Regents Park Limited

49 Regents Park

Inspection report

49 Regents Park
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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

Overall summary

The inspection took place on 11 and 20 May and 2 June 2015. The first two visits were unannounced. During weekdays the people attended a day centre; therefore we visited in the evenings so that we could meet them and find out about the support they received. On the third day we visited the providers' main office where records such as staff files were held.

49 Regents Park is registered to provide accommodation with personal care for up to four people who have learning disabilities and/or physical disabilities. The property is a large terraced house and the adjacent property, 47 Regents Park, is also a registered care home run by the same provider. Although separately registered the two properties were closely linked and shared the same staff team.

At the time of this inspection there were four people living at 49 Regents Park. The property was divided into two separate units. In the basement there was a self-contained flat for one person, and on the ground and

Summary of findings

first floors there was accommodation for three people. Each unit was independently staffed, although staff said they frequently worked in 47 Regents Park or in other services run by the provider.

There was a registered manager in post who also managed two other care homes in the Exeter area. 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.

Where people were subject to restrictions, Deprivation of Liberty Safeguards (DOLS) applications had recently been submitted. The provider and registered manager had recently been made aware of changes in legislation by members of the local authority safeguarding team. This meant the provider and registered manager were not fully up-to-date with current legislation or good practice guidance.

People were offered a range of main meals although these were not always home cooked and did not fully meet people's dietary needs. People were not always offered a pudding course. Some puddings and 'extras' such as jellies, cakes and Angel Delight had been purchased by people from their own money. One person was restricted from having extra food such as biscuits when they requested.This meant people were not offered a full choice of foods to suit their individual preferences.

Staff rotas showed there were sufficient staff to support people when they were at home. During weekdays three people attended a day centre that is not regulated by the Commission and therefore we did not look at staffing levels while people were at the day centre. During our visits to the home we saw people received support from staff when they needed it. However, following the inspection we received information that indicated staffing levels sometimes fell below the levels shown in the staff rotas. This information has been passed to the local authority safeguarding team for further investigation.

Staff knew how to protect people from the risk of abuse. They had received training on safeguarding adults and knew who to contact if they suspected abuse may have occurred. Systems were in place to ensure people's cash or savings were managed safely. This meant people were protected from financial abuse.

Staff recruitment, supervision and training records showed staff had been carefully recruited by obtaining references and carrying out checks on their suitability before they were offered employment. Information provided by the registered manager showed staff received training on relevant health and safety topics, but only four staff out of a total staff team of 18 had received training on autism, challenging behaviour, or epilepsy. Information received after the inspection indicated that some shifts had been staffed by new and inexperienced staff who may not have the skills or knowledge to help them support people effectively. This information has been passed to the local authority safeguarding team for further investigation.

Staff received regular supervision and support. Staff meetings were held regularly. Staff said they worked well together as a team.

Each person attended a day centre every weekday operated by the provider where they were offered a range of activities they could participate in. This service is not regulated by the Care Quality Commission and therefore we did not check the services or care provided to people while they attended the day centre. In the evenings and weekends they were able to choose to go out, for example to a local pub, walks in the area or the cinema, or stay at home and do activities of their choice.

Medicines were stored and administered safely, although procedures for discarding medication when no longer safe to use were not fully effective. Staff had received adequate training on safe administration of medicines.

People were supported to maintain good health. However, risks to people's health and welfare had not been assessed and reviewed regularly. Staff were given guidance and training on how to recognise risks and reduce the risk of occurrence.

People had not been fully consulted or involved in drawing up and reviewing their care plans. The care plans had not been regularly reviewed or updated and some information was out of date. This meant staff did not have access to up to date information about people at all times.

Summary of findings

During our visits we saw staff interacting with people who lived there in a caring and empathic manner. Staff understood each person's individual communication methods. People were offered choices.

There were systems in place to monitor the daily routines in the home. Daily reports on all aspects of the support given to each person were completed by staff. The reports were returned to the provider's head office each month to be checked by the provider and manager. However, the registered manager did not regularly work in the home and there was a risk some poor practice or ineffective routines were not picked up or addressed. There was also a risk that incidents and accidents may not be reported to the Care Quality Commission correctly.

We found 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?

Requires improvement

The service was not safe.

People were supported by sufficient staff at the time of our inspection, However, concerns received about staffing levels and the safety of the service after this inspection have been passed to the local authority safeguarding team.

Risks to people's health or safety had not been identified or managed in ways that ensured people were safe or their needs were met

Staff knew how to recognise potential abuse and the actions to take if they suspected people may be at risk

Medicines were stored and administered safely, although procedures for discarding medication when no longer safe to use were not fully effective

Is the service effective?

Requires improvement

The service was not fully effective.

People were not always supported by staff with the knowledge, training or skills to meet their needs effectively.

People were not supported with person centred care regarding food choices that reflected their individual preferences.

People's human rights were protected because the provider followed appropriate legislation.

Is the service caring?

Good

The service was caring.

Staff interacted with people in a caring and empathic manner.

Staff were able to communicate effectively with people and understood their verbal and non-verbal means of communicating choices and preferences.

Is the service responsive?

Requires improvement

The service was not fully responsive.

People had not been fully involved or consulted in drawing up and agreeing their care plans.

People's care needs had not been regularly reviewed and care plans contained out of date information which meant there was a risk people would not receive the support they needed to meet their needs fully.

People were able to participate in a range of activities and led active lives.

Summary of findings

Is the service well-led?

The service was not consistently well led.

Systems for monitoring the quality of the service were not fully effective.

The provider did not have effective quality assurance systems in place that ensured people received a safe service that responded fully to their individual needs.

Requires improvement

49 Regents Park

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 checked 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 11 May and 2 June 2015 and was carried out by one inspector. There was a delay between the first and second visit because the registered manager was unavailable during that period. The first visit was unannounced and took place in the evening because people were out during the day at a day centre. On our first visit the provider showed us the accommodation

Before this inspection took place we received information that may have been relevant to this service which included concerns about the use of restrictive practices, unsafe recruitment processes, safeguarding, fire risks due to locked doors, inadequate budgets for food and activity, medication and specialism and isolation of the service. During this inspection we found no evidence of unsafe recruitment practices, or fire risks due to locked doors. However, we found some restrictions relating to food for one person and also concerns relating to how food budgets were used.

We spoke with one person who lived there and observed staff interacting with two people who were unable to communicate verbally. We relied on our observations of care and our discussions with staff and external professionals to help us understand people's experience of the service. We spoke with two staff while they were working in 49 Regents Park. We also spoke with a further four staff during our visit to 47 Regents Park who regularly worked in 49 Regents Park. We also spoke with the provider. We looked at records of support given to three people including support plans, daily reports, and medicines stored and administered in the home. On the second day we agreed in advance to meet the registered manager at the provider's offices to look at the records stored there. These included staff recruitment, supervision and training records, and records of cash and savings managed on behalf of people.

Before the inspection we looked at the information we had received on the service since the last inspection including communication from a relative. We had received no notifications of incidents or accidents.

Requires improvement

Is the service safe?

Our findings

People could not be confident there were always sufficient staff on duty with the skills and experience to meet their needs. During each of our visits we found there were two staff on duty to support three people in the main part of the house and one staff was supporting one person who lived in a self-contained flat in the basement of the building. Two people attended the day centre run by Regents Park during weekdays and therefore staffing levels during these periods were lower. At evenings and weekends the staff rota showed the planned staffing levels were usually two staff on duty in the main house and one staff on duty for one person in the basement flat. During our visits staff were relaxed and able to respond to each person's needs promptly

However, some staff told us that on a number of occasions staffing levels had fallen below safe levels. They told us that at times there had only been one staff on duty to support three people. They also told us there had been occasions when the only member of staff on duty did not have the knowledge or experience to meet the needs of each person fully.

Medicines were safely stored and administered. People were generally in good health and were on very low levels of prescribed medicines. Medicines were supplied in packets and there were clear records showing these had been administered safely. Two staff checked the medicine stock remaining in the home and recorded the amounts carried forward to the following month. They checked the amounts tallied with the prescription to ensure the medicines had been administered correctly. The medicines were securely stored in a locked cabinet. Staff told us they had received training on the safe administration of medicines and we saw certificates to confirm this. No creams or lotions were prescribed.

After the inspection we were given information that indicated some staff had not received sufficient information or training on how to administer emergency medication for people with epilepsy. Information on staff training provided by the registered manager showed that only four staff had received this training (out of a total of 18 staff). This information was passed to the local authority safeguarding team. We have been given reassurances by the registered manager that none of the people living at 49 Regents Park have been prescribed emergency medication for epilepsy and therefore staff who work at this home do not require training on administration of emergency medication.

Before our inspection we received a concern from a relative about possible physical interaction by staff in response to being grabbed by a person who lived in the home. The matter was shared with the local authority safeguarding team for their investigation. During our inspection we spoke with the registered manager about this concern. We asked what training and instructions staff had been given on alternative measures they can take to reduce the need for restraint or restrictive practices. They told us staff had received training on non-abusive psychological and physical intervention (NAPPI) and staff followed this training when they needed to protect themselves or other people who may be at risk of being harm from others. The staff had also been given guidance on how deal with specific and predicted incidents. They planned to review the training and the guidance to staff.

We asked one person if all the staff were kind. They were unable to answer our question fully, but told us about members of staff they liked. They also told us they knew who to speak with if they were concerned about the care and support they received.

We asked two staff if they were confident they could recognise abuse and knew how to report any suspicions of abuse. They explained how they would recognise any signs of illness, abuse or upset. They also explained who they would report their concerns to. They had received training on safeguarding adults.

Risks to each person's individual health and safety had been assessed and the records showed these had recently been reviewed. Care plans provided information to staff on how to support people with identified risks.

We looked at staff employment records for all care staff recruited by the provider since the last inspection. These included records of staff working in other homes operated by the provider. The staff we met also worked shifts in other services operated by the provider. The records were neatly filed and contained clear evidence of checks carried out before new staff were suitable to work with vulnerable adults. Staff were not allowed to begin working with people

Requires improvement

Is the service safe?

until satisfactory checks and references had been obtained. This meant the risk of abuse to people who used the service was reduced because effective recruitment and selection procedures were followed.

We looked at records in the provider's main office of cash and savings held by the provider and managed by staff on behalf of people using the service. The records showed regular checks and balances were carried out that ensured people's money was managed and held safely.

The premises were well maintained and safe. Each person had a comfortable bedroom that had been decorated and furnished to suit their individual preferences. The registered manager provided us with information about regular safety checks carried out on the premises, for example gas and electricity equipment checks.

We recommend the provider reviews the support needs of each person living at 49 Regents Park to ensure that at all times there are sufficient staff with the knowledge, skills and experience to meet people's needs safely.

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Requires improvement

Is the service effective?

Our findings

We were given a copy of the provider's training matrix that showed there were 12 staff who regularly worked in 49 Regents Park. Of these, three staff held relevant qualifications in care, while nine staff held no relevant qualification. All staff had received training and regular updates on all required health and safety related topics. One staff had received training on autism in the last year and more training was planned for four staff on this topic. One staff had received training on non-abusive psychological and physical intervention, and more training was planned for the future for a further four staff. One staff had received recent training on epilepsy and also epilepsy medication, although training on this topic was planned for four staff in the future. This meant that a high number of staff had not received training on topics relevant to the support needs of the people living at 49 Regents Park.

Staff told us they had received a good range of training. They said "We do lots here." They were keen to do as much training as possible. One staff was in the process of completing a nationally recognised qualification in care, and the other staff said they hoped to sign up for this training in the near future. However, one staff said felt they would have benefitted from more training on autism and challenging behaviour at the start of their employment.

Staff told us they had received training on safeguarding adults, but had not yet received training on the Mental Capacity Act 2005 (MCA) or Deprivation of Liberty Safeguards (DOLS) although they were aware this training had been booked for the near future. The training records showed three staff had received this training.

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

Staff told us they were well supported by their team leader who provided regular supervision. They told us new staff received supervision every week until their probation period was completed, and from then on supervision was received every six weeks.

Staff were knowledgeable about people's individual support needs. They described how one person liked meeting new people. Another person enjoyed shopping trips. They also explained each person's daily routines such as getting up, going to bed, sleeping and eating. They also described each person's likes and dislikes.

One person's care plan described behaviour that may cause upset to other people living in the home. The staff told us these behaviours had decreased and were not a problem. The staff respected the behaviour. They also encouraged the person to go to their room when they displayed behaviours that were upsetting to others. However this restrictive practice had not been agreed under Mental Capacity Act 2005 (MCA) or best interests. The MCA provides the legal framework to assess people's capacity to make certain decisions at a certain time.

Before this inspection took place checks were carried out through the safeguarding adult's team that showed that no DOLS applications had been submitted for people living at 49 Regents Park. The provider was advised to submit applications where applicable. Deprivation of Liberty Safeguards (DoLS) provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. The provider gave assurances that these would be completed as a matter of priority. During this inspection we were assured by the registered manager that in the previous few days they had submitted applications for each person. This was needed because people were unable to leave the home without staff support.

Before our inspection a relative raised concerns about the food provided to one person and had been concerned the person was losing weight. The provider told us they considered the person needed to lose weight and that the weight loss had been the result of a healthy eating plan. However, this healthy eating plan had not been agreed with the person or been part of a best interest decision.

The manager showed us evidence that people were weighed regularly and the weights were monitored to ensure people maintained a healthy weight. During our inspection one person asked for biscuits but staff refused. We asked why the biscuit was refused and staff explained they were told they must follow the 'programme'. They described how the person had recently shown signs of weight gain. They restricted the amount of unhealthy foods such as crisps and biscuits to help the person maintain a

steady weight, and therefore the person was limited to two biscuits with their drink at supper time. This restrictive practice had not been agreed or evidenced through a multi-agency best interest process.

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

People were able to make choices about their main meals and drinks but were not always offered a choice of puddings. Fresh fruit was available in the dining room. The main meals were varied, although included some shop-bought meals such as pies and pizzas which staff heated, rather than homemade meals. People took packed lunches with them to the day centre. One person told us they had curry for their evening meal that day. Other meals they enjoyed included cottage pie, sausage and chips or burger, chips and beans. Roast meals on Sundays were home cooked. Staff told us they sat down with people on a Sunday and helped people choose the menu for the following week using picture menus.

A member of staff told us the food budgets were good and they always had plenty of food stocks. However, when we looked at the records of money spent by staff on behalf of people we saw people had purchased items such as packets of jellies, cakes and Angel Delight. We spoke with the provider about this and they told us if people wanted extras or 'treats' such as puddings or cakes they were expected to purchase these out of their own personal money. This meant that, although people were offered a variety of main meals, they were not offered a varied choice of pudding courses. The purchases of jellies and Angel Delight showed that people would request a pudding course if this had been offered.

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

During our visits people were offered drinks regularly and staff encouraged people to help prepare the drinks where they were able to do so safely.

Reports were completed by staff about each person regularly throughout each day. The report sheets had been specially printed for each person to include any tasks specific to their needs. The reports were bound in monthly books that provided a complete record of the person including risks assessments. The reports covered all aspects of each person's daily routines and provided good information about their health and welfare, the activities they had participated in, times of getting up and going to bed, the foods they had eaten, and their mood. The reports showed that each person's health and wellbeing had remained stable, and they were happy and contented.

Support plans provided information about each person's medical conditions including signs and symptoms and how it affected the person. The plans also explained each person's communication methods, including sign language such as Makaton, or use of pictures to help them express their needs. However, not all staff had the skills or training to use sign language effectively.

We spoke with the registered manager about the systems they followed for recording health appointments and making sure appointments were not missed. The manager told us there had been a misunderstanding a few months earlier over annual influenza inoculations. They also told us some appointments such as dental appointments had been offered at times that were not suitable for some people, for example one appointment had been offered for 8am. They told us they planned to improve the systems for recording medical appointments to ensure these are not missed in future.

We looked around the house and found all areas were well maintained and homely. Bedrooms were bright and attractively decorated to reflect individual interests. All areas were comfortably furnished. The people living at 49 Regents Park were able to move around safely without the need for adaptions or specialist equipment.

Good

Is the service caring?

Our findings

During our visits we saw staff interacting with people who lived there in a caring and empathic manner. For example, we saw a member of staff supporting a person who wanted to go to bed at 7pm. The staff explained this was the person's own choice and we saw they recognised the person's non-verbal signs that they wanted to go to bed. A member of staff offered the person support to go to their bedroom in a patient and friendly manner.

One person told us the staff were kind. They talked about the staff they liked, for example "I like (staff) – she is nice – gives you things you want." They also talked about other staff who shared interests with them such as hair and beauty magazines. They described the things they did not like doing and how staff supported them with their choice not to do certain things. They also described the support they received from staff to choose new clothes and how they enjoyed shopping trips. They said "I like living here."

Staff were able to describe each person's likes and dislikes and individual personalities. For example they told us that one person "Likes things done in a certain way." They explained how important it was that new staff got to know each person and the things that were important to them. This helped people to remain calm and happy.

People were supported to keep in touch with their families. One person told us about visits to stay with their family. We also heard how another person received regular visits from members of their family.

A key worker system was in place. This meant each person had a member of staff who ensured their needs and preferences were known and respected by all staff.

Each person had their own individual bedroom where they could spend time in private if they wished.

Daily reports completed by staff were factual and non-judgemental and showed staff understood each person's needs and were meeting these in a caring manner.

Requires improvement

Is the service responsive?

Our findings

People living at 49 Regents Park had not been fully consulted or involved in planning a care service that met their individual needs. Care plans were in place and we were told these had recently been reviewed and updated. However, some information remained out of date. For example, two care plans contained information about people's behaviour that may have caused problems for themselves or others around them. Staff told us the problems had improved but this had not been reflected in their care plans. This meant there was a risk that new or inexperienced staff may not understand each person fully and may not know how to respond or support people appropriately when they showed signs of agitation, or behaviours that may cause upset.

Care plans had not been drawn up in formats that supported people to be involved in the process. Some photographs were used, but plans were otherwise drawn up using text. This meant that people who were unable to read did not have access to information about their care and support needs in a format they were able to understand. We spoke with the provider and the registered manager about the care plans. They told us they were aware the care plans needed updating and they were in the process of carrying this out urgently. They planned to introduce a new electronic system of recording all information using tablet and desktop computers. They expected this to take a little time to implement and they planned to run both systems of care planning and recording until the new system is fully established. They also told us they planned to give people greater involvement in the care planning process by incorporating more photographs and symbols into the plans.

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

Staff told us about the activities people enjoyed doing. The provider ran a day centre which people attended on weekdays. The day centre provided a range of activities including arts and crafts, cookery, animal care, and a cinema. One person told us they had recently decided they did not want to attend the day centre and preferred to stay at home instead. They told us the staff team leader has said "That's ok (you) can do what you want." They told us about other things they enjoyed doing instead, such as shopping trips and outings. However the staff had not explored the reasons behind this person's decision to n longer attend. Choice?? for people to go elsewhere for social engagement?

Support plans provided information about the activities each person enjoyed and the places they liked going to, including activities during the evenings and weekends. These included pub trips and walks in the local area. At the weekend people enjoyed group outings to places such as Dawlish and Seaton. People also enjoyed sitting in the back garden in warmer weather.

Where possible people and their families were encouraged to participate in house meetings. Satisfaction surveys had been sent out to all families in December 2014 to gather their views of the service. The registered manager told us that responses had not been received from every family member. However, the completed surveys we were shown included positive comments such as "Very satisfied" and "Extremely positive." The registered manager told us families, visitors and staff have been encouraged to use the CQC website to view Regents Park's reports and use the "Share your experience" section where people were encouraged to give their views on the service.

One person told us if they had a complaint they knew who to speak with. Other people who used the service were unable to make formal written or verbal complaints but we were assured by the staff we spoke with they would recognise signs that people were unhappy. The complaints procedure was displayed on the notice board in the kitchen.

Staff told us they were confident they would recognise any signs of distress and these would be reported to their line manager, the registered manager or the provider. They told us they could raise concerns or opinions during staff meetings. They told us they were confident any issues they raised would be resolved.

Requires improvement

Is the service well-led?

Our findings

The home was not well-led. The home was managed by a person who was registered with the Care Quality Commission as the registered manager for the service. This person also managed two other care homes owned by the provider.

During our inspection we found the registered manager was not fully aware of some issues or concerns relating to the home, for example the manager was unaware of the risk of medical appointments being missed.

We spoke with the registered manager about the provision of meals. They told us they were unaware of some of the decisions that had been made by the provider, for example the decision not to provide a pudding course after the main meal. This meant there was a lack of communication between the manager and provider. This also indicated the management roles and decision making procedures between the provider, registered manager and team leaders were not clearly defined or fully effective.

We asked how they monitored the service to make sure all aspects were running smoothly. Daily reports completed by staff which contained detailed information about and monitoring checks on their health and welfare were returned to the provider's main office each month where they were checked by the manager and provider. The provider visited the service regularly and took a keen interest in each person's welfare. The provider carried out informal monitoring of the service and had a good awareness and close involvement with all aspects of the day to day running of the service. However, there was no overall quality assurance system in place to show how the provider and manager monitored the quality of the service.

We heard that a team leader provided supervision and support to the staff team. However, staff told us they only saw the registered manager "as and when we need him". This meant that the registered manager relied on reports by team leaders and checks on records rather than direct involvement in the service or observation of care provided.

Since the last inspection no notifications of serious incidents had been submitted to the Care Quality Commission. Staff told us there had been no serious accidents or incidents since the last inspection. We spoke with the registered manager who told us they were unaware of the need to submit notifications of accidents or incidents. They told us they will ensure these are submitted for any future accidents or incidents.

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

Staff meetings were held regularly and these were a useful opportunity to share information or discuss any issues. Staff said the meetings were helpful and gave them opportunity to discuss individuals and their support needs. They were able to make suggestions for changes or improvements to the service.

After the inspection the manager told us they planned to improve communication and monitoring procedures through the introduction of new computer equipment for staff to record all information relating to the day-to-day running of the houses.

We recommend that the provider reviews the management of service and the roles of the management team to ensure there are clear job descriptions and job specifications for each member of the management team including the registered manager.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).** People's care was not person-centred. Care needs including potential risks to their health had not been fully assessed, monitored or reviewed and people had not been fully consulted or involved in drawing up or agreeing how their care needs should be met. **Regulation 9(3)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).** People were not offered a choice of food that met their needs and preferences as far as reasonably practicable.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).** The registered manager failed to evaluate and improve their practice, or ensure they were aware of all changes in legislation and good practice recommendations relevant to the services people received. The provider has failed to establish clear and effective management systems and monitoring of the service that meets the changing needs of people who use the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People were not fully consulted and their consent was not gained before care and treatment was provided.
	Regulation 18(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014). Staff had not received appropriate supervision, support, training or professional development to enable them to carry out the duties they were employed to perform.