

# The Orders Of St. John Care Trust

## OSJCT Wyatt 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?

Good



Is the service responsive?

Good



Is the service well-led?

Requires improvement



### Overall summary

This unannounced inspection took place on 13 and 14 October 2015.

Wyatt House provides nursing, residential, and respite care for up to 30 people living with dementia and some day care places. At the time of our inspection 30 people were living there. The home is purpose built over two floors. There is a small day centre which people from outside the home can access four days a week and join in with activities there.

There was no registered manager but the home manager had already applied to become registered with us. 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 were no legal breaches of legal requirements at the last inspection in July 2013.

Generally people were supported by sufficient staff but this was not the case at all times. Some people did not have access to a call bell when they needed assistance from staff. There was a shortage of activity staff when we visited, which the manager was aware of.

# Summary of findings

People had access to health and social care professionals but referrals were not always made quickly to relevant health services when people's needs changed. This required improvement.

Staff had not completed regular training updates to ensure they had sufficient knowledge to carry out their roles. Staff supervision had not been completed regularly to identify staff training needs. This required improvement.

People were kept safe by staff trained to recognise signs of potential abuse and they knew what to do to safeguard people. The CQC had not been notified of all safeguarding incidents and this required improvement. Some staff required an update to their safeguarding training. The people and relatives we spoke with felt the home was safe and the service provided was safe. They were complementary about the security of their surroundings. Relatives told us, "My wife is very settled here, I feel she is in good hands, I love it here", "I have been impressed by the staff and their care" and "I have only seen kindness".

People's medicines were managed safely and regular checks were made to monitor staff practice.

People were supported to have a well balanced diet that met their individual needs. Meal times were an important social time. Staff sometimes joined people at lunchtime and this encouraged people to eat and engaged them in conversation.

Staff knew people well and were concerned for their well being and responded to them in a caring way. Age appropriate language was used and people's preferred term of address which was recorded in their care plans. There was evidence of genuine friendships between

people and this was supported and encouraged by staff. A person told us, "I meet X and we have a chat and a laugh together". The activity organiser was passionate and enthusiastic and had prepared a varied and active activity plan.

Personalised care plans and input from the provider's specialist dementia nurse helped staff support people with the care they needed. People were monitored to prevent pressure ulcers and maintain their health and well being. The activity organiser had forged links with the community and people had enjoyed memory walks.

The service had been without a registered manager for nine months but staff told us the new manager was approachable and had some great ideas for improvements. Quality assurance procedures were used to improve the service for people but it was unclear when some actions identified had been completed. The monthly review visits recorded by the provider's area operations manager looked at various aspects of the service.

People were asked about their satisfaction with the service at six monthly reviews. Residents meeting were held to include people in developing and improving the service. Recently people had said they wanted to go out more often and have additional entertainment in the late afternoons. We saw people were entertained in the afternoons. Staff meetings were held and changes were completed and planned. Some systems had been audited to improve the service but not all.

We found three 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.

# 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?

This service was not consistently safe.

People's levels of care and support needs were not monitored to ensure there was sufficient staff at all times.

People were safeguarded as staff were trained to recognise abuse and to report any abuse.

People's medicines were generally given, managed safely and kept under review to ensure people were receiving appropriate medicines.

People were protected by thorough recruitment practices.

**Requires improvement**



### Is the service effective?

This service was not consistently effective.

People had access to healthcare professionals but omissions meant they were not always contacted quickly.

People's dietary requirements and food preferences had not been fully met for their well-being.

Staff training required updating and formal supervisions were not completed regularly.

**Requires improvement**



### Is the service caring?

The service was caring.

People were treated with compassion, dignity and respect.

Staff treated people as individuals and interacted with them positively.

People were supported and encouraged to be independent.

**Good**



### Is the service responsive?

The service was responsive.

People received the care and support they needed and were involved in decisions about their care when possible.

Staff knew people well and how they liked to be cared for.

People took part in many activities and went out in the community. Staff engaged with people individually.

Comments or complaints were listened to and responded to respectfully and changes made where required.

**Good**



# Summary of findings

## Is the service well-led?

The service was not consistently well led.

The quality checks completed were inconsistent and required clear action plans to ensure improvements were made.

The manager was accessible to staff and people and knew what the visions for the service were.

Regular resident and staff meetings enabled everyone to have their say about how the home was run.

**Requires improvement**



# OSJCT Wyatt 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 13 and 14 October 2015 and was unannounced. The inspection team consisted of one adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Prior to the inspection we looked at the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which

the service is required to send us by law. We received 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 used this information to assess how the service was performing and to ensure we addressed any potential areas of concern.

We spoke with the manager, deputy manager, one nurse staff, six care staff, the activities organiser, catering staff and an Admiral nurse. An Admiral nurse is a dementia care specialist nurse employed by the provider. We spoke with nine people who use the service and four relatives/friends. We looked at six care records, three recruitment records and maintenance records. We had a copy of the staff duty rosters, quality assurance information and an overview record of all staff training.

We contacted Gloucestershire County Council Quality Review Team, local GPs and a consultant psychiatrist. We asked them for some feedback about the service.

# Is the service safe?

## Our findings

People were supported by sufficient care staff to meet their needs during the day. There were 30 people accommodated when we visited. There was a small residential care unit on the lower ground floor where five people lived. They and a few people accommodated in the nursing unit joined in with activities in the day centre. The nursing unit on the ground floor accommodated 25 people. There were two nurses on duty every morning, a care leader and five care staff. There was one care staff member allocated to the residential unit. There was four night staff, which included a nurse, to cover two floors which may not be sufficient. The manager told us the monthly people's dependency level tool had not been used but they planned to use it. There was insufficient activity staff to organise activities and complete the required records. We have made a recommendation staffing levels are regularly assessed and monitored.

People were kept safe by staff trained to recognise signs of potential abuse and they knew what to do to safeguard people. Some staff required an update to their training. There were clear policies and procedures for safeguarding people which included 'whistle blowing'. Whistle blowing is a term used when staff report an allegation of abuse by another staff member. We looked at three safeguarding records where staff had taken appropriate action for example; people's behaviours had caused harm to others. Staff had contacted the local safeguarding team and recorded any injuries.

The people and relatives we spoke with felt the home was safe and the service provided was safe. They were complementary about the security of their surroundings. Relatives told us, "My wife is very settled here, I feel she is in good hands, I love it here", "I have been impressed by the staff and their care" and "I have only seen kindness".

The manager told us there was a nurse vacancy to fill, which had been covered by existing staff. The manager had been able to reduce the amount of agency staff used but for continuity the same agency staff were used. There were thorough recruitment procedures where checks to help make sure suitable staff were employed to care and support people had been completed. Nurse's registration

with the Nursing and Midwifery Council was checked. The provider employed specific staff to complete the safety checks for the three volunteers employed. All volunteers had checks to ensure they were suitable.

Medication administration records demonstrated people's medicines were being managed safely. There were policies and procedures in the safe handling and administration of medicines. One 'as required' medicine required a protocol from the GP for nurses to follow. Medicine audits were completed by the dispensing pharmacy and the provider to check the management of medicines. Nursing staff completed medicine training every two years and visual competency assessments for medicine management. People who required covert medicines had a mental capacity assessment and best interest record which included the GP, family and staff. The pharmacist had advised staff with regard to administration when medicines were given covertly.

Individual risks were identified and minimised to maintain people's freedom and independence. The care plans had clear risk assessments for people for example; falls, moving and handling, nutrition and skin integrity. The risks were reviewed monthly and any changes were noted and action taken to minimise risks and deterioration in health and wellbeing.

Some people who remained in their bedrooms were not able to reach or access call bells, nor was there a designated timely check system in place. This was a possible risk. One person told us they had missed breakfast and could not call. The manager told us people had capacity assessments recorded for the use of a call bell. All people had a call bell in the residential unit and only three in the nursing unit. The manager agreed to check people's capacity and personal choice to have access to a call bell.

Any accidents and incidents were recorded and included reflective practice and preventative measures. A recent example showed that the person who had fallen was referred to the nurse lead for falls and intervention. The action required had been completed. Accidents and incidents were audited monthly.

There was a contingency business plan for staff to follow and know what to do in the event of service interruption for example; adverse weather conditions, power failure and IT interruption. A local place of safety was recorded with relevant contact details.

## Is the service safe?

There were infection control procedures for staff to follow and they were trained to prevent cross infection. Staff used personal protective equipment and disposed of soiled linen appropriately. All areas were clean. One area had an offensive odour which was dealt with immediately.

**We recommend that staffing levels are regularly assessed and monitored using a recognised method to ensure there is flexibility to meet people's individual needs and keep them safe.**

# Is the service effective?

## Our findings

People had access to health and social care professionals but referrals were not always made quickly to relevant health services when people's needs changed. There were instances where records were incomplete or there was an omission. A person required a revised epilepsy protocol as staff had not responded appropriately when they had a prolonged seizure. A response from a healthcare professional was not recorded for advice and to review the person's health. Another person had shown behaviours that challenged staff and they had hit a person. There was no behaviour chart completed, as was usual, to record any possible triggers and to monitor the support the person may need from a mental healthcare professional.

### **This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

We contacted health and mental healthcare professionals about the service. They were positive about the care people received and had no concerns. They said the staff were attentive to people's needs. The care plans recorded visits by health and social care professionals and the advice and action required to support people's changing needs. For example people had been referred to the speech and language team when they required support with swallowing their food. Community mental health professionals had supported people living with dementia and staff usually maintained regular contact with them for advice.

Staff had not completed regular training updates to ensure they had sufficient knowledge to carry out their roles. The training information we had indicated that there were many staff that required an update to their training. For example in safeguarding, moving and handling and infection control. The new manager was aware of where staff need to update their knowledge and some of their training was already planned. A member of staff told us they wanted more dementia care training. The provider's specialist dementia Admiral nurse told us about the planned training and a workshop in November where staff will explore how their actions effect people and improving people quality of life. The workshops were planned as peer group supervision where staff can identify additional

training. Individual staff supervision had not been regularly completed since the previous manager left almost a year ago. Staff told us the training they had was good. Senior care staff had completed NVQ level 2 and 3.

### **This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

When people lacked mental capacity to make a decision staff recorded a 'best interest decision' in line with legislation. Many staff had completed Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) training. The MCA provides a legal framework for those acting on behalf of people who lack capacity to make their own decisions.

The manager had a good awareness and understanding of DoLS. There were 11 DoLS authorisations in place to protect people. DoLS provides a lawful way to deprive someone of their liberty in the least restrictive way, provided it is in their best interests or is necessary to keep them from harm. The 'Admiral' nurse who specialised in supporting people living with dementia told us how they checked the care plans to ensure people had the least restrictive care in their 'best interest'.

People were supported to have a balanced diet that met their individual needs. People living with dementia were engaged throughout the lunch time meal and enjoyed sitting and eating together. There was a lively interaction between people and a lot of laughter. Staff who worked a 'long' shift also joined residents at meal times, this encouraged participation and engagement. We observed meal times were an important sociable time. The main dining room was in the process of refurbishment. People had chosen the decorations and furnishings. Condiments were available and included painted ones where they looked full but only had a small amount in them. This avoided people adding too much unnecessarily. People had a linen napkin or a tabard to protect their clothes at meal times.

There were pictorial menus to support people in making a decision and staff offered additional visual clues by showing people alternative foods. People in the residential unit did not have sight of a menu or any alternative food choices. The manager was unaware of this and agreed to ensure this was rectified. Staff told us that people had snacks in between meals such as fruit, biscuits and cakes.

## Is the service effective?

The catering staff told us about snack plates that were provided after lunch and supper for people to choose healthy snacks. Special diets were provided to include diabetic, soft and fortified meals. Six people had their meals fortified with butter and milk as they were at risk of malnutrition. The staff had meals with people and they told us the food was “alright”. People told us they liked their meal. Staff were aware of the people at risk from choking and who needed a special diet.

Some people were supported to eat their meals and this was completed with dignity and engagement. Staff explained to people what the food was and encouraged them to eat at their own pace and in an appropriate manner. Some staff were still using the term ‘feeding’ and ‘to be fed’. This terminology lacked dignity and the preferred term is ‘assisted mealtimes’. This may be a lack of insight and the need for some staff to update their training.

A screening tool was used to assess people's risk from malnutrition. We saw some people had a food and fluid chart where there was a risk of malnutrition and their weight was monitored. Charts were correctly maintained to provide information for monitoring.

The environment was in the midst of refurbishment and the manager was introducing a more dementia friendly environment and meaningful walking paths. When completed this will greatly enhance the facilities. People had access to a secure garden area where some hand rails were provided. There were plans to improve the garden, most people needed support there as the garden was sloping. The refurbishment improvements had elements that supported purposeful activity such as tactile stations along corridors and strategically placed artefacts.

# Is the service caring?

## Our findings

Staff knew people well and were concerned for their wellbeing and responded to them in a caring way. People told us about the staff, “X is lovely, she is so kind” and “they are all so nice and friendly”. Staff engaged with people with kindness and care. Staff used age appropriate language and used peoples preferred term of address which was recorded in their care plans.

Communication was prompted via “memory life picture boxes” adjacent to each person’s bedroom. Staff knew people’s life stories well and used the information to engage with them. The staff told us they had completed privacy and dignity training. They described how they put this into practice, for example by making sure people were covered during personal care and communicating with people in their preferred way.

There was evidence of genuine friendships between people and this was supported and encouraged by staff. People told us, “I meet X and we have a chat and a laugh together”, “I like to chat and wait for X to meet me here” and “We are mates”. A relative told us, “Everyone is so friendly, I was worried that mum would be lonely, she isn’t”. People were seen to be relaxed with staff while eating their lunch with them.

The activity organiser was passionate and enthusiastic in her role and approach. She had prepared a varied and active activity plan. There was evidence of sessions being planned in advance to engage all participants and engage people with cognitive impairment. During our visit people enjoyed a very lively music session and people were engaged and involved. Volunteers assisted with activities.

The provider told us people were encouraged to personalise their rooms and maintain their independence and personal strengths. People’s room were well personalised and we observed them enjoying talking to the volunteers and joining in with entertainment.

Peoples preference for their care at the end of their life was recorded where they had chosen to tell staff. There were no restrictions on visiting for friends and relatives. Family and friends were encouraged to be involved in the home and we saw a lively interaction between visitors and people.

There was information posted on noticeboards to inform people, their relatives and friends about the home and local services. The manager intends to identify a dignity champion within the staff team and provide information for all to read to develop the subject. Development of people’s life stories and information ‘clouds’ with pictures for people to engage with was in progress.

# Is the service responsive?

## Our findings

Personalised care plans identified the support people needed from the staff. When we visited the providers Admiral dementia specialist nurse was reviewing care plans and identifying patterns of behaviour to ensure staff were supporting people correctly. Sometimes people's behaviour patterns were monitored hourly to assess where improvements could be made in their care and support. The specialist looked at the least restrictive practice that would be in people's 'best interest' and had requested training for staff from the mental health trust to support one person. Currently the Admiral nurse was training staff in distress reaction, changing how staff reacted to people's anxiety so they could engage with them effectively and reduce their anxiety. The nurse looked at how the environment could be changed to benefit people's mental health and where in the home they could be more relaxed.

There were plans to complete more formal observations of people to monitor how staff reacted and learn from this by sharing good practice. Staff completed some online dementia care training to update their knowledge. Some staff had completed a two day foundation dementia awareness training called 'Tomorrows another day' to improve their response to people living with dementia. Staff told us that people need more individual engagement on the main ground floor unit whereas the downstairs unit was less busy and they had time to sit and chat with people, do puzzles and some arts and crafts.

The provider told us about the daily monitoring of people's individual charts for example, position change and fluid and food charts. We found people's change position charts were completed as indicated 2-3 hourly and people were monitored when out of bed. Food charts were completed as required to monitor people at risk of malnutrition. People's body charts recorded where any skin tears or wounds were. Wound care was monitored and there were details of each dressing applied. The deputy manager had completed wound care training last year and managed the progress of wounds. There was a Resident of the Day to alert staff to complete a monthly care review with them. A six monthly care review was recorded.

Handover information between staff at the beginning of a shift made sure important information about people was shared and acted upon where necessary to monitor their progress. Nurses and care staff had their own handover

records to complete to monitor different aspects of people's care. For example care staff recorded when people required their position changed in bed and nurses recorded clinical support people required.

People and relatives were confident their voice was heard and they felt involved in their care. A relative told us, "I feel that I have been involved in X care, I ask questions all the time"

The activities organiser had provided and sourced excellent resources and had shown great innovation in developing activities to engage all residents. Evidence was seen of excellent "grab bags" which contained individual activities which enabled staff to be proactive and take these to people who were isolated by their condition or within their rooms.

The activity organiser said that activities were aimed to be in line with people's life history and the record "All about me" in their care plan. Unfortunately there were no records of the activities and records available were not current and did not evidence person centred planning. The lack of records meant the service was not able to measure the value or therapeutic improvement of the activities provided.

The activity organiser had forged excellent community links and community memory walks had proven very popular. When we visited a community volunteer was playing music to people, who were in their bedrooms, this engaged people who were restricted in their interaction. People told us about their activities, "I love the singing", "X and I love these sessions it takes us back to when we were courting", "He (the community volunteer) is so funny", "My favourite day, he is lovely". A relative told us, "Mum loves the activities, we wish there were more things for her to do" and "X loves joining in".

Two people were of different cultural heredity and there was insufficient opportunity to explore and embrace this by offering culturally sensitive activities or experience. The part time activity organiser needed additional support as they found it difficult to complete the records and provide people with the activities they needed. The manager was gradually introducing "dementia friendly" elements to the service environment to support meaningful lives and provide texture exploration and visual stimulation.

The home had recently had reflective heat covers applied to the windows to keep the environment cool this had

## Is the service responsive?

caused the home to be darker and had altered people's natural circadian rhythm. Some people were affected and were getting up later and going to bed late. This had become problematic so the manager had requested the walls to be painted a lighter shade to compensate

The provider told us that in the last 12 months there had been nine compliments mainly about the care and

attention provided by friendly and attentive staff. Relatives told us, "This [the home] is so good, I sleep happily knowing X is living here" and "We feel lucky that mum is here".

There had been five formal complaints all completed satisfactorily within the complaints procedures 28 days. The themes were people's property and housekeeping. Relatives felt that any concerns were dealt with promptly and satisfactorily. They told us, "We had a concern about laundry, this was resolved swiftly".

# Is the service well-led?

## Our findings

The manager had not notified the Care Quality Commission (CQC) about all safeguarding events as required by the regulations. A person had alleged they were hit by another person, this was recorded on the services system but CQC had not been informed. The manager knew about informing CQC about all safeguarding incidents.

### **This is a breach of Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents.**

The service had been without a registered manager since October 2014. The new manager had been in post since August 2015. A staff member told us it had been a difficult nine months without a manager but the new manager and the deputy manager were both approachable. The manager had recently been interviewed by CQC for the registered manager post. After the inspection the manager was notified of her success.

The provider told us there was an 'open door' policy to enable staff, people and visitors to talk to the manager. To facilitate this the manager had moved their office to a more accessible position near the entrance. The manager also shared information through meetings, memos and notice boards. Leadership was visible at all levels and staff communicated openly. There had been a long period without a manager and staff told us the new manager was approachable and was making positive changes. The manager was enthusiastic and had already made some improvements and planned others. They provided us with information about the planned wall art around the home. The main corridor circled the home and areas of interest were planned. For example, a beach, Hollywood stars, transport, music and sport themes. Some areas had already been started.

Quality assurance procedures were used to improve the service for people but it was unclear when some actions identified had been completed. The last health and safety audit was completed in 2014. The manager told us there were no outstanding environmental health and safety concerns. There was work scheduled to convert an unused bathroom to a hoist storage area to prevent hoists being stored in people's bedrooms. There was no action plan for when this outstanding work would be completed. A kitchen audit completed in October 2015 identified minor items for action.

The plan to audit 10 percent of care plans monthly had not been completed. The Admiral nurse had reviewed certain aspects of some care plans to monitor improved support for people when they were anxious. A recent infection control audit completed by the services lead infection control nurse was rated over 96 percent and the manager told us this would go for accreditation as a good example.

The providers Care and Quality Compliance Tool for 2015 - 2016 looked at all areas of the service and identified shortfalls. The information highlighted outstanding actions. The action plan was addressed during monthly operational reviews. The servicing of equipment was up to date and completed.

The monthly review visits recorded by the provider's area operations manager looked at various aspects of the service. They included health and safety, accidents, care plans and peoples/relatives comments. The September 2015 monthly operational review identified actions for completion, for example, staff had not received formal supervision and they required Mental Capacity Act training. It was unclear from the action plan if these and previous issues identified were completed. We made a recommendation that governance and quality assurance systems were effective to drive improvements.

Staff told us that people were asked about their satisfaction with the service at six monthly reviews. Not all six monthly reviews had been completed. Residents meeting were held to include people in developing and improving the service. The August 2015 residents meeting identified the changes people wanted in the dining room and the decoration process had begun. The last meeting in September 2015 was attended by nine people, which included a relative and a friend. The meeting minutes told us people, relatives and friends had helped to choose the new wallpaper in the lounge. People had also wanted to go out more often and have additional entertainment in the late afternoons. The activity person had explained that extra staff was needed to go out more often and they would explore if volunteers could be used. People said they were happy with the variety of activities provided. The service had not surveyed relatives/friends or people living in the home to ask their opinion.

Staff meetings were held in August 2015 with the new manager to include the night staff, nurses, team leaders and the catering staff and we looked at the recorded minutes. Change to be implemented included removing all

## Is the service well-led?

hoists from people's bedrooms to a new storage area. The new manager had informed staff about change made to allocation of night staff and the need to recruit additional staff. Staff expressed they agreed with the changes.

A pharmacy audit was completed by the supplying pharmacist in August 2015 some minor issues were noted for action. These had been addressed and discussed during the nurses meeting, for example, a new medical alert folder was in place and staff recorded when they had read the alert. Care staff told us, "The nurses are very knowledgeable and I have learnt a lot from working with them".

A catering staff meeting discussed the organisation of meals in the dining room and peoples bedrooms. We observed this ran smoothly and people were assisted with eating where necessary. Staff told us they felt well-led by the new manager and said, "I am proud to work here, the manager has great ideas", "I have worked in care for a long time, this is the best home I have worked in" and "the manager is very approachable and has supported me to undertake further training"

**We recommend that governance and quality assurance systems are effective to drive improvements.**

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

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

People who use services were not referred to healthcare professionals soon enough and monitored to protect them against the risks associated with Regulation 12 (1) (2) (a) & (b)

### Regulated activity

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Staff had not completed regular training updates to ensure they had sufficient knowledge to carry out their roles. Regulation 12 (1) (2) (c)

### Regulated activity

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents

People who use services and others were not fully protected against the risks associated with abuse and allegations of abuse as The Care Quality Commission was not notified of all incidents. Regulation 18 (1) (2) (e)