Care Quality Commission

Care UK Community Partnerships Ltd

Britten Court

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

The inspection took place on 19 May 2016 and was unannounced.

Britten Court provides accommodation, nursing and personal care for up to 80 people, some living with dementia. At the time of our inspection, there were 78 people living in the service.

There was a registered manager in post. 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.

At the last inspection on 30 April 2015, we asked the provider to make improvements in how the service protects people in relation to medicines management, and this action has been completed. Despite this there were still some areas in the management of medication that could be improved.

There was an open culture in the service, which ensured that staff were able to speak up, however, some staff lacked confidence in the registered manager and their ability to take action when needed. The management team were implementing new systems and processes to improve care, but this was being undertaken too quickly, leaving some staff feeling uncertain of their roles and responsibilities. Although there was a registered manager in post the provider had put in a relief manager to ensure that changes were implemented effectively.

During this inspection we found there were significant variations in the quality of the care being provided across the service. Whilst in some areas the service was actively improving, in others people received inconsistent care which did not always consider or fully meet their needs. The registered provider was in breach of three regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to ensuring people throughout the service were consistently supported by the skills and deployment of sufficient numbers of staff, providing care which was individualised, and ensuring that the governance and oversight was effective at improving the overall quality of the service. Governance systems were being improved, but they were still not robust enough to demonstrate how they supported the leadership to make improvements needed to provide a consistent service.

People did not always receive the time and attention they needed to fully meet their needs. At times care was task focussed and hurried with staff unable to respond to people as quickly as they would like or perform their role effectively. This also had an impact on staff's ability to provide care which was consistently dignified and respectful.

Staff were not always sure how to support people with when they were anxious, and further training was needed to help staff be more confident when supporting people with specific needs. Care records did not always provide appropriate guidance to support staff in how their needs should be met. We have made a recommendation about the specialist needs of people living with dementia.

Care records did not reflect people's personal preferences and were incomplete in some areas. Risk assessments also contained contradictory or incomplete information, putting people at risk of harm.

Though improvements were seen in the way the service managed medicine systems and processes, people did not always receive their medications in a timely manner due to staff being interrupted on medicine rounds.

Activity provision was not consistent throughout the service, and we observed that it was difficult for care workers to find the time to provide this in addition to their other duties.

Staff were able to recognise abuse and knew how to report concerns if they suspected a person was being abused. Systems were in place to discuss potential safeguarding issues so they were escalated appropriately.

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 consistently safe.

Staffing level arrangements were not consistent to ensure people's needs were met.

People could not be assured of receiving the medication they needed in a timely manner.

Staff were knowledgeable in how to recognise and report abuse.

Is the service effective?

Requires Improvement ●

The service was not consistently effective.

Staff required further training to ensure that the care delivered was effective.

People were asked for their consent before any care, treatment or support was provided. Staff were knowledgeable about their responsibilities in line with the principles of the MCA.

People's nutritional needs were assessed and professional support was obtained for people when needed.

Improvements were needed in people's mealtime experience.

Is the service caring?

Requires Improvement ●

The service was not consistently caring.

Care was hurried and task focussed.

People's privacy and dignity was not always respected.

Is the service responsive?

Requires Improvement ●

The service was not consistently responsive.

Care records did not always provide staff with the information needed to provide individualised care.

Activity provision was inconsistent between the units. Further improvements were needed to ensure these met everyone's individual needs.

The service had involved other professionals to support people with their health and access to health care services.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Some staff did not have confidence in the registered manager.

Systems and processes were being implemented too quickly and staff felt unsure of what was expected of them in their role.

The provider and manager had put quality assurance systems in place, but areas identified for improvement at out last inspection, still required attention.

Britten Court

Detailed findings

Background to this inspection

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

The inspection took place on 19 May 2016, was unannounced and undertaken by four inspectors.

Prior to the inspection we reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also spoke with community healthcare professionals and local safeguarding teams.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not speak with us, for example, people living with dementia.

During the inspection we spoke with 13 people living at the service, three relatives, two social care professionals and one health professional. We spoke with the registered manager, relief manager, regional director, and nine members of care staff. We also observed the interactions between staff and people.

To help us assess how people's care needs were being met we reviewed nine people's care records and other information, including risk assessments and medicines records. We reviewed five staff recruitment files, maintenance files and a selection of records which monitored the safety and quality of the service.

Requires Improvement ●

Is the service safe?

Our findings

The deployment of care workers did not demonstrate that there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the people using the service at all times. We received mixed views from people and relatives about staffing levels. One person said, "They've got to build up the staff", and another said, "Yes, plenty of staff about". A relative told us, "There is always someone available, sometimes they are a bit busy". A care worker told us, "Everyone is stressed [Referring to staff]".

Some people required a high level of support to meet their needs, often with assistance of two care workers. Care workers told us they were often moved around the units and this did not provide continuity of care for people and, in some cases, staff did not have a full understanding of people's needs because they did not know them well. The relief manager explained that it was sometimes necessary to move staff around the units, but this was to ensure that care workers got to know residents on all of the units in the event that there is last minute sickness or annual leave.

On one of the units we observed a relaxed atmosphere, where staff knew people and were working well as part of a team. However, at certain times of the day on another unit, we observed staff were only able to perform task based work. They were rushed and hurried, unable to ensure that the time they spent with people was of high quality. Staff were unable to spend any meaningful time with people, which resulted in many sitting alone for long periods without any form of stimulation or activity. We observed staff were disorganised with no clear direction or leadership. We witnessed a dispute between care workers, in public, regarding the deployment of staff. They were concerned that they did not have a team leader and were not confident that an agency nurse who was working knew the needs of the people they were caring for. The relief manager took immediate action to diffuse the situation and manage the issue through the company's investigation policies and procedures.
People who spent time in their rooms told us that staff were too busy to talk with them. This meant that people who chose not to, or were unable to join in with organised activities in communal areas, were at risk of social isolation. We spoke with the management team who were unable to demonstrate how this was being addressed. This was identified as a concern during our last inspection in April 2015 and the situation had not been adequately addressed by the management team.

We received information which suggested that staffing levels were not sufficient to meet people's needs. This included that there were insufficient registered nurses on duty who had the skills to complete tasks such as syringe drivers, catheterisation, and venepuncture [taking blood], and that community staff were being used frequently to provide support to people with nursing needs. This was discussed with the relief manager, who told us that they had only needed to use nurses outside of the service on two occasions, and that they had taken action to address any outstanding training needs by arranging training for venepuncture, catheterisation, and syringe drivers. The relief manager also told us there were 18 people within the service who required nursing care, and there was a nurse on duty at all times, which they felt was sufficient to cover people's nursing needs.

Full consideration had not been given to ensure that staff were deployed effectively to complete the tasks they needed to or support others to do so. For example, the staff members completing medicine rounds were constantly interrupted, delaying and increasing the time it took them to administer people's medication. Interruptions included, answering call bells, phone calls, attending meetings, and attending to a person who had fallen [An isolated event which further demanded staff time]. On Lighthouse unit people were still receiving their breakfast medicines at 11.30am. The relief manager told us that they record times for drug rounds on all units, and that start and finish times are recorded. This data is reviewed as a part of the weekly drug audit and any excessive times for medication rounds are investigated and accounted for. Also the relief manager told us they would start to pass any phone calls to the admin team to support staff further when administering medication. However, our observations were that medicines had been delayed which could impact on people who need their medicines at specific times, or with a specific intervals between.

The relief manager told us they calculated staffing levels using a dependency tool. Rotas confirmed the calculated levels of staff were being used, and additional members of staff at busier times were also used. Whilst there were plans to review and support team leaders more, the provider had not recognised the experience for people using the service was inconsistent and not effective in meeting their care needs in a timely way. We were concerned that the tool was not effective because it did not take account of or fully consider the needs of people against the number, skill level and deployment of staff.

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

At our previous inspection we identified that people living at the service were not always receiving their medicines as prescribed because records were not complete and there were discrepancies in documentation. The service developed an action plan and we found that steps had been taken to improve. For example, all staff who administered medicines had been trained to do so, and new staff were not permitted to do so unless they had received training. Additionally, two staff had been allocated as 'medication leads' to oversee medicine systems and support staff to increase their skills by providing observation assessments which checked the competency of staff.

One staff member told us, "We do medication training frequently. We have a medicines competency check when things change". There was a robust system in place which identified staff who needed further training and supervision, and disciplinary action would be taken if staff did not make the required improvements. Staff were more accountable for their actions and knew what the expectations of this role were. Weekly medicines audits were being carried out, and where shortfalls were found, staff were taking action to address these. Further improvements were still needed in some areas, for example, where people had medicines 'as required'. Protocols were in place to guide staff on when to offer these, but the information was generic and not reflective of individual needs.

People's care records contained risk assessments which provided guidance on how to minimise risks which could affect a person's daily life, for example, falls, skin integrity, nutrition and mobility, however, we found inconsistencies in some of the records. For example, one person had a risk assessment for shopping and outings which said that they required one to one assistance due to the risk of falls. The same person's mobility risk assessment stated that they had no history of falls and if they went outside they would not need supervision. In another case, a person who was assessed as needing four hourly repositioning had no documented entries made by staff during the night, and during the day the entry was not signed. This meant that the provider could not fully demonstrate that the person had received the appropriate care or that staff were referring to the most up to date information.

People received care and support from staff who had been appropriately and safely recruited. Recruitment files we viewed confirmed that references and a criminal records check had been completed to ensure staff were suitable for their role.

People lived in a safe environment, and staff knew what action to take in the event of an emergency. Risks in relation to the premises had been assessed and regularly reviewed. We saw that fire doors were kept closed and that the emergency exits were well sign posted.

Staff had received safeguarding training and were able to identify different types of abuse and what action they needed to take if they suspected someone was being abused. One care worker said, "I'd go straight to the manager. You can go and speak to someone straight away if you need to". Another said, "I've just done SOVA [safeguarding of vulnerable adults] training. It depends on the concern; I'd go to team leader first". All safeguarding referrals were discussed with the relief manager to ensure they were escalated to the relevant professional bodies. The service had been working closely with the local authority to improve in this area and ensure that they worked collaboratively by sharing information and learning from referrals they had made.

Requires Improvement ●

Is the service effective?

Our findings

Care workers told us they felt the training they received enabled them to fulfil their roles but they also identified more areas which could help meet some people's individual needs. One care worker said, "There is always training going on. I have medicines training tomorrow", another said, "The training is generally quite good, but it would be nice to have more specific training like Parkinson's". Additionally, care workers raised concerns about supporting people with dementia and the impact on their behaviours if they become agitated or anxious. This was because at times they did not feel confident managing this.

We saw that some care plans did not provide care workers with clear guidance on how to support people who may become agitated. For example, one care plan said that the person may display aggressive behaviour, but there was no clear direction on how to diffuse a situation or how to distract the person. This did not guide care workers effectively and as a result they felt uncertain of how to support that person. The relief manager told us they were aware of this and had arranged training sessions for staff to support them more.

We recommend that the service explores current guidance from a reputable source in relation to supporting staff to effectively manage the nursing and specialist needs of people living with dementia, and the range of approaches and interventions which can be considered in meeting people's individual needs.

The relief manager shared their improvement plans to ensure that training of staff was relevant and reflected the needs of the people they cared for. Care workers had received regular opportunities for mandatory training sessions. Whilst there was some concern about the ability and skill levels of registered nurses, further training had been arranged to address this. Some staff had been allocated lead roles in areas such as, safeguarding, medicines, wound care, MCA/DoLS and continence. There were also two dignity champions [a champion is a person with increased knowledge in a specific area] and a dementia ambassador. These roles had been allocated to staff who had an enhanced level of knowledge, and could be called upon by others for advice to ensure that knowledge was shared to improve the quality of care overall. The relief manager had identified that these roles needed to be used more effectively within the service and planned to develop the roles significantly by working closely with staff and people.

Supervisions and appraisals provided staff with the opportunity to discuss how they are working, receive feedback on their practice and identify how they would like to develop their skills. The relief manager told us that staff should receive supervision sessions six times a year and an annual appraisal. However, we could not be assured that all staff had received these regularly. One care worker said, "I have mine with [unit manager], I had it a couple of weeks ago". Another said, "Can't remember when I had my last one. What's a supervision?". The management team were aware that some staff had not received regular supervision and were reviewing the situation to ensure consistent support was offered to staff.

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 can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

DoLS applications had been made to the local authority as required to ensure that any restrictions on people were lawful. Records documented if they were standard or urgent authorisations, and the date of their expiry. Records outlined decisions people could make for themselves, and where they could not, best interest decisions were in place. One care worker said, "Families participate [in best interest decisions], the person is also there". Staff we spoke to understood the principles of the MCA. One care worker said, "I try and give people as much choice as possible. You might have to repeat yourself but it doesn't matter".

Referrals had been made to Independent Mental Capacity Advocates [IMCA]. IMCA's are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person. This demonstrated that people were being proactively supported in these situations.

People told us they enjoyed the food. One person said, "The food is lovely here. The chef is so nice [they] always ask, how do you like the food". Another said, "The food is pretty good. They cater for people with different needs". Food supplements were used to increase nutrition and people who had problems with swallowing were served softer diets and thickened fluids. People sitting in communal areas and in their rooms had drinks accessible to them, however, some people had jugs of juice on their tables that were too heavy for them to pour independently so relied on staff for this.

We observed the lunchtime experience on Lighthouse and Heron units. On Lighthouse staff assisted people to the dining room. Some people required hoists to transfer from wheelchair to dining chair and this therefore took some time. Lunch arrived on a hot trolley when some people were still being assisted into the dining area. People were looking around for their meals and people ate at staggered intervals, which was not conducive to a dining experience which provided an opportunity for social interaction with others. The activities co-ordinator served lunch from the hot trolley but did not show knowledge about people's dietary needs as this was not their usual role. There was a risk people may be served food that was not suitable for them. There were three jugs of blackcurrant squash on one table with two people seated at it, but no other choice was offered. We observed some positive interactions between staff and people during lunch, however, the overall experience on both units was not effective in ensuring people enjoyed their dining experience and that opportunities were taken to promote independence, choice and social interaction.

We recommend that the service explores current guidance from a reputable source to ensure that mealtime experiences are an opportunity to support and promote independence, in addition to creating a positive mealtime experience, particularly for those with specialist needs including dementia.

People had access to health care services and received on-going health care support where required. We saw that referrals to health or social care professionals were done so in a timely manner. There was also a nurse practitioner who visited the home fortnightly. This ensured that any concerns about people's health could be discussed and monitored.

Requires Improvement ●

Is the service caring?

Our findings

The provider needed to develop their approach to ensure that it was consistent in delivering care in a way that supported a positive and person centred culture.

The routines of the service did not always promote opportunities for staff to ensure that the time and interactions with people was of good quality. We saw some staff walking into people's rooms without knocking or waiting to be invited in first, and observed staff talking with one another whilst assisting a person to move. Staff talked about their own issues over them, rather than ensuring the person was provided with reassurance during the manoeuvre. On another occasion we saw staff talking about people over them, for example, one staff member said to another, "I'm going to move her around, it's easier to feed her", without any interaction with the person they were assisting. In comparison there was also some good interactions between staff and people. One person said, "They always ask me if I need help, they make sure I have privacy when I need it".

People and relatives were also complimentary about the staff. One person said, "People [staff] make you feel lovely". Another said, "They're very polite, all of them the same". A relative told us, "I think [name of relative] is getting very good care. The carers seem to be nice to everyone, they are very good here". One care worker spoke about the importance of continuity of care. They said, "They know you, they trust you, you build a rapport". Another care worker said, "When you are based on a unit you know them and their little ways".

Monthly reviews were carried out on people's care plans and risk assessments. We saw that people's views had been recorded within these and the views of family members. In some cases the information had been used to improve people's care, for example, where more regular communication was needed with relatives to reduce a person's anxiety. However, two people told us that they had not seen their care plan, and when asked whether staff had involved them in their care plan, one person said, "I can't say they do". We brought this to the attention of the management team to explore further.

There were monthly resident and relatives meetings which provided an opportunity for people to express their views. Requests made by people, such as more evening entertainment, had been actioned, along with trips into town which the activity co-ordinator was organising.

Relatives were able to visit as they chose, and there were no restrictions. One relative said, "I come and see [name of person] regularly, no problems coming in whenever I like". This meant that people were able to socialise with family and friends as they chose.

Requires Improvement ●

Is the service responsive?

Our findings

People and relatives provided mixed views on the responsiveness of the care provided. One person said, "They always ask if things are ok, they get me what I need". Another said, "It's a bit slap dash". A relative told us, "The staff are constantly backward and forward chatting to [name of person]".

Care records contained information for staff about how to manage people's behaviour but we did not see that this was always put into practice. For example, one person's record said that at times they became anxious and unsettled and to manage this behaviour staff were advised to use distraction techniques such as talking about things that were in their room. The person was heard calling out throughout the day, but we only observed one member of staff using this technique, which worked well. This meant that the person was not consistently receiving care which was effective in minimising their anxiety.

Care records were not personalised and contained incomplete or little meaningful information about people's life history. This meant that opportunities were being missed to tailor care for the individual needs of people. For example, one contained the question "Did you work and when did you retire?". The answer documented by the staff was "Yes". And, "Are or were you married?", The response documented by the staff was, "Was married". Another person's care plan asked for information about hobbies that they enjoyed, the response was "Craft", with no information about what sort of craft activities they enjoyed. One person who had recently been admitted to the home was low in mood and their care plan stated, "Staff must give [them] the chance to talk to someone". When we asked the person if this was happening they told us, "No" and that, "Staff were too busy". We were concerned the person's emotional needs were not being met. Care records and risk assessments were generic and written in the form of bullet points, and provided no detail of what was important to people. We brought this to the relief manager's attention, who told us that they were aware of the issues and care plan training had been arranged for staff in May 2016.

People's care plans, daily records and charts were held in several different places, including electronic daily notes, paper care plans and a charts folder. Information such as people's weights were kept in a book before being transferred onto the computer. We were concerned that it was difficult for staff to easily access information about people, and there was a risk that important information could be missed. One team leader said, "Carers forget to update paperwork as they put it on the computer". When we brought this to the attention of the management team, they told us that this system allowed staff to see at a glance where weights needed to be monitored and recorded with actions taken. Additionally, each resident's weights could be reviewed at the weekly clinical review meeting. The systems in place had been developed locally and the management team were confident that important information would not be missed.

The approach to supporting people with their interests and have meaningful and fulfilled days was inconsistent. There was an activity co-ordinator working in the service and a programme of activities included quizzes, hand massage, sensory games, skittles and card games. Other activities included weekly exercise sessions, trips out and live entertainment. One person said, "They [entertainer] come every other week, it's always the same, the same old songs, it's long and loud". Organisations such as the Royal Society for the Protection of Birds, and the Royal British Legion were invited into the service for people to attend if they chose to. Each day 'Tea at 3' was convened in the café where people came down to socialise. There was a singer, and people had attended the event, including their relatives. The atmosphere was lively, and people were seen to be enjoying the entertainment.

Despite this there was minimal activity during the day on Heron unit. The expectation was that care workers would provide activities for people in addition to their caring duties. The relief manager told us they had introduced an activity log sheet which detailed who took part in which activity. We asked a person on Solebay unit about what goes on in the lounge, and they said, "People just come and sit here, that's all". A care worker was playing a game with some people which involved catching a ball with questions on it, but the game was rushed as the care worker said they, "Needed to be somewhere else". Although the relief manager assured us that activities were carried out regularly by staff on the units, we did not observe this to be the case. The relief manager told us that the new activity logs would be evaluated weekly to monitor which people were taking part in the activities.

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

There was a complaints procedure in place for people to access. Complaints had been recorded with information about the nature of the complaint and how these had been resolved. One person said, "On the whole it's very good. I do know if there was anything I wasn't happy about I could report it". A relative said, "I have no complaints at all. If I did I would just come to see who's in charge. Any little thing they tell you straight away, they are very good at communication".

Requires Improvement ●

Is the service well-led?

Our findings

Since our last inspection in April 2015, the service had implemented systems which were intended to improve practice. They had made a positive impact in some areas, for example, medicines management which had improved overall, although there were still areas of development needed. Monthly quality assurance audits were being carried out in various areas such as care plans, staffing level requirements, health and safety, and call bell response analysis. Whilst this work had triggered action plans to address some shortfalls highlighted by these reviews, and in response to survey feedback, improvements were not consistently being applied and there was a significant challenge in delivering change because of a lack of effective leadership and oversight as a whole.

A relief manager had been brought in to support the registered manager and leadership team to improve. Changes in working practices and documentation procedures were being introduced to ensure staff's confidence and ability to do what was being asked of them. However, there was still work to do to ensure all staff understood this and worked in line with the services main objective; "To achieve a high quality service which supports individual's health and social care needs".
Staff were concerned about the amount of changes they were being asked to implement, for example one care worker said, "Every time I come in on nights there is a new piece of paper". In addition some staff practice did not reflect the values and culture that the management team were trying to embed. Effective strategies for communication and introducing new systems and processes, needed to be considered further to ensure staff were clear on their roles and know what is expected of them.

In addition there was confusion about the structure of the service, who was in charge, and what staff roles were. People and staff commented on the leadership of the service. One person said, "I'm not sure who the manager is". A staff member said, "It's a bit more settled now [relief manager] is here". The registered manager was present during the inspection, but it was the relief manager who was pro-active in taking on board our comments and explaining future planning.

Staff told us they felt able to speak up and raise concerns with the registered manager, however, they sometimes lacked confidence in their ability to take action or address certain issues promptly. Provider representatives were present during the inspection and reassured us that they were continuing to support the management team to achieve improvements in practice. The regional director told us they had been visiting the service regularly to closely monitor progress and offer support and guidance where needed, and that this level of support was on-going and would continue as long as it is needed. This demonstrated that the provider was taking an active role in ensuring improvements were made. However, given this level of involvement we remain concerned about the timeframe for improvement and its sustainability.

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

People, relatives and visitors told us they were able to express their views about the service through regular meetings, and we saw that resident and relative satisfaction surveys had been completed. We saw that an action plan had been created in response to the comments, and actions such as implementing an activity log, and inviting relatives in to review care plans had been carried out. This demonstrated that the service was responding to comments made, however, the planned improvements were not fully embedded yet so it was not possible to see their full impact.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The service did not make sure that people received personalised care that met their individual care and support needs. Regulation 9 (1) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Improvements were not consistently being applied across the service. The service did not understand the quality of people's experience in the care they received. Regulation 17 (2) (a) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing arrangements were not consistent to ensure there were sufficient numbers of staff with the skills and knowledge to meet people's care and welfare needs. Regulation 18 (1)