The Regard Partnership Limited

The Regard Partnership Limited - Church Road

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Inadequate
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

The inspection took place on 11 December 2014. The Regard Partnership Limited - Church Road is a care home that provides accommodation and personal care and support for up to six people who may have mental health needs. There were five people who lived in the service when we visited.

At this inspection we found the service had not taken proper steps to ensure that each person was protected against the risks of receiving unsafe or inappropriate care. There were insufficient members of staff available to meet people's care needs and staff were not appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to people safely. The service also did not assess and monitor the quality of service provision adequately.

Summary of findings

People's safety was being compromised and they were at risk of harm because on going care was not being assessed and delivered which met their changing needs. Assessments of risk to people had been developed but were not up to date. Staff had not completed essential paperwork.

Staff did not have the knowledge and skills they needed to carry out their role and responsibilities effectively. They did not recognise poor practice which might put people at risk of injury, for example when supporting people to move and transfer with a hoist. People were provided with sufficient quantities to eat and drink however meals were delayed at times due to a lack of staff available to help people who needed assistance.

People were not actively encouraged consistently to take part in activities that interested them and to maintain contacts with the local community due to staff constraints. Care records we viewed did not show that wherever possible people were offered a variety of meaningful chosen social activities and interests and hobbies.

Systems were not fully in place to gain the views of people, their relatives and health or social care professionals. The provider had quality assurance systems in place to identify areas for improvement, however appropriate action to address any identified concerns had not always been taken. Audits, completed by the provider and registered manager and subsequent actions had not all resulted in improvements and development of the service.

Staff interacted with people in a caring, respectful and professional manner. Where people were not always able to express their needs verbally we saw that staff responded well. Where people were not always able to express their needs verbally we saw that staff responded to people's non-verbal requests and had a good understanding of people's individual care and support needs.

The home had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run.

The provider had a robust recruitment process in place. Records we looked at confirmed that staff were only employed within the home after all safety checks had been satisfactorily completed.

CQC is required by law to monitor the operation of the Mental Capacity Act, 2005 Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions for themselves and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. Staff had followed guidance and were knowledgeable about submitting applications to the appropriate agencies. The service was meeting the requirements of the DoLS.

There were systems in place to manage concerns and complaints. No formal complaints had been received in the last year. Informal concerns received from people had been recorded and included the action taken in response. People understood how to make a complaint and were confident that actions would be taken to address their concerns.

You can see what action we told the provider to take at the back of the full version of the report summary.

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 safe.

There were insufficient numbers of staff available to meet people's needs and to keep people safe.

Care records had not been updated to reflect people's health needs.

Staff knew how to recognise and report concerns of abuse. There were processes in place to listen to and address people's concerns.

Recruitment practices at the service were safe.

People had their prescribed medicines administered safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The provider did not fully ensure that people's needs were met by staff with the right skills and knowledge. Staff had not got up to date training, supervision and opportunities for professional development.

People were cared for by staff who knew them well. People had their nutritional needs met.

Staff had a good knowledge of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards and how this applied to people in the home.

Is the service caring?

Good

The service was caring.

Staff had a caring and supportive approach to the care they provided for people.

People told us that staff respected their privacy and dignity and supported them to be involved in making decisions about their care.

People were positive about the care they received. People told us staff treated them with respect and we observed caring interactions between staff and people who used the service.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had personalised care plans in place but these had not been regularly reviewed and updated.

People were not supported to make choices about how they spend their time and pursued their interests.

Summary of findings

Appropriate systems were in place to manage complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The leadership of the service did not always recognise poor practice or acknowledge where improvements were needed.

People were not always formally asked for their views.

The service did not have an effective quality assurance system. The quality and safety of the service provided was not being adequately monitored or reviewed fully.

The Regard Partnership Limited - Church Road

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.

We visited the home on 11 December 2014. Our visit was unannounced and the inspection team consisted of one inspector.

Before our inspection we reviewed the information we held about the service, which included the Provider Information Return (PIR). This is a form in which we ask the provider to give us some key information about the service, what the service does well and any improvements they plan to make. We also reviewed other information we held about the service including safeguarding alerts and statutory notifications which related to the service. Statutory notifications include information about important events which the provider is required to send us by law.

On the day of our inspection to the home we focused on speaking with people who lived in the home and their visitors, speaking with staff and observing how people were cared for. A few people had complex needs and were not able, or chose not to talk to us. We used observation as our main tool to gather evidence of people's experiences of the service. We spent time observing care in communal areas and used the Short Observational Framework for Inspectors (SOFI). This is a specific way of observing care to help us understand the experiences of people who were unable to talk with us, due to their complex health needs.

During our inspection we spoke with three people who lived in the home, two support workers, one visiting healthcare professional and the registered manager.

We looked at two people's care records, two staff recruitment records, medication charts, staffing rotas and records which related to how the service monitored staffing levels, complaints and the quality of the service.

Inadequate

Is the service safe?

Our findings

Some people told us they felt safe. One person told us, "I feel safe here, staff are good and kind." However, some people told us there were insufficient numbers of staff available to support them with their needs at all times.

On the day of our inspection there was only one member of staff on duty to provide care for four people. Two of these people required the assistance of two staff members. The manager was also on duty, but at the time of our arrival, was supporting one other person to attend a healthcare appointment. This meant that the staff member left supporting the four people at the service at the time, would not be able to respond to people's needs if they required more than one staff member's support. The manager was also included in the staff numbers and was therefore unable to fulfil any management tasks.

Staff told us that it was extremely difficult to provide assistance in a timely manner due to a lack of staff which they told us had been on going for some months. For example, we saw one person who had been recently assessed by the Physiotherapist because they were at risk of falls, required two staff members to mobilise. The person sat in the lounge for over two hours with no help or engagement offered at all. We noted on one occasion this person held up their hand for help but this was not seen by staff. The care plan also detailed that the help of two people was required when mobilising and that they also required regular pressure area relief and help with personal hygiene needs.

Additionally, another person who was visited by the District Nurse, had had an assessment completed which identified that they required two people to operate the hoist they used. This was also detailed in the moving and handling assessment that had been compiled for this person. Only one member of staff was available to manage this task with the assistance of the visiting healthcare professional. They then assisted the healthcare professional for a further 45 minutes behind a closed bedroom door and out of sight of all the other people in the lounge. There were no staff present and no call bells visible or accessible to people in the lounge to call for staff assistance.

A third person then called out for assistance from the lounge area. No staff were available to assist as the manager was out with another person. This person waited over one hour for assistance and as a direct result of insufficient staffing numbers, staff were not able to meet people's needs or keep them safe.

Two people required assistance to eat their lunchtime meal. The lunch time meal was still in progress at 14:40pm and we were told this was because of the staffing levels being insufficient. We were told that lunch should be served earlier but one person may have to wait for their meal if not enough staff were available to assist. Following a discussion with the manager, they called in the afternoon staff member two hours early as it was clear staff were unable to meet people's needs in a timely manner.

The provider was unable to demonstrate how staffing levels were reviewed to ensure there were sufficient staff available. Staffing numbers had been calculated according to the number of people using the service rather than against individual needs which varied.

Staff told us, "It's horrendous we have to make meals and complete personal care, do the laundry and housework, there is just not enough time to do our jobs and give care as we would wish." Our observations showed that people received their care in a task led way, for example staff had specific chores to attend to throughout the morning such as putting laundry away and cooking meals. This meant that staff were not always able to meet people's needs when required.

Following our inspection we contacted the provider who was unaware of the situation and instigated an immediate investigation and increase in the staffing numbers. We did this because the manager told us they had requested support and this had been denied. Had we not engaged with the provider we were concerned staffing levels would have remained at a level where people's basic needs were not being met and they were not being cared for safely.

We identified that the service was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people were unable to tell us about their experiences of the care they received so we observed how staff supported them. A small proportion of people had mobility issues which required the use of manual handling equipment to support them. Concerns had been raised by

Inadequate

Is the service safe?

a visiting professional about the inappropriate use of moving and handling equipment. Manual handling risk assessments had not been completed in all cases. They did not identify the model of hoist and type of sling to be used. People's care records did not accurately reflect the risks associated with people's care because they had not been fully maintained or updated. The manager confirmed these were currently under review but were noted to be some months out of date in one case.

We observed one person sitting on their sling in their wheelchair. None of the risk assessments we saw identified if the sling in use was safe to remain in place when the person was seated. The risk of this causing or contributing to developing pressure area breakdown had also not been considered. One person waited for over two hours to be moved from their chair to relieve their pressure areas and had previously received care from the District Nurse for a pressure sore and there was no current moving and handling risk assessment in place. This did not ensure staff had guidance to ensure the person was kept safe, and put them at risk of injury as the guidance provided to staff did not accurately reflect their needs. This placed people at risk of receiving care that was unsafe or inappropriate to meet their needs.

We identified that this was in breach of regulation 9 (1) (a) and (b) (i) (ii) (iii) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 (1) (a) and (b), (2), (3) (a-i), (4), (5) and (6) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All staff had received training in the safeguarding of adults from abuse. Staff knew how to recognise signs of harm and knew who to report any concerns to. One staff member told us, "I am ok with the reporting of any concerns or suspected abuse." The provider had up to date policies which included safeguarding adults and whistleblowing. Staff were able to demonstrate their awareness of the whistleblowing policy and who to report their concerns to.

The provider had a safe system in place for the recruitment and selection of staff. This ensured that staff recruited had the right skills and experience to work at the service. Staff told us that they had been offered employment once all the relevant checks had been completed. This meant that people could be confident that they were cared for by staff who were safe to work with people who lived in the service.

Medication was stored securely. Records were maintained of medicines received into the home and disposed of, as well as medicines administered to people. This demonstrated that people had received their medicines as prescribed. We observed medication being given to people at the lunch time meal, and although this only applied to one person this was done with due care and safely. Staff had received up to date medication training and had completed competency assessments to evidence they had the skills needed to administer medicines safely.

Requires Improvement

Is the service effective?

Our findings

The provider was not supporting staff by ensuring they received regular supervision, training and development to enable them to deliver care and treatment to people safely and to an appropriate standard.

The Providers Information Return (PIR) stated that the manager of the service recognised that the provision of supervision and appraisal had not been delivered in a timely and appropriate manner..

The manager confirmed that due to time constraints supervisions and appraisals for staff had lapsed. One staff member told us, “We have not had any supervisions recently as there is just not time with the staffing as it is.” Staff also did not attend any group supervision sessions such as team meetings.

One staff member told us, “We received e learning as training and I don’t think that is adequate. I prefer to learn in a classroom setting and can’t learn properly this way.” Another staff member said, “We complete e learning in our own time sometimes and I don’t always take it in. All our training is e learning nothing else.” They also went on to say that they felt moving and handling training would be better taught in a classroom and practical setting. Not considering staff’s concerns about how they experienced the training provided, and the lack of practical training meant that staff were not confident in their duties and placed people’s wellbeing at risk.

We observed a member of staff operate a hoist on their own when the care plan for this person stated that they should be supported by two staff for their safety. Staff told us they had not completed any practical moving and handling courses and only completed a theory course online. The staff member did not follow a safe process when supporting this person because they had not received the appropriate practical training to do so. The manager told us that external moving and handling courses were not usually held. This placed the person’s safety at risk. We also noted that other specialist training courses had lapsed and the manager told us a review of all staff training was required. Staff had not been provided with updated training that gave them the skills, knowledge and qualifications to ensure people’s needs were being met. As a result the staff could not demonstrate a consistent approach to support people.

We identified that the service was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because staff were not receiving adequate support and training to deliver their duties safely.

People and their relatives told us the staff met their individual needs and that they were happy with the care provided. A full assessment was carried out before a person moved into the service. This included working with the individual to identify their needs and wishes and speaking to all professionals and relatives (were appropriate), involved in their support. This enabled the service to gain a full understanding of the support that a person would need. Person centred support plans were then developed with each person which involved consultation with all interested parties who were acting in the individual's best interest.

We looked to see how the Deprivation of Liberty Safeguards (DoLS) were applied in the service. 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. Documentation in people’s care plans showed that where people’s liberty was being restricted to protect them from harm or the risk of harm, appropriate requests had been made and authorised by the local authority, to ensure that this was done in accordance with the law.

We saw from individual care plans that people were involved in making decisions where they were able. Where people did not have the mental capacity to consent to care and treatment an assessment had been carried out and we saw that relatives had been involved in making decisions. We also noted that health and social care professionals and staff were involved in making decisions in the best interests of the person and this had been recorded in care plans.

People had enough to eat and drink and were supported with their nutritional needs. Staff told us that people all made their own choices when eating. And although the lunch time meal took a long time due to staff constraints and people had to wait for support in some instances, people were engaged and enjoyed the experience.

Requires Improvement

Is the service effective?

People's care records showed that their day to day health needs were being met and that they had access to healthcare professionals according to their specific needs.

The service had regular contact with GP support and healthcare professionals that provided support and assisted the staff in the maintenance of people's healthcare.

Good

Is the service caring?

Our findings

People were supported by caring staff. One person told us, “They do look after us. Yes.” Relatives told us they were happy with the care and support received at the service. Relative’s comments included, “I think they look after the people in the service.” And, “The staff all seem very nice they know what my relative needs I have no concerns really.”

Care plans were available for people who could become anxious and/or distressed. These provided guidance to staff so that they managed the situation in caring and positive way.

Staff demonstrated their understanding of what privacy and dignity meant in relation to supporting people with their personal care. For example, we saw that personal care was provided for people in their own rooms with doors shut and when people were taken to the restroom staff spoke in a low tone which ensured other people could not overhear the conversation. Staff described how they supported people to maintain their dignity and how they respected people’s wishes in how they spent their day. Although we saw little engagement with people, when we did, we saw and heard staff interact with people in a caring and respectful way. Staff addressed people by their preferred names, and chatted at times with them about everyday things. They also discussed on one occasion the entertainment taking place that morning, a visiting singer. This showed that staff knew what was important to the person. One staff member told us, “I would love to spend longer talking to them but we just do not have the time. It is hard as some of the people here love just having that one to one moment.”

Positive caring relationships had developed between people and staff. One person who could communicate with us a little, told us they knew who their keyworker was and how they supported them. Staff we spoke with were aware of people’s life histories and were knowledgeable about their likes and dislikes and the type of activities they enjoyed.

Staff sat with people when they spoke with them and involved in them in things they were doing.

During the lunchtime meal staff sat next to people and actively engaged them in conversations. One person looked up and smiled and then just said, “Good yes, family yes.”.

People were supported to maintain relationships with others. The manager told us that where some people did not have family or friends to support them, arrangements had been made for them to receive support from an advocate. Advocates are people who are independent of the service and who support people to have a voice and to make and communicate their wishes.

Requires Improvement

Is the service responsive?

Our findings

People told us there were not enough meaningful group or individual activities provided and they were not always fully supported to access the local community. Staff told us that they did not have enough time to take people out as the present staffing levels could not accommodate everyone. One staff member said, "We just don't have enough time with everything else we are expected to do. I would like to just sit down and chat with the people here but we can't."

One person told us, "I want to go out more." Another person told us, "I like to go shopping." Relatives told us that they felt that there could be an increase in things people could do, and that outings did not take place very often. It was also noted that two people would have needed two people to assist them when going out and this could not have happened with the staffing levels as they were.

On the day of our inspection there was a singer in attendance singing Christmas songs. The manager told us that this was an on going arrangement and that she alternated each fortnight with a drama lady as the only external entertainment in the service. We saw that people all sat listening but did not join in and they were not activity involved. Staff were also not engaging with people to ensure they enjoyed the activity. This meant that although there were some organised activities it lacked meaning in occupying people's time.

Care plans contained some information about people's life histories, social interests and preferences but this was not up to date and was not personal to them. Staff could not use this information to help people make choices. For example one person's care plan included comments on their activities and interests as 'I go out' and, 'Staff support me.' Additionally we did not see any scheduled activities or arrangements in place to support people's hobbies and interests. One person told us, when asked what they had planned for the day, "I don't know."

On the day of our inspection we saw that most people just sat for long periods in the lounge without any form of engagement or activity to occupy their time or add meaning to their daily lives. This showed that activities had not been planned and delivered in a way that met people's individual welfare needs.

We asked the manager how they routinely listen and learn from people's experiences, concerns and complaints. They told us they had not had time to carry out regular residents and relatives meetings. Additionally staff told us they had not had any team meetings in the last year.

This is also in breach of regulation 9 (1) (a) and (b) (i) (ii) (iii) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 (1) (a) and (b), (2), (3) (a-i), (4), (5) and (6) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Suitable arrangements were in place to ensure that people and their relatives were able to raise complaints or issues of concern and provide feedback about their experiences. These included a complaints policy and procedure. Information about how to raise concerns and provide feedback was displayed in key areas and in a large print/ pictorial format for everyone who lived at the service. No complaints had been received in the last twelve months. Records of complaints received previously showed that they were acted upon promptly and were used to improve the service. Staff were aware of the actions that they should take if anyone wanted to make a complaint.

Requires Improvement

Is the service well-led?

Our findings

People told us the manager was approachable and fair. One staff member told us, "I think they are under pressure and not supported as well as they could be from above." One relative told us, "I think the manager is pleasant however my personal view is that they could be stronger. Maybe they should have more support? The job is hard I know and I am not saying they aren't good at their job."

There was a registered manager in post at the time of our inspection. The manager understood their role and responsibilities however could not fulfil their role appropriately. From our discussions with them it was clear that they were familiar with the people who used the service. However, they were not always available in the service. We also noted that they were included in the staffing numbers at least three times a week to perform caring duties. The manager told us they did not have time to complete their management tasks fully because of the way their hours were rostered. The management team acted in a reactive way, and had not been proactive in it's assessment of people's needs, for example staffing levels and how this impacted on people's care. The manager was not being supported by their manager at regional level, despite alerting them to these issues. This meant the service did not run smoothly. We raised our concerns regarding staffing levels with the provider and we received an immediate and positive response.

The manager told us that assessment of staffing levels were set by the provider based on budgetary requirements for each service and they had to adhere to that. They were unable to demonstrate to us how they had responded to people's feedback and assessed staff needed to support people based on their dependency needs. This meant that they did not have an effective system in place to monitor and manage the on going staffing levels within the service to meet people's needs safely.

We looked at the quality assurance systems in place and saw that regular audits had been completed. However despite there being action plans to show if concerns had been identified, these had not been responded to effectively. For example, the last audits completed in July 2014 and October 2014 identified some actions needed regarding the environment, moving and handling and staffing issues. These were incomplete and yet to be addressed. This meant that although the regional management and manager were aware of issues which needed addressing and systems were in place to assess the quality of service provided. Where these issues were identified; they were not always clearly reviewed and actioned to continually improve the service people received.

Although the manager told us that meetings took place with staff and relatives, there were no minutes of these meetings held which showed how staff and people were encouraged to feedback about the quality of the service and to share ideas and suggestions for improvements. Responses and analysis from the last annual satisfaction completed in October 2014 was not available. This meant that the manager was unable to evidence how these surveys had given people the opportunity to comment on the way the service was run and how the manager responded to this feedback to improve the service for people. However, relatives told us they had expressed their views about the service through one to one feedback directly and through individual reviews of their relative's care when applicable. This showed us that people's views and experiences were not consistently taken into account and acted upon.

There was no system in place to provide staff with support and training and to monitor their performance and provide them with the opportunity to develop their knowledge and skills. This lack of system and support meant that people were at risk of receiving inappropriate or unsafe care.

Systems were in place to manage and report accidents and incidents. Staff understood how to report accidents, incidents and any safeguarding concerns. The service had notified us of any incidents that they were required by law to tell us about, such as the death of people and accidents and injuries. However, we were unable to see, from people's records, that actions had been taken to learn from these incidents. For example, when accidents had occurred they had not reviewed risk assessments to reduce the risks of these happening again and make sure that people were safe.

We identified that this was in breach of regulation 10 (1) (a) and (b), (2) (a) to (e) and (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 (1), (2) (a-f), (3) and (4) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

The manager and staff told us that they all worked together as a team and that their work involved supporting people to be as independent as possible and respecting people's choices about how they spend their day.

Discussions with staff and the manager demonstrated that although they understood the service's aims and objectives, shortfalls in the service were not actively identified at all times. Although some processes were in place the service had not been monitored sufficiently to ensure that people were provided with safe, caring, effective and responsive care and were supported in a service that was well-led.

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 18 HSCA (RA) Regulations 2014 Staffing **We found that the registered person had not protected people against the risk of insufficient staffing levels. This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 – Staffing How the regulation was not being met : The registered person did not ensure there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed in order to meet the provision of the regulated activity. Regulation 18 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **We found that the registered person had not protected people against the risk of inappropriate care and treatment that met people's needs and preferences. This was in breach of regulation 9 (1) (a) and (b) (i) (ii) (iii) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 (1) (a) and (b), (2), (3) (a-i), (4), (5) and (6) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014 - Person Centred Care How the regulation was not being met:

This section is primarily information for the provider

Action we have told the provider to take

The registered person did not take proper steps to ensure that the care and treatment of each person was appropriate, met their needs and reflected their preferences.

Regulation 9 (1) (a) and (b), (2), (3) (a-i), (4), (5) and (6)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **We found that the registered person had not ensured that staff were appropriately supported, supervised, appraised and trained in relation to their professional development and duties they were employed to perform. This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 – Staffing How the regulation was not being met: The registered person did not ensure that staff were appropriately supported, supervised, appraised and trained in relation to their professional development and duties they were employed to perform. Regulation 18 (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **We found that the registered person had not ensured systems and processes were established and operated effectively to ensure compliance. This was in breach of regulation 10 (1) (a) and (b), (2) (a) to (e) and (3) of the Health and Social Care Act 2008**

This section is primarily information for the provider

Action we have told the provider to take

(Regulated Activities) Regulations 2010, which corresponds to regulation 17 (1), (2) (a-f), (3) and (4) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 - Good Governance

How the regulation was not being met:

The registered person did not ensure systems and processes were established and operated effectively to ensure compliance, and in order to meet the provision of the regulated activity.

Regulation 17 (1), (2) (a-f), (3) and (4) (a) and (b**)**