Partnerships in Care Limited

Shottsford House

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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 27 June 2017 and was unannounced. The inspection continued on 29 June 2017 and 4 July.

Shottsford House is registered to provide personal care with accommodation for up to 10 adults. At the time of the inspection four people were living at the service. There were two units on the ground floor with five ensuite bedrooms in each. There was a communal lounge and dining room. Shottsford House supported people with learning disabilities, autism and personality disorder.

The service had a Registered Manager in place. 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.

Staff did not consider that there were sufficient staff to support people safely should more than one person require support to manage their behaviour. Staffing levels were assessed as part of people's pre-admission assessments. The service had a number of vacancies which the provider was actively trying to fill. The registered manager told us that they used agency staff to cover vacant shifts and tried to block book staff to ensure consistency, however this had not always been possible. On occasion agency staff had not reported for duty.

We recommend that the provider reviews their processes for assessing and monitoring staffing levels at Shottsford House.

On day one of the inspection we found that three fire doors in Shottsford House had been broken and removed following an incident involving a person who lived at the service. We were told that this had happened approximately six months ago. This had put people, staff and the service at an increased risk harm during this period of time. We reported this to the fire officer at Dorset and Wiltshire Fire and Rescue who told us they would arrange for a fire audit to take place.

Information was not always provided in an accessible way to enable people to be involved about decisions about their care. Agreements had been signed in relation to restricted areas of the home. Two people told us that they preferred information to be bullet pointed short, simple sentences. They said that sometimes pictures help. The agreements were written in long sentenced paragraphs with no bullet points or pictures to aid understanding. The registered manager told us that these agreements had been put in place in the short term following findings of a recent provider audit and that the restricted areas were under review.

People told us that they did not have the choice to eat meals in other areas of the service and staff confirmed this. We noted that one person shouted a lot and required staff support. People told us that this disturbed their meal time experience. One person told us that they were sensitive to noise and that the

shouting made them anxious.

People's privacy and dignity was not always respected by staff. People were often interrupted by staff when they met with CQC and other health and social care professionals. We noted that people had holes in their bedroom doors which allowed observation of them from outside the room and that hourly observations took place.

Shottsford House did not always provide personalised care and support which was responsive to people's needs. We found that people who were working towards living in their own flats in the community did not have plans to support them become more independent.

Individual assessments had not been completed to ensure that the environment met everyone's needs. We found that everyone had restricted access to the kitchen, laundry, exiting the home and to one door to the lounge. We were told that people could have a drink or food but would need to find staff and ask them for access into the kitchen.

People were not actively involved in the reviewing of the care and support. Staff and people told us that feedback was not sought prior to multi-agency review meetings. Professionals, relatives and people told us that there were often communication breakdowns at the service which meant that peoples changing needs were not always responded to efficiently.

People were not regularly supported to access meaningful occupational activities either inside or outside of Shottsford House. People attended community meetings with staff where topics were discussed. However, people were not always listened to nor did the service actively learn from people's experiences.

Shottsford House was not always well led. Staff and professionals feedback demonstrated a mixed understanding of the services purpose. The registered manager told us that the services Statement of Purpose was due for review.

Staff told us that the registered manager was not always visible and that their office location took them away from what was happening in the service. Communication was not always effective between the management and staff. Quality monitoring systems did not capture people's experiences and quality questionnaires had not been submitted to people or stakeholders.

Medicines were managed safely, was securely stored, correctly recorded and only administered by staff that were trained to give medicines. Medicine Administration Records reviewed showed no gaps. This told us that people were receiving their medicines.

Staff were aware of risks people presented to themselves and others. Risk assessments formed part of peoples care and support plans.

Staff had a good knowledge of people's support needs and received regular mandatory training as well as training specific to their roles for example, personality disorder, intervention and learning disabilities.

Staff told us they received supervisions which were carried out by management. We reviewed records which confirmed this.

People were supported with shopping, cooking and preparation of meals in their home. The training record showed that staff had received food hygiene training.

People were supported to access healthcare appointments as and when required and staff followed health professional's advice when supporting people with ongoing care needs.

People told us that some staff were caring. During the inspection we observed some positive interactions between staff and people.

There was an active system in place for recording complaints which captured the detail and evidenced steps taken to address them.

Some staff and people told us that they found the registered manager to be good. One person said, "The registered manager is really sweet and caring. They seem to genuinely care about us all and want's what is best for us".

The service understood its reporting responsibilities to CQC and other regulatory bodies and provided information in a timely way.

We found a number of 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 not always safe. Staff did not consider that there were sufficient staff to support people safely should more than one person require support to manage their behaviour.

Three fire doors had been missing for approximately six months prior to our inspection. This had put people, staff and the service at an increased risk of harm.

Risk assessments formed part of peoples care plans.

Staff had completed safeguarding adults training and were able to tell us how they would recognise and report abuse. However, people had not seen the providers easy read safeguarding policy.

People were at a reduced risk of harm because medicines were managed safely, securely stored, correctly recorded and only administered by staff that were trained to give medicines

Is the service effective?

Requires Improvement

The service was not effective.

Information was not always provided in an accessible way to enable people to be involved about decisions about their care.

People did not have the choice to eat meals in other areas of the service. This disturbed some people's meal time experiences.

Contracted staff received training, supervision and appraisals to give them the skills and support to carry out their roles.

People were mostly supported to maintain healthy balanced diets however people could not independently access food or water without asking staff.

People were supported to access health care services and local learning disability teams.

Is the service caring?

Requires Improvement

The service was not always caring. People were supported by

staff who did not always respect their choices, privacy or dignity.

People were supported by staff that did not always use person centred approaches to deliver the care and support they provided.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care planning, reviews, and assessments were not always completed with people and relatives. Information was not always made available in ways that people understood.

People did not have clear independence goals and outcomes set with them with a view to move into the community.

People didn't always have timetables in place or supported to access the community and take part in activities which were linked with their own interests and hobbies.

A complaints procedure was in place which included an accessible easy read version. However, people had not seen the easy read version.

Community meetings took place however, the service did not always learn from people's experiences.

Is the service well-led?

Requires Improvement

The service was not always well led. The registered manager did not always promote or encourage an open working environment.

The service did not have a clear up to date Statement of Purpose in place.

Good leadership and management was not always demonstrated. There were communication breakdowns between the management, staff and stakeholders.

Local quality monitoring systems were not robust.

Shottsford House

Detailed findings

Background to this inspection

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

This inspection took place on 27 June 2017 and was unannounced. The inspection continued on 29 June 2017 and was announced. We visited the service again unannounced on the 4 July 2017. The inspection was carried out by two inspectors on day one and a single inspector on day two and three.

Before the inspection we reviewed all the information we held about the service. This included notifications the provider had sent us. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive.

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 spoke with three people who use the service and one relative. We spoke with the Registered Manager and charge nurse. We met with four staff and two agency staff. We reviewed two people's care files and looked at other documents and records that related to the running of the service such as policies, medication records, risk assessments, health and safety records and management audits.

We walked around the building and observed care practice and interaction between care staff and people who live there. We looked at incident and accident reporting, four staff files, the recruitment process and at staff and people's meeting notes.

Requires Improvement

Is the service safe?

Our findings

Staffing levels were assessed as part of people's pre-admission assessments. The service had a number of vacancies which the provider was actively trying to fill. The registered manager told us that they used agency staff to cover vacant shifts and tried to block book staff to ensure consistency, however this had not always been possible. On occasions agency staff had not reported for duty. A person told us, "There aren't really enough staff. They use agency but some don't turn up".

Staff did not consider that there were sufficient staff to support people safely should more than one person require support to manage their behaviour. Comments included, "I don't feel the staffing levels reflect the needs of the people. We have to be prepared for managing people's behaviour" and "If more than two people reached crisis point people may be at risk of harm as we would have to separate them but would not have enough staff to do this safely".

We recommend that the provider reviews their processes for assessing and monitoring staffing levels at Shottsford House.

On day one of the inspection we found that three fire doors in Shottsford House had been broken and removed following an incident involving a person who lived at the service. We were told that this had happened approximately six months ago. This had put people, staff and the service at an increased risk harm during this period of time. The registered manager told us that there had been a delay in getting new ones ordered due to suppliers and that these were booked to be fitted the following Monday. On day three of the inspection we saw that the fire doors had been replaced by taking fire doors off of other door frames in the unused area of the service. We reported this to the fire officer at Dorset and Wiltshire Fire and Rescue who told us they would arrange for a fire audit to take place. We noted that the provider had carried out an internal inspection at the home the week before we inspected the service. The fire doors had been identified as part of that inspection.

Fire checks took place regularly and evacuations had taken place. The maintenance person told us that the provider paperwork systems were being used effectively. We noted that during the last evacuation it was recorded that agency staff were uncertain of what to do in the event of a fire. Actions had been set to provide evacuation training. People had personal emergency evacuation plans (PEEPS) in place. These plans told people and staff what to do in the event of a fire.

Staff were aware of risks people presented to themselves and others. Risk assessments formed part of people's care plans. We found that one person was at risk of self harm. The plan gave staff some background information about this and listed measures in place to support them. For example, it told staff to monitor the person when using sharps, attend to any wound as prescribed and instructed by medical staff and for them to wear Personal Protective Equipment (PPE).

People were protected from avoidable harm. Staff were able to tell us how they would recognise signs of potential abuse and who they would report it to. Staff told us they had received safeguarding training. We

reviewed the training records which confirmed this. However, three people told us that they had not seen the provider easy read safeguarding procedure which we were given by the registered manager. One person told us, "This is useful, there is information on the notice board but I can't understand all the writing".

Recruitment was carried out safely. We reviewed four staff records, all of which had identification photos in them. Details about recruitment which included application forms, employment history, job offers and contracts were on file. There was a system which included evaluation through interviews and references from previous employment. This included checks from the Disclosure and Barring Service (DBS). The DBS checks people's criminal record history and their suitability to work with vulnerable people.

Medicines were stored and managed safely. Medicines were signed as given on the Medicine Administration Records (MAR) and were absent from there pharmacy packaging which indicated they had been given as prescribed. We reviewed two peoples MAR which were completed correctly and showed no gaps. Staff were required to complete medication training as well as undergo a competency test by management before administering medicines. There was a comprehensive up to date medicines policy in place which staff were aware of and told us they had read.

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 who were able told us they were involved in their care, attended regular reviews and had access to their records.

Some of the people receiving support from Shottsford House were living with a learning disability, emotional personality disorder and autism. This affected two people's ability to make some decisions about their care and support.

Information was not always provided in an accessible way to enable people to be involved in decisions about their care. Agreements had been signed in relation to restricted areas of the home. Two people told us that they preferred information to be bullet pointed short, simple sentences. They said that sometimes pictures help. The agreements were written in long sentenced paragraphs with no bullet points or pictures to aid understanding.

Where agreements had been signed there was no process to check people's understanding or continued agreement. One person told us, "We signed these agreements because we feel we have to not because we understand or agree with them". Another person said, "We have been told we can't access the kitchen on our own so we go along with it". Two people had been assessed as not having the capacity to understand why the restrictions were in place; however one of these people had signed the agreement. Two people had been assessed as having capacity to d consent to their care however, these people could not leave the service as and when they wished without asking staff to let them in and out because the main door was locked. The people told us this made them feel restricted. The registered manager told us that these agreements had been put in place in the short term following findings of a recent provider audit and that the restricted areas were under review.

People and staff ate together in the dining room. People told us that they did not have the choice to eat meals in other areas of the service and staff confirmed this. We noted that one person shouted a lot and required staff support. People told us that this disturbed their meal time experience. One person told us that they were sensitive to noise and that the shouting made them anxious. The registered manager said that they encouraged people to eat together but agreed to review this.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found that two people had urgent applications

completed and were pending further assessment by the local authority.

People were supported to maintain balanced diets. People told us they weren't often involved in menu planning. However, we noted that meals were discussed in community meetings with people on a weekly basis and observed people being supported by staff on different occasions to make meals in the kitchen. The registered manager told us that food was being delivered from a catering company in bulk however, they said that the service was about to change to weekly food shops with people which would give them more involvement in menu planning and food shopping. Staff told us that alternative food options were available to people on request.

We noted that people were unable to access food and water independently due to the restricted access to the kitchen. Staff told us that people could have access to these on request and people confirmed this. Following the inspection the registered manager informed us that water coolers had been purchased for people to use at the service.

People were supported by staff that were knowledgeable about their needs and had the skills to support them. Newly appointed staff undertook an induction, which followed the Skills for Care, Care Certificate framework. The Care Certificate is an identified set of standards used by the care industry to help ensure care workers provide compassionate, safe and high quality care and support. Following the induction staff shadowed more experienced staff and did not work alone until the management were confident they had the right skills to carry out their role.
The training record showed that staff had completed core training in areas such as first aid, food hygiene, medicines, safeguarding and mental health. Staff had also received training in areas such as intervention, personality disorder and learning disability. A health and social care professional told us, "Our team has delivered some personality disorder training".

We reviewed staff files which evidenced that supervisions and appraisals took place and were carried out by management. Staff said that they found supervisions very useful and confirmed that they took place. We saw that the registered manager had a supervision and appraisal table which identified dates of upcoming meetings and recorded the dates of previous ones.

People were supported to attend health services outside of the home as and when required. We found that visits were recorded and any actions advised by professionals were logged. We found that people had recently attended doctors and dentist appointments. A health and social care professional told us, "I always feel welcome. They always involve community teams and professionals".

Requires Improvement

Is the service caring?

Our findings

People's privacy, dignity and choice was not always promoted or respected at Shottsford House. A health professional told us, "I often meet with people in the quiet room and find staff pop in. This is disruptive and not respectful". During the inspection we met with three people in the lounge. People asked if they could close the door to speak to us which we agreed. Staff interrupted this meeting on four occasions despite peoples request to talk privately. One person told us, "This is so frustrating". Another person said, "I can't take it when staff are disrespectful and rude like all these interruptions and noise".

At 10.09 a staff member came into the lounge and told a person they had to have a shower and get ready. We heard the person say they were talking to CQC however, the staff member told them they need to get ready now. The person got up and left the room. A person said, "I really think it is unfair how staff tell (name) to do things". At 10.35am (name) came back from getting ready and said, "Now I have done that I can go to the shop". Another person said, "its bribery". We noted that this person was not supported to go out until 2.46pm. The three people all told us that they are told to get up at certain times each morning and were not unable to lie in at weekends. A staff member told us that they all need to be up for their medicines.

We noted that people had holes in their bedroom doors which allowed observation of them from outside the room. The registered manager said that these had covers meaning staff need an allen key to open them. We were told that this takes place mostly at night. We found that each person had hourly observation sheets in place but no individualised assessment giving specific reasons for these. People told us that they did not like the spy holes. They said they didn't like the thought of staff watching them. One person said, "When I'm in my room it's my time. I want to relax". We were told that not all staff knock on people's doors and wait for a response before entering the room. One person said, "Staff sometimes talk to us when we are on the toilet". Another person told us, "Yesterday a staff member asked to come in my room. I said no but they still came in". A person said, "We maybe naked. This is a breach of our personal space and dignity". We were told by another person that they had covered the spy hole in their bedroom door with blue tac before but was told to remove it by staff. Staff were not sure why observations took place on each person 24/7. The registered manager told us the hourly observations were agreed under the old set up. They went onto say that these were going to be reviewed.

A staff member said, "It takes time for staff and agency to get to know people. Especially (name). People told us that some staff were caring whilst others weren't. During the inspection we observed on several occasions people being told by some staff to go and sit down, listen to music or watch TV rather than them positively engaging with people.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

We observed some positive caring practices between staff and people during the inspection. For example one person was feeling anxious and a staff member took time to reassure them by speaking calmly using a soft tone. Staff, relatives and health and social care professionals told us that staff were caring. A staff

member said, "We are a caring team. We work together and help each other and people". A health and social care professional told us, "Staff are caring. I've seen some good practice. I have observed soft polite staff speaking with people". Another health and social care professional said, "From what I have observed staff appear caring". A relative said, "Staff are very caring, they do a great job".

Requires Improvement

Is the service responsive?

Our findings

Shottsford House did not always provide personalised care and support which was responsive to people's needs. We found that people who were working towards living in their own flats in the community did not have plans to support them become more independent. One person said, "They may tell you these are in place but we haven't seen them". A person told us, "I am on the housing list. I have no goals around learning particular life skills for community living". Another person said, "I have no set goals here but I did in my last placement". Another person told us, "We are more likely to achieve if we have clear plans and set goals to achieve".

Individual assessments had not been completed to ensure that the environment met everyone's needs. We found that everyone had restricted access to the kitchen, laundry, exiting the home and to one door to the lounge. We were told that people could have a drink or food but would need to find staff and ask them for access into the kitchen. Three people told us they felt they were safe in the kitchen. A health and social care professional told us, "(name) is safe in the kitchen".

People were not always involved in the reviewing of their care packages. We saw that weekly multi-disciplinary team (MDT) meetings took place with the registered manager, a psychiatrist and other professionals who were able to attend. We asked people if they attended these meetings. Two people said no and one person said, "I do go to some of my MDT meetings. I am vocal and am able to speak up if I want to attend but those who may be quiet or lack confidence don't get the opportunity". We noted that there was a box on the MDT form to log discussions with people however, these were not completed. Staff told us that they didn't actively seek people's feedback for these meetings. The registered manager told us that people's views and opinions would be logged in the MDT meeting if they wanted to contribute.

On day two of the inspection MDT meetings were taking place. We asked the people if they were going to attend their meetings. Two people weren't sure where they were held or what was discussed in these. A relative told us, "I get the feeling I am not wanted at MDT meetings. I am not invited". A health and social care professional said, "(name) often attends these meetings and I try and see others outside of the meeting". Staff could not show us where professional meetings with people were recorded. The registered manager told us that they did not record whether people had been given the opportunity to attend meetings nor if they had declined.

Professionals, relatives and people told us there were often communication breakdowns at Shottsford House. One health and social care professional said, "Actions that come from MDT meetings can take a long time to be actioned." They explained that actions that were set for one person had taken eight weeks to be implemented and that this had had a negative effect on the person. A family member explained that their loved ones weekly activity timetable had still not been completed. They told us, "I sent an email on 9 June which was then chased again by the occupational therapist on the 12 June. It was followed up again last week and is still not up. This is disappointing". A health and social care professional told us, "There are currently a number of communication breakdowns. We have submitted a lot of information about (name) bed and bath but have been asked again to send this through. There has also been a lot of information

provided about activities for another person". This meant that peoples changing needs were not always responded to efficiently.

People were not regularly supported to access meaningful occupational activities away from the home. We observed some people being supported into the local town with staff. These outings seemed to be for short periods of time as people soon returned back to Shottsford House with staff. One person said, "I have an activity planner which has like bedroom chores on it and other things like card making and scrap book. However, this planner has too much writing on it and it is not visual. The activities on there aren't what I enjoy doing now either. I can't make cards as there are no resources. Staff haven't picked up why I'm not following it. It needs reviewing but staff don't listen to what I want to do".

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

People attended community meetings with staff where topics were discussed. However, people were not always listened to nor did the service actively learn from people's experiences. People told us that they had tried moving the furniture around in the lounge to make it more homely but staff had moved it back. The TV was wall mounted in a fixed box surrounding it with a Perspex front. People told us they had to turn the TV up high to be able to hear it as the sound is muffled in the box. We were told that people had asked for the fixed box to be removed but were not told why this had not been agreed. A staff member told us, "The TV in the box is historic. People have asked to move it out but it's not been agreed. People changed the furniture around but night staff moved it back. (Name) was not happy about this and it caused unnecessary distress".

There was a system in place to capture complaints which logged steps taken to resolve these. On day three of our inspection a complaint was received and dealt with appropriately. We noted that the charge nurse took down the person's details, apologised and told them that they would pass this on to the registered manager once they returned from their annual leave.

Requires Improvement

Is the service well-led?

Our findings

Shottsford House was not always well led. Staff and professionals feedback demonstrated a mixed understanding of the services purpose. Some thought that it was a specialist service for people with personality disorders; others thought it was a specialist learning disability service whilst others said it was a step up or step down service between hospital and the community. We reviewed the services statement of purpose and noted it said that the service was for people with a learning disabilities who are working towards living independently in the community. The registered manager told us that the statement of purpose was due a review.

Management was not always visible or easily accessible. The registered manager had an office on the first floor which staff told us took them away from what was really happening on the floor. Some staff told us that the registered manager did not always acknowledge them when they said hello to them in passing. A health and social care professional said, "The registered manager is process led". Another health and social care professional told us, "The registered manager seems under pressure from a number of people. Staff are thin on the ground. They have recently been unavailable as they are here there and everywhere. The registered manager is not easily contactable". A relative told us, "My loved one has been here five weeks and I met the registered manager for the first time today. When (name) was admitted I wanted to make sure they were happy/ok but I found that it was me doing the chasing".

Some staff told us they found the registered manager good. One staff member said, "The registered manager is alright. When I have questions they are happy to answer them". A person told us, "The registered manager is really sweet and caring. They seem to genuinely care about us all and want's what is best for us". We were told by staff that the registered manager occasionally works on the floor if it's needed.

Communication was not always effective. The registered manager told us that the organisation had gone through a number of changes following the acquisition by another company and that they were still familiarising themselves with the changes. We found that some of these changes had been communicated to staff in team meetings however staff told us that because of staffing levels they were not always able to attend these meetings. A staff member told us that due to this some meetings were held downstairs in the dining room. Staff told us that these didn't work very well due to constant disruptions from people living in the service.

The registered manager told us that the week prior to our inspection the provider had completed an internal inspection which linked to the five key questions used by the CQC. The provider had identified a number of areas which linked to our concerns such as restrictions within the home and hourly observations. We found that some responsive actions had been taken following the provider inspection such as the replacement of fire doors.

We found quality monitoring systems covered areas such as medicines, health and safety and infection control. However, these did not capture people's experiences. We noted that under governance in the services statement of purpose it stated that "service user audits take place". However, we were told that

these did not take place at Shottsford House.

The provider told us that quality questionnaires were yet to be sent out to stakeholders and people and that this had been planned for October 2017 time.

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

The registered manager had notified the Care Quality Commission of significant events, which had occurred in line with their legal responsibilities. The management team and director were aware of their responsibilities under the Health and Social Care Act 2008, Duty of Candour, that is, their duty to be honest and open about any accident or incident that had caused, or placed a person at risk of harm.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People who were working towards living in their own flats in the community did not have plans to support them become more independent. Individual assessments had not been completed to ensure that the environment met everyone's needs. Peoples changing needs were not always responded to efficiently because of communication breakdowns. People were not always involved in the reviewing of their care packages. People were not regularly supported to access meaningful occupational activities away from the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's privacy and dignity was not always respected by staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Information was not always provided in an accessible way to enable people who used the

service to be involved about decisions about their care.

People who used the service did not have the choice to eat meals in other areas of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance There was not a clear up to date Statement of Purpose in place. Communication was not always effective and the management was not always visible or easily accessible. Quality monitoring systems did not capture people's experiences of the service.