcomes of appointments were recorded and where guidelines and suggestions

were not effective, the registered manager contacted the healthcare professionals for further advice. Another member of staff said people were observed for signs of deterioration and the GP was then contacted. They told us other healthcare specialists such as Occupational Therapists (OT) and Speech and Language therapists were involved in the care of some people at the home.

Health Action Plans for people were in words and photographs. They described "the things you need to know about me" and contact details including the people and staff providing support. We saw a brief overview of the person's medical history and a medicine profile which included the purpose of the medicines. Health action plans listed the person's ongoing healthcare needs for example, current medicines to be administered, healthcare professionals involvement, reports of GP visits and of check-ups such as dental visits.

People at risk of choking had input from Speech and Language therapist (SaLT). Guidance from SaLT specialists gave staff guidance on the texture of food to be served. However, Eating and Drinking support plans were not updated with the guidance from the SaLT specialists. Occupational Therapists (OT) were involved and for one person we saw they had recommended meaningful activities to help develop a "now, next and what to expect" technique. For another person, the OT had provided equipment and advised the staff provided more sensory experiences. For example, sitting on a "peanut/swiss" ball. We saw a risk assessment in place for using a "peanut" ball. However, a support plan had not been developed. A member of staff said this was because the person had lost interest in the equipment and it was no longer used.

Staff said the training provided by the organisation was good and enabled them to meet people's needs. A member of staff said there was a training programme developed by the organisation's training officer. They listed the training recently completed which included first aid, epilepsy awareness, diversity and moving and handling.

Another member of staff told us there was an induction when they started work at the service. They said the registered manager provided an in-house induction which prepared them for the role they were employed to perform. This member of staff also told us there was essential training set by the provider which they attended. For example, first aid and safeguarding of vulnerable adults. However, as part of their development they had requested to complete a vocational qualification but this had not happened since their employment of 14 months.

Staff told us they had regular one to one meetings with the registered manager. They said at the one to one meetings they discussed their performance and any concerns. They said requests for personal development were actioned by the registered manager.

Good

Is the service caring?

Our findings

The person we asked said the staff were kind and felt what staff said was important. A member of staff said they gained knowledge about people by reading their support plans that had their background histories. They said time was spent observing behaviours and spending time with people. For example, reading books and listening to music with people. This member of staff said it was important to develop trust to "get a bond". They said "it's good for them and its good for you [staff]." Another member of staff said they knew people's preferences. They knew how to diffuse situations and at times "banter" was used to make people laugh.

During our inspection visits we saw staff taking one person on an outing and spending time with them in their bedroom. We saw staff supporting two people with eating their meals. When staff approached people they explained the task to be undertaken. We saw one person stand and follow the member of staff when they explained the task to be undertaken. This showed agreement with the task to be undertaken.

One person invited us into their bedroom. They told us they had chosen the colour scheme including lampshades and bed linen. We saw the person's personality reflected in their personal items and family photographs.

Daily routines lacked a person centred approach as action plans were based on staff's actions and not people's preferences. Daily routines support plans gave staff some guidance on how to interpret the person's preferences on providing personal care. For example, the times to get up. For one person the background information included their medical history, the way the person communicates and the involvement of relatives and their preferred activities.

Dignity support plans described the likes of the person, for example noise level. The support plan for one person stated the person needed encouragement to get up. However, the action plan on how staff were to assist the person was not included in the support plan

The rights of people were respected and staff supported people to maintain family relationships. The person we asked said the staff closed the doors before personal care was delivered by the staff. They said their relatives were welcome at the home and visits took place in their bedroom and if additional privacy was needed they closed the bedroom door.

Staff gave us examples on how people's privacy was respected. A member of staff said where moving and handling techniques were needed, staff ensured that as much as possible people were covered and not overexposed.

Requires Improvement

Is the service responsive?

Our findings

Support plans were not person centred and the reviews provided little evidence on the effectiveness of the plans. The person we asked said they were not aware of a support plan but was aware that records about them were kept. They confirmed their keyworker [staff assigned to specific people] discussed with them their care needs. A member of staff said the registered manager devised the support plans and keyworkers reviewed them. Another member of staff said they spoke with people about their goals but some were set in staff's perception of the person.

Person centred Plans (PCP) were inconsistent with support plans and lacked detail on how staff were to support the person. For example, the communication support plan stated the person "needs a lot of support to regain his speech and needs to express himself other than yes and no." The communication support plan reviewed in 2016 was inconsistent with the PCP as it stated the person was able to respond in short sentences. The objective was to interact more, encourage verbal communication and to give time and space.

The communication PCP for another person said this person "will lead staff to the place for activity or tasks". The decision making support plan confirmed the person used hand gestures and body language to communicate. However, the communication support plan stated the person had no formal speech and the staff were to use photos and eye contact to communicate. The manner the person communicated was not included in the support plan.

Eating and drinking support plans for one person dated February 2013 stated the person must have their food "cut small enough to make chewing easier". Staff told us they followed Speech and Language Therapist (SaLT) guidance and the consistency of the person's food was texture "E". The SaLT guidance stated the food must be "fork mashable or Texture E". The risk assessment stated the person must have a soft diet. This meant support plans were inconsistent with each other and they were not reviewed or updated to include advice made by professionals.

The personal care dressing support plan stated this person was dependant on staff as they showed little interest in choosing clothing. The staff were to encourage the person to participate in the decision making. Action plans on how staff were to do this person were not part of the support plan.

Staff said there were handovers of information when they arrived on duty. A diary was used by the staff to record the date of appointments and for undertaking specific tasks. For example, car maintenance. Individual diaries were used to record the times when people woke up and went to bed, appointments and their outcomes and activities undertaken.

Staff had signed and dated support plans as reviewed. We noted some support plans had been ongoing for significant periods. For example, the bathing and toileting support plan for one person was dated 2009 and had been dated as reviewed and current for seven years. We saw advice from healthcare professionals was not drawn together to develop detailed support plans. This meant there was little evidence to show the

effectiveness of the support plans.

Activities support plans included people's preferred activities. For one person their support plan stated watching television, looking at books and photographs and weekly hydrotherapy. During the inspection visit we saw a member of staff going through books with this person in their bedroom. For another person the person centred plan (PCP) for activities stated the person was "being re-introduced with leisure activities. For example, colouring, reading magazines, watching television and going to the pub. Within the PCP the staff were to provide interesting books and stimulation. However, the effectiveness of the plan was not included.

We saw an Occupational Therapist (OT) report on guidance of developing activities for two people. The OT advice for one person was for the staff to help this person understand what was to happen "now and next". They said well-structured routines with meaningful activities had to be created. The PCP goal was for staff to collate photos for a scrapbook. There was little evidence to show the person had identified the goal and how it was to be achieved. A support plan that included the guidance from the OT was not developed. A member of staff said a record of activities undertaken was maintained. The record showed where the person had declined to get up, which impacted on the programme of activities. The member of staff said the decision on the nature of activities to take place were taken daily and based on the person's health.

The OT report for another person provided staff with guidance on providing sensory experience. For example, sitting on a Swiss/peanut ball and this guidance was in a photograph format to ensure staff used the equipment correctly. The risk assessment in place advised the staff to supervise the person when they were sitting on the "peanut" ball. However, support plans were not developed on the OT advice given and the risk assessment lacked the guidance from the OT. A member of staff said the person had lost interest. There was little evidence to show the comments made by the staff.

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

The person we spoke with said they kept themselves occupied with puzzles and watching the television. They said they also enjoyed going out in the car. A member of staff said one person was supported with their preferred activity of swimming and their relative joined them on this activity. Another member of staff told us about the activities in place for two people. They said one person went to restaurants while the other person accompanied staff when doing the grocery shopping. They said although the staffing levels were sufficient for people to go on outings the activity had to be planned.

On display in the home were photographs of events in the home and outings. These included Christmas at the home and activities.

The person we spoke with said if they had any concerns they would tell the staff. A member of staff said relatives usually approached the registered manager with their concerns. There were no complaints received at the home since the last inspection.

Requires Improvement

Is the service well-led?

Our findings

On the first afternoon of the inspection the registered manager for the service was on duty. On the second day of the inspection we were told a registered manager was no longer in post. Senior manager told us the registered manager was leaving their post by 31 August 2016. The staff we spoke with were complementary about the previous registered manager. A member of staff said the registered manager was "brilliant and a good manager. You can say anything to her". Another member of staff said the registered manager "is brilliant, firm but fair".

Quality Assurance systems included a self-assessment of services. The registered manager carried out monthly audits of systems. The self-assessment for July 2016 showed support plans were assessed to ensure all appropriate information was included and that fire risk assessments and training records were up to date. While fire risk assessments and training records were up to date we found support plans lacked detail and were not person centred. This meant our findings were not consistent with the self assessment for July 2016.

Quality assurance visits were undertaken by members of the quality assurance team which included an area manager, Human Resources (HR) and the Chief Executive. The most recent quality assurance visits were to assess the improvements of the environment.

The views of people and staff were gathered during tenant meetings. The minutes of the tenants meeting held on 31 July 2016 listed the people attending. One person said they needed equipment and described their preferred activity. At the previous meeting the views of people were gathered about returning to the location following refurbishments.

The minutes of the team meeting that took place in June 2016 showed the people at the service and the use of agency staff to maintain staffing levels was discussed. A member of staff said team meetings were monthly. They said at the meetings they were able to make suggestions which were acted upon.

Questionnaires were completed by visitors and by agency staff. The agency staff that completed the questionnaires stated there were detailed handovers and the medication systems were "good."

A member of staff said there was good support from senior managers within the organisation. They said "I am privileged to work in this home". Another member of staff said "we are supportive towards each other and we help each other".

Staff valued the people they cared for. A member of staff said "people are looked after, everything centres around them. They said "empowerment and letting people make mistakes" was a value of the organisation. Another member of staff said the OLPA organisation was based on "freedom of choice and what is in their [people] best interest".

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Support plans were not person centred. Support plans were not updated to include the advice from healthcare professionals.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's capacity to make specific decisions was not assessed. Staff gained consent from relatives without legal powers to make care and treatment decisions. The legal framework for depriving people of their liberty was not in place. This included the use of bed rails and covert medicines.