Hightown Housing Association Limited

The Old Forge

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

Summary of findings

Overall summary

This inspection took place on the 11, 12 and 13 April 2018 and was unannounced. We made two recommendations following our previous inspection in February 2017. These related to staffing levels and activities for people.

The Old Forge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care service has not been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. The values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen. We found that people were not able to be included in their local community due to its geographical location and the lack of transport and staffing. At the time of our inspection, two people were living in the service.

The service did not have a registered manager in place. The previous manager deregistered with the Care Quality Commission (CQC) in January 2018. 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.

People's relatives spoke positively about the care being provided within the service. We observed staff who cared for people in a respectful and kind way. We saw positive relationships had been formed between staff and the people they cared for.

The provider had failed to monitor the quality of the management in the home and this had resulted in a lack of progress concerning the expected improvements from our previous inspection in February 2017. There were still not enough staff available to meet people's needs and to keep them safe. Activities were not regularly available outside of the home. This prevented people from accessing their local community and placed them at risk of social isolation.

We identified breaches to Regulation 12 of the Health and Social Care Act 2008. This was because personal emergency evacuation plans did not accurately reflect people's needs and did not give clear and consistent guidance to staff on how to evacuate the service safely. Furthermore, the fire emergency plan was not up to date. Risks related to the care being provided and the environment had not always been mitigated. When risks were identified, appropriate action was not always taken to minimise the risk.

In addition, there were gaps and inaccurate records alongside a lack of managerial oversight. This placed people at risk of receiving inappropriate or unsafe care. Insufficient staff members meant people did not

always receive the care they required at the time they needed it. Staff were not always trained in the areas needed to carry out their role.

People did not always receive food that was safe for them to eat. Professional advice was not always followed.

Medicines were administered appropriately, and records reflected this. Staff understood how to protect people from the risk of infection. Recruitment records contained the relevant checks and staff had received training in how to protect people from the risk of abuse. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems at the service supported this practice. We have made a recommendation to ensure staff were trained in Mental Capacity Act and were following the best interest process. We found this was not always happening.

There was a lack of care reviews taking place with people and their representatives. Although we found some good practice in relation to how people were assisted to communicate, we also found guidelines were not being followed. We have made a recommendation about the Accessible Information standard.

We found this was not a well-managed service. There was a lack of management presence, with no clear reason given. The service manager was managing two services, but appeared to spend little time at The Old Forge. The senior staff were clearly struggling to manage the service, and management support had been slow to respond. A lack of management oversight meant the service had not operated to an acceptable level. Where areas of the service had been identified as requiring improvement these had not been acted upon in a timely way.

We found senior staff were not aware of the requirements related to the Duty of Candour. We have made a recommendation about this.

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

Some aspects of the service were not safe.

Fire evacuation procedures were not appropriate or safe. They did not protect people or staff from the risk of harm.

Some staff had not completed all the training deemed mandatory by the provider. Not all staff had been provided with specialist training to ensure they could meet the needs of people.

Measures had not been put in place to identify all risks associated to the care being provided. Action had not always been taken to minimise the risk to people from risks that had been identified.

Is the service effective?

Requires Improvement

The service was not always effective.

The correct food types and appropriate supervision was not always provided to people at mealtimes to ensure their safety.

People's rights were not always protected because the best interest process was not always followed in line with the Mental Capacity Act code of practice.

Records related to staff training were not maintained. The service manager could not be assured all staff had the necessary training to carry out their role effectively.

Is the service caring?

Good

The service was caring.

Staff demonstrated a caring nature when supporting people. They were patient and respectful.

People's preferences were described in their care plans. This enabled staff to provide care in line with people's choices.

The service had an equality and diversity policy in place. Staff were trained in equality and diversity. We observed care was provided in a non-discriminatory way.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not provided with the means or support to integrate into their local community. Activities were mostly confined to within the service. This did not protect people from social isolation.

We found no evidence in the care records people had had their care reviewed with them or their representatives.

Documented guidance on how to communicate with people was not always followed. Without reinforcement and reciprocal communication, this meant people would lose their ability to develop or maintain their communication skills.

Is the service well-led?

Requires Improvement

The service was not well led.

There was a lack of management presence in the service. This meant staff were not receiving the support they required to carry out their role appropriately.

A lack of management oversight meant that some areas of the service that required improvement had not been identified or actioned.

A lack of understanding of Regulation 20 Duty of Candour, did not demonstrate the service would be open and transparent when things went wrong.

The Old Forge

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 11, 12 and 13 April 2018 and was unannounced. The inspection was carried out by one inspector.

Prior to the inspection we reviewed the information we held about the service, this included notifications we had received from the provider. Notifications are changes or events that occur at the service which the provider has a legal duty to inform us about. We had not asked the provider to complete 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 covered these areas during our inspection.

During the inspection we spoke with six staff members including the regional manager, two assistant managers, the service manager and two support workers. During our visit we were not able to speak with the people who were present in the service due to communication difficulties. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. Following the inspection we spoke with two relatives of people living in the service and one local authority professional.

We reviewed documents associated with two people's care and their medicines. We examined records associated with the employment of three staff. We read records related to health and safety, incidents and accidents and audits connected to the running of the service.

Requires Improvement

Is the service safe?

Our findings

People's relative's overall opinion of the service was that it was safe. However, we had concerns about the risk management policies and procedures in relation to fire evacuation. The service had three fire risk assessments in place. A different organisation or individual, including the property owner, the contractor and the provider had completed one. However, when we looked at the Personal emergency evacuation plan (PEEP) for each person this was not in line with the fire evacuation plan for the service. In the event of a fire, the service procedure instructed staff to meet at the front door and then evacuate. The PEEPs referred to evacuating each person separately and returning into the building to evacuate others.

Because staff carried out lone working at weekends, nights and evenings it was not possible to evacuate both people who used wheelchairs at the same time. Following the inspection we were sent copies of the updated PEEPS, these again were not clear. This was because the regional manager told us that for one person their physical mobility depended on them receiving medicines, which took half an hour to take effect. The PEEPs did not refer to this. This would limit the person's ability to get out of bed. The issue of returning into the building was not addressed.

The fire emergency plan dated February 2016 referred to four people living in the service. This had not been changed to reflect only two people were residing there.

Due to concerns raised by staff about the welfare of night staff (who worked alone), a system had been introduced whereby night staff from another service would contact each other during the night to ensure they were safe. However, this did not address the issue of one staff member working alone and the need for effective fire evacuation plans. We also observed when people required support for their own safety this was not always available, because staff were busy doing other things. The provision of in adequate numbers of staff did not sufficiently manage the risk to people. This placed people at risk of serious harm.

We examined other records related to risks, these included risk assessments and care plans related to the care people received. We found one person was supported to mobilise from their bedroom to the bathroom using a shower chair. There was no risk assessment in place to record the risks associated with this activity.

One person displayed behaviours that were challenging when they became upset or distressed. A behaviour support plan was in place. This stated that the use of any physical intervention must only be carried out by trained staff. Records did not identify how many staff had received this training. Not all staff were able to tell us what the care plan said they should do in such situations. This presented a risk of staff acting inappropriately and in a way that was unsafe.

Another risk we identified was around staff completing training. Some staff had not completed all the training deemed mandatory by the provider. Without sufficient skills and knowledge this placed people at risk of harm.

Records associated with people's health had not been monitored. For example records showed one person

had not had their bowels open for two periods of seven days. No action had been taken to address this. Care plans and risk assessments did not identify this as a problem. Records showed one person had experienced a skin integrity problem. There were no care plans or risk assessments in place to address this issue and prevent a reoccurrence.

One person scratched themselves. The risk assessment stated staff were required to fill out a body chart, add details to the daily notes and to the accident and incident log. We found no body charts had been completed, no accident or incident reports but mention of the scratches in the daily notes. When we spoke with one staff they told us the staff were not required to document all injuries as they were regular occurrences and staff were familiar with them. This placed people at risk of harm.

During our previous inspection, we made a recommendation about the deployment of staff. This was because we found there were occasions when there were not enough staff deployed to meet the needs of people. During this inspection, we found there were two people receiving care from one staff member and during the week an assistant manager was also available. Extra staff were brought in for half a day on three times a week to assist with activities. Staff worked alone in the evenings, weekends and at night-time.

We observed that staff were not always available to support people when needed, for example when eating. Care plans described how people needed to be supported but this did not always happen. Where accidents or incidents occurred, these were recorded by staff. There was space on the document to record any lessons learnt. We read for one person they had caught their foot on the leg of a chair and they fell. The records showed no lessons had been learnt from this incident.

Paving slabs in the garden were not safe. These had been reported to the provider's maintenance team. When reviewed by the provider's worker they decided they did not need to take any action. As a result, the risk remained of people falling on the uneven slabs. This had not been followed up by senior staff or management.

These were all breaches of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Each person had their medicines safely stored in locked cupboards. We noted that one staff member had not got up to date medicine training, but had been assessed as competent to administer medicines. Medicines policies and procedures were available to ensure medicines were managed safely. Clear records of medicines were maintained. We checked the balances of people's medicines. We found these to be correct.

Not all staff had up to date training in infection control. However, when we spoke with staff they were aware of how to maintain a safe environment and what measures were in place to protect people from the risk of infection. This included the use of protective gloves, aprons and separate cleaning equipment for different areas of the service. The service appeared clean and hygienic.

Environmental risk assessments were in place to minimise the risk of harm to people from the environment or equipment. Health and safety checks were taking place regularly for example the fire alarms and equipment were serviced regularly. Fire drills were taking as a minimum every six months.

Recruitment records contained the relevant checks including a Disclosure and Barring Service (DBS) check. A DBS check allows employers to check whether the applicant has any past convictions that may prevent

them from working with vulnerable people. References were obtained from previous employers as part of the process to ensure staff were suitable and of good character. Health declarations, and documents related to proof of identity and of address were filed. This process reduced the risk of unsuitable staff being employed by the service.

Staff were trained in how to safeguard people. The provider had implemented a safeguarding procedure. Staff were aware of their roles and responsibilities when identifying and raising concerns. The staff felt confident to report concerns to their line manager. Procedures for staff to follow with contact information for the local authority safeguarding teams were available.

Requires Improvement

Is the service effective?

Our findings

People's needs had been assessed and risk assessments and care plans were designed based on the information gained in the assessment. However, the practice was not always in line with guidance. For example, one person had been referred to a speech and language therapist for advice and guidance on eating and drinking, because there was a risk of choking. Guidance stated the preferred types of food to be eaten. One food type that was not recommended was sausages. However we saw on the daily records this had been served to the person. On the day of our inspection sausages were on the menu. After we spoke with the staff they agreed to remove the skin to make sure they were safe for people to eat. One person required supervision during eating and drinking to ensure they ate at a safe pace. We observed this did not always happen. This placed the person at risk of choking.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were offered a choice of food and drinks. Where the speech and language therapists had recommended thickener to be added to a person's drinks this was being done. Menu planning was done with people, who were able to choose from a range of pictures what food they wished to purchase and eat. Where people did not wish to eat what was on offer an alternative was offered. People's likes and dislikes were recorded in their care plan, to assist staff in offering food and drinks the person enjoyed.

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

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The service used a mental capacity assessment tool to assess some decisions.

We found the records related to best interest decisions were not always reflective of the process used. For example, we reviewed records related to best interest meetings. When we challenged the senior staff whether meetings had been held, we were told they had not. Relevant people were not always involved in the process, for example family members, or other relevant individuals. Where people had restrictions placed upon them for their own wellbeing, applications had been made to the supervisory body. These were awaiting authorisation. Not all staff had received training in MCA and DoLS. One staff member was not aware of how this legislation impacted on the people they cared for.

We recommend that the service finds out more about training for staff, based on current best practice, in relation to MCA and DoLS.

During the inspection, we were told the staff-training matrix was not up to date and we would be sent an up to date version following the inspection. Because the information we received during and after the inspection related to staff training was inconsistent, it was difficult to determine how accurate the records were. As a result, we could not be certain staff had completed all the areas of training deemed mandatory by the provider.

New staff attended an in-house induction and completed The Care Certificate. The Care Certificate is a recognised set of standards that health and social care workers adhere to in their daily work. This involved observations of staff performance and tests of their knowledge and skills. Documents verified this.

Supervision was carried out with staff on a regular basis. This gave the staff member and the supervisor the opportunity to review the staff's performance and to discuss any issue that may have arisen. One staff member told us "It gives you a chance to air your concerns; it gives you a voice as well as your manager."

Staff supported people with their healthcare needs. We read documentation related to health appointments with external professionals to assist people with their mental and physical health needs. A range of professionals were involved in assessing, planning, implementing and evaluating people's care and treatment. Documents verified contact with the GP practice along with dietitians, opticians, dentists, physiotherapists and speech and language therapists. Advice from external healthcare professionals was documented in care plans to inform staff how particular needs should be met. For example, the Speech and Language Therapist (SALT) had assessed swallowing difficulties and made recommendations such as the consistency of food and the use of thickener in fluids.

Good

Is the service caring?

Our findings

Relatives told us they found the staff to be caring. One relative told us this was because the person was always well "Turned out" and appeared well cared for. Other comments included they felt people's needs were being catered for and they had no complaints about the staff. One relative told us they were able to visit whenever they wished to and they were made to feel welcome.

We observed interactions between staff and people. Staff were able to interpret people's non-verbal communication and reacted quickly to support their needs. Staff were kind to people and nothing appeared to be too much trouble.

Some staff had worked in the service for a long time. They were aware of people's family members, their history, likes and dislikes. Through discussions with staff it was clear they knew people well, and were familiar with their needs and how to meet them.

Involving people in making complex decisions was not always possible. In some situations relatives were involved as part of best interest decisions. In decisions related to finances, each person had a solicitor who oversaw their finances and acted on financial matters on their behalf.

People's preferences were described in their care plans. There was a process for capturing the likes, dislikes, preferences and the person's personal interest and hobbies. For example in one person's care plan it stated "[Named person] prefers to sleep on his left hand side, light off and door closed." It also informed staff that they only enjoyed drinking hot drinks. This enabled staff to provide care in line with people's choices.

Staff were able to describe to us how they protected people's privacy and dignity in relation to personal care. They did this by closing curtains and doors. We also observed how people were supported in such a way that their dignity was intact, for example when being supported with food and drinks, their clothing were protected. People were informed and asked permission before we entered their bedrooms and reviewed the records held in there.

People enjoyed interacting with staff and it was apparent they knew each other well. Staff did not hurry people and allowed people to take their time. Staff responded appropriately when people expressed their needs.

The service had an equality and diversity policy in place. Staff received training on equality and diversity. This enabled them to understand and respect people's preferences and needs and their protected and other characteristics under the Equality Act. For example, age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation.

Requires Improvement

Is the service responsive?

Our findings

During our previous inspection we made a recommendation that the service increased the opportunity for people to participate in activities that were relevant to their individual interests. We found this had not improved during this inspection.

We reviewed the daily records for both people in the service from 3 March 2018 to 12 April 2018. Records showed for one person they had only left the house on one occasion to attend church during this period of nearly six weeks. The other person had left the service on three occasions when supported by his relatives. For one person the activities listed in the care plan included attending a social club, shopping, along with visits from relatives. Another person's care plan stated they enjoyed car rides, walking in the village, visiting the zoo, picnics and attending a session at a local community centre. None of these activities had taken place according to the daily records.

We spoke with the senior staff about this. They told us they did not have a vehicle at the service and could not afford taxi fares. The service was situated in a rural community. Staffing was restricted although extra staff had been brought in for three half days per week to carry out activities. These were carried out in the service. During our inspection the TV was on all of the time, as well as music playing on the CD player. Although staff did interact with people, the actual amount of interaction was limited due to the other tasks staff had to perform. We observed one session of aromatherapy and people had access to sensory lights and a sensory scent box. This did not protect people from social isolation.

We found no evidence in the care records people had had their care reviewed with them or their representatives, apart from care plans and risk assessments being reviewed. One relative told us they chose not to participate in review meetings. Another told us, in January 2018 a review meeting was held for their family member, they had not been invited to attend. They found this surprising, as they had attended all the previous review meetings. They told us this was unusual and put it down to the changes in management at the service.

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

The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. We found descriptions in care plans on how to support people with their communication. Care plans described how body language could be interpreted. For one person when they wanted to say "No" they would fold their arms. Alongside these were diagrams of signs the person used. The file also contained pictures and suggested the use of objects of reference. Objects of reference are used to communicate a person, place or event. For example a spoon may represent lunch. The object has to be meaningful to the person.

Although we found this guidance we saw no evidence of it being used with people. Staff we spoke with told

us they understood the person's signs but they did not sign language and did not use objects of reference. From the training records we viewed we did not find any evidence staff had been trained in Makaton. (Makaton is a communication system that uses signs, symbols and speech to help people communicate.)

Without reinforcement and reciprocal communication this meant people would lose their ability to develop or maintain their communication skills.

We recommend that the service seek advice and guidance from a reputable source, about implementation of the accessible information standard framework.

At the time of the inspection, no one was receiving end of life care. People did not have end of life care plans in place. Care plans detailed what actions should be taken once the person had died, for example funeral arrangements. The regional manager told us that end of life care plans were written when someone had a diagnosis of a terminal illness.

Relatives told us they had not had to make a complaint and were happy with the service provided to people. One relative told us they knew how to make a complaint. There were no reported complaints documented at the service since our last inspection.

Requires Improvement

Is the service well-led?

Our findings

Relatives told us they felt the service was well managed. One relatives comments stated "I think the new organisation (Hightown Housing Association Limited) is still bedding down. I think they will get better in time."

At the time of this inspection, the service had not had a registered manager in place since January 2018. A service manager managed two services, one of which was The Old Forge but they had not applied to be a registered manager. An assistant manager was based in the service from Monday to Friday each weekday.

Comments from staff when asked if they felt the service was well led included "It is like the blind leading the blind." "I don't think it is. Yesterday was the first time in weeks [Named service manager] was here." Throughout the inspection, references about the lack of skills of the senior staff were shared with us. Staff were not sure if the senior staff had received sufficient support and training to do their job effectively. We spoke with the service manager who told us they had not had the time to be at the service to support the assistant manager. Without being present in the service the service manager was not able to be aware of the day-to-day culture of the service. An assistant manager from another service had been deployed to offer support.

We found there was a lack of management oversight at the service. Records showed an audit completed in January 2018 highlighted the need for the fire procedure to be changed to reflect only two people living in the service. The deadline for this had been February 2018. This had not been completed. A review of care files recognised "The service user files need some work and the new manager will oversee this." this had not happened.

Mandatory staff training had been not all been completed; the service manager told us they did not have an oversight of the staff training for The Old Forge.

When a person fell and injured themselves, there were no recorded lessons learnt to prevent a reoccurrence. Staff had not completed charts correctly in relation to a person's behaviour. The service manager or senior staff had not monitored the records. Documents in relation to injuries for people had not been completed; no management oversight had highlighted or addressed this.

Confusion over staff annual leave and a lack of clear communication between the senior staff and staff had resulted in a lack of staff to care for people. This resulted in a staff member having to work during the day and remaining awake all night to ensure care was provided to people. This placed both the staff member and people living in the service at risk of harm. The change of management and lack of consistent support had resulted in low staff morale as reported to us by staff. The lack of strong effective management oversight meant there were areas of the service, which were not meeting the needs of the people living there. For example, a lack of activities for people. Senior staff in the service had not identified all the areas requiring improvement that we found during our inspection.

When a staff member responsible for the health and safety of the service reported a concern with the paving slabs in the garden to the provider, no action was taken. Because of a lack of management intervention and support for the staff member the risk of trips or falls remained. This was a dangerous situation that could have been rectified.

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

We spoke with the regional manager about their understanding of the requirement to meet Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Duty of Candour. This regulation relates to the provider being open, honest and transparent with people when things go wrong. The regional manager was unaware of the requirements of the act. From our dealings with the regional manager, we are aware they are honest and open but it remains necessary for registered persons to be aware of their responsibilities under this regulation. As there was no registered person in the service, it was important the regional manager could fulfil this requirement.

We recommend that the service seek support and training, for the management team, about Regulation 20 Duty of Candour.

We were told questionnaires had been sent to people to receive feedback on how the service could improve. However, the provider was unhappy with the results, as they did not feel it was a true reflection of how the services provided care, so work was being undertaken to review these. We were told staff were sent questionnaires; however staff we spoke with could not confirm this. They did tell us they were able to feedback ideas in team meetings and they were listened to and where possible action had been taken. They felt the assistant manager was accessible and supportive.

The service worked in partnership with other organisations to enable the care provided to be relevant to the people living in the service. For example, speech and language therapist, GP services and the local authority. Records reflected the advice given.

Audits had been undertaken to establish where improvements to the service needed to be made for example finance, health, and safety. However, we found that the necessary actions were not always followed through to improve the service to people.

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 provider failed to provide care and treatment to people that was appropriate, met their needs, and reflected their preferences. Regulation 9 (1) (2) (3) (b) (f) (i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to provide safe care and treatment to people Regulation 12 (1) (2) (a) (b) (c) (d) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); Regulation 17 (1) (2) (a) (b) (c) (d) (e) (f)