Ocean Community Services Limited

Cherry Tree House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Cherry Tree House provides accommodation and personal care for up to 11 people. At the time of our visit there were 10 people living at the service. The service had one room reserved for a person however the transition was on hold.

At the previous inspection carried out on 17 September 2016 we rated the service as good and did not identify any breaches in regulation. At our inspection on 30 and 31 October 2018 we found that the registered provider was in breach of multiple regulations 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.

There was not a registered manager in post. A new manager had started and was in the process of completing their induction. They planned to apply to CQC to be the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

Why we have rated this service as Requires Improvement?

Medicines were not managed safely. We identified discrepancies and recording errors with the medicines system.

Risks had not always been assessed and the appropriate action was not always taken to minimise the risk of harm to people and staff.

Staff were not being supported within their role. Staff did not receive supervision and guidance within their role.

When restraint had been used debriefs were not carried out by staff. Documented debrief information, and detailed clear recording and support are used to learn from the incident and to ensure that restraint has been used legally, appropriately and safely.

The home was not always caring which had affected the wellbeing of people. They did not receive continuity of care which was important to their needs. There was a lack of respect and regard of the person's needs.

There was a lack of effective leadership in the home and the staff did not feel supported. The provider did not have insight into what was going on in the home and this led to multiple breaches of regulations.

Quality assurance systems were not effective to assess and monitor the quality of service people received

and identify any areas that required improvement.

People were protected from the risk of infection. Staff understood the importance of infection control and prevention.

We received mixed feedback about staffing levels at the home. Appropriate checks were made before staff started to work to make sure they were suitable to work in a care setting.

Staff received training to develop the skills needed to care for people effectively. People told us they enjoyed the meals and we saw staff offered people hot and cold drinks throughout the day.

People's care was provided in line with the Mental Capacity Act and staff understood the importance of seeking appropriate consent for care and treatment.

People were encouraged to attend appointments with other health care professionals to maintain their health and well-being.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks to people and staff were not always assessed. . When risks had been identified we found lack of evidence of actions taken to prevent further harm.

Staff did not always maintain accurate and complete records. We found discrepancies with the medicines system and found this was not safe.

Staff understood their individual responsibilities to report any suspected or witnessed abuse.

We received mixed feedback about staffing levels at the home. New staff were recruited safely.

Is the service effective?

Requires Improvement

This service was not always effective.

Staff did not receive supervision to support them to effectively carry out their role.

When restraint had been used the provider did not complete a debrief with people or staff.

Staff received sufficient training to enable them to effectively meet people's individual needs.
The principles of the Mental Capacity Act (2005) had been adhered to. The appropriate assessments of people's capacity had been undertaken.

People were supported to have enough to eat and drink.

Is the service caring?

Requires Improvement

The home was not always caring.

There was a lack of dignity, respect and regard towards people's needs.

Staff were caring towards people and offered them reassurance when they were distressed.

People's rooms were personalised with photos and items of furniture in their rooms.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff did not always carry out the care that people had been assessed to receive.

People were supported to participate in activities, in line with their interests and preferences. Improvements were being made to the activity's provided to people within the home.

There was a complaints procedure in place and people were informed about how to make a complaint if they were dissatisfied with the care provided

Is the service well-led?

Requires Improvement

The service was not always well led.

There was not registered manager in post which was a legal responsibility for meeting the requirements of the Health and Social Care Act 2008.

There was a clear lack of leadership and staff did not feel supported. There had been multiple failings in the running of the home.

Systems in place to monitor and improve the quality and safety of the home were not effective.

Cherry Tree House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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.

We undertook a comprehensive inspection at Cherry Tree House on 30 and 31 October 2018. Prior to this inspection concerns were raised with CQC about the home. We shared our concerns with the local authority. We used the information as intelligence to help us plan this inspection. This involved inspecting the service against all five of the questions we ask about services: is the service safe, effective, caring, responsive and well-led.

The inspection was unannounced. This meant the staff and the provider did not know we would be visiting. The inspection was carried out by two adult social care inspectors.

Prior to the inspection we looked at the information we had about the home. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We had not requested the provider to complete the Provider Information Record (PIR) before the inspection. This is a form that asks the provider to give information about the home, tells us what the home does well and the improvements they plan to make.

We contacted seven health and social care professionals as part of our planning process and invited them to provide feedback on their experiences of working with the home. We received a response back from two professionals. However, this was not direct feedback about the home. We met and spoke with four people who lived at the home. We also spoke with the relatives of one person.

We spoke with seven staff which included the area manager, manager, team leaders and support staff. We looked at the care records of four people living at the service, three staff personnel files, training records for all staff, staff duty rotas. We looked at other records in relation to safeguarding, complaints, mental capacity and deprivation of liberty, audits and accidents and incidents.

Requires Improvement

Is the service safe?

Our findings

Prior to the inspection concerns had been raised about the complex needs of people living at the service. One of the concerns raised was that staff did not feel safe. The staff on duty when asked told us they did not always feel safe. Staff told us this was due to the risks posed by the complex needs of some of the people they supported.

Staff told us they had been assaulted by some people. One staff member told us that one person 'goes for their neck to strangle them'. Another staff member told us, "You have to be careful around X they can erupt". They told us X had gone to a pub with staff and had smashed glasses. One staff member told us that X was not suitably placed at the home. There were two agency nurses who supported one person at all times. Staff told us this was for safety reasons and because the person could make threats towards staff as well as allegations about them. We were told by staff they were being injured almost daily by some people they supported. On the first day of our inspection we were told one person was unsettled and agitated. We asked staff if there were any safety issues at the start of our visit that we needed to know about. Staff told us when we started our visit to 'be careful around certain people'. They told us one person had bruised an agency member of staff's arm by pinching them. The same person had scratched another member of staff across their chest just hours after. Other injuries to staff included being spat at and hit. We discussed this with the area manager who told us they were looking to reassess a further two people as their needs were not being met at the home.

We looked at the care records of the person who would try and strangle staff. The person would reach to grab staff by their neck when physically expressing their needs. Staff told us that the person was known to 'come up behind you' and could 'grab and sometimes try to strangle you'. We checked risk assessments for this person and found this information was not included within their risk assessments. This meant there was a risk of serious harm towards staff and other people. Risk assessments should contain information setting out how to reduce the risk of the person causing harm to others. We brought this to the attention of the area manager who told us they would ensure this was put into place.

Medicines were not always managed safely. Some prescription medicines were controlled under the misuse of drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs. We looked at the home's controlled medicines record book and we identified a number of discrepancies. The provider was storing and recording medicines as a controlled drug for a number of people. However, the controlled book did not tally up with the actual amount of stock within the cabinet. For one person the record book stated there were 24 ½ tablets in stock which had been double signed. We found in the cabinet an extra bottle which contained 28 tablets. This meant the total number of stock should have been 52 ½ tablets and not 28. Records for another person showed they should have had 70 tablets in stock. However, 13 tablets had been given to the person's family as they had gone to stay with them. The 13 tablets had not been signed out of the medicines system by staff so there were 57 in stock. Another person was prescribed just in-case medicine to be given by a pre- filled syringe. The medicines book recorded that they had 6mls of the medicine in stock. However, within the medicines cabinet we found further pre-filled

syringes for the person that had not been entered into the medicines system. This meant the total balance should have been 14mls and not 6mls. The medicines system was unsafe.

These were breaches of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People were not able to tell us if they felt safe living at Cherry Tree House, due to their communication needs. People were supported by staff who had received appropriate training and understood how to recognise and report signs of abuse or mistreatment. Safeguarding and whistleblowing policies and procedures were available for staff to access and safeguarding was regularly discussed with staff. Staff were aware of the procedure for making appropriate alerts to the local authority regarding people's safety.

There were suitable systems to protect people from the risk of cross infection. Records showed that the provider had assessed, reviewed and monitored that good standards of hygiene were maintained in the home. We found the home was clean and had a fresh atmosphere. We noted that soft furnishings, beds and bed linen had been kept in a hygienic condition. Staff recognised the importance of preventing cross infection. Prior to our inspection we were told that staff did not have access to blue aprons and gloves when carrying out food preparation. We checked the main kitchen and found that this was in place and available for staff. Staff supported people with their meals and had received training in food hygiene. Staff were aware of good practices when it came to food preparation and storage.

Comprehensive health and safety checks and maintenance of the building and equipment were undertaken. Health and safety checks of the premises had been completed to ensure the home was well maintained and any risks to people's health and safety were identified and addressed. Fire drills had been carried out, testing of the fire alarm and equipment were completed weekly by the maintenance person. The local fire service had inspected the home in December 2015, no concerns were identified at the inspection. Other maintenance records checked included water temperatures, electric and gas supply. Systems were in place to ensure the home kept up to date with annual safety checks in relation to fire safety equipment.

The provider used a staffing assessment tool to calculate the number of staff needed to support people each shift. Most people the home supported required either one to one or two to one care. This ratio increased when people went out of the home to three to one or two to one due to people's complex needs. The provider had a high turnover of staff. Staff we spoke with told us that staff retention was an issue. The provider was in the process of recruiting into 12 full time support staff roles. The area manager told us that four new staff were due to start their induction which would ease some pressure. Agency staff were being used to cover any shortfalls and permanent staff picked up extra shifts. We were told that the agency staff being used knew the home well and the needs of the people they supported. We received mixed feedback from staff when we asked them about staffing levels at the home. Comments included, "We use regular agency staff that know people well. However, we try and allocate them with people who are not so complex" and "I feel we have enough staff but could always do with more. We could then apply for more funding to take people out more". Another comment included, "I am told we have enough staff. I have not witnessed any shortfalls. The area manager told us that one person was commissioned by the local authority. This was for two to one care to be delivered by agency staff only. The person was waiting to move to another home. The area manager also told us that the team leaders also helped to support people.

The provider continued to have recruitment systems in place that aimed to protect people from the risks of unsuitable staff being recruited. Recruitment files showed that an enhanced Disclosure and Barring Check (DBS) had been completed. The DBS check ensured that people barred from working with certain groups of people such as adults who were vulnerable would be identified. We saw that the process included

completion of an application form, an interview and two references including a previous employer to assist in assessing the candidates' suitability for the role. Other checks such as identification, availability to work in the UK and a medical questionnaire were also completed. These processes were completed prior to a person starting work at the home.

Requires Improvement

Is the service effective?

Our findings

Staff on duty told us that they usually supported people with very complex challenging needs for a whole shift. This meant at least six hours supporting people with no break for the staff member which was confirmed by the team leaders. This conveyed a lack of suitable support for the staff if they were not able to have regular breaks from people whose behaviours could be and often were very challenging.

People were supported by staff who did not receive supervision and guidance in their role. Supervisions are meetings with a line manager which offer support, assurance and learning to help staff to develop in their role. We asked staff and the team leaders if they received supervision. We were told by the team leaders that this was not being carried out and that this was one of the issues at the service. Staff we spoke with told us, "I have not had any supervisions since being here. I even had to ask for my probation meeting to take place", "No, I have not had any supervision's and I do not feel very supported in my role. Senior managers do not listen" and "Since one of the managers left things have slipped and the lack of staff support is one of the issues here". We were told by staff and senior staff that no supervisions had taken place for quite some time. We asked to look at the minutes from staff meetings. We were shown the minutes from a staff meeting held on 20 June 2018 and a team leader meeting held on 15 June 2018. No other meetings had taken place. The area manager told us they looked to hold a staff meeting within the next few weeks. This had had a negative impact on morale within the home as staff did not feel supported.

These were breaches of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked staff if restraint was practiced at the home. Staff told us on occasion physical restraint was used as a last resort. We asked to see the review processes for debrief after the use of restraint. We asked for the plans for staff and people who receive support and documentation of debrief occurring. Staff told us currently that a verbal debrief took place but this was not recorded. This was confirmed by the area manager. This meant there was potentially an unlawful use of physical restraint at the service. Documented debrief information, and detailed clear recording and support are used to learn from the incident and to ensure that restraint has been used legally, appropriately and safely.

These were breaches of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We were contacted by a whistle blower before this inspection who raised concerns that staff were having to lock the sensory room door with themselves and one person in the room. We were told that this was because the person had complex needs which the staff were struggling to meet. Prior to this inspection we raised a safeguarding alert to the local authority to advise them of the concerns. The provider was therefore already aware of the concerns raised. We spoke to staff about what had happened and we were told this was not done maliciously. The staff told us when the person was distressed the two-staff supporting the person would often become exhausted. The person had high energy levels and would become frustrated. They told us if they were in the sensory room staff had locked the door to try and calm the person. They

recognised that this was not the appropriate thing to have done. As a result, from the concern being raised the area manager told us the lock to the sensory room had been removed. We checked this had been removed. The staff were working with the local authority safeguarding team and commissioners to look at if this was the appropriate placement for the person.

New staff attended a two-week induction at head office before they started working in the home. The induction introduced staff to the aims and objectives of organisation and included mandatory training. New staff then shadowed more experienced staff for a further two weeks. We observed senior staff showing an agency staff member around the home at the start of their shift.

People were cared for by staff who had completed training in subjects which were relevant to their needs. We saw a training matrix which highlighted that staff had completed training in subjects which the provider considered necessary. For example, understanding autism, positive behaviour support training (Positive Behaviour Support (PBS) is a person-centred approach to supporting people who display or are at risk of displaying behaviours which challenge), safe moving and handling theory and practice, fire safety, equality and diversity, food hygiene awareness, infection control, health and safety awareness, and safeguarding.

At this inspection we checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DOLS). We saw seven DOLS applications which had been approved by the local authority. We also saw that one other DOLS application had been submitted but not yet been approved as they had been deemed a low priority by the Local Authority. There was correspondence which demonstrated that the service had followed up these applications appropriately.

The Mental Capacity Act provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so themselves. When people lack this capacity, any decisions made on their behalf must be in their best interests and as least restrictive as possible. We saw notes of a meeting where the best interests of a person were considered by a group of people including someone who was their appointed representative. This was in relation to dental treatment that one person required in their best interests. The staff we spoke with told us this had been a positive meeting. This focussed on how best the professional could support the person with the necessary treatment.

Menus showed people were offered balanced choices at meal times. Since the last inspection the home had changed its food production process to cook and chill. Staff we spoke with told us people enjoyed the food which appeared nicely presented. We were told food tasting sessions had a great influence about menu choices. Staff told us people's dietary requirements were catered for along with their individual choices. The area manager spoke positively about change over to a cook and chill process. People had access to drinks throughout the day. The service had two kitchens which were kept locked. This was to keep people safe away from appliances and to protect them from items that could cause injury. We observed people in the kitchen with staff preparing a snack and drink.

People's care records contained information about their dietary needs along with likes and dislikes. People's nutritional needs were assessed and kept under review. People's care records contained information about people's nutritional intake and the support they needed. Staff we spoke with told us in the past advice had been sought from the dietician or the speech and language therapist (SALT).

Care records evidenced referrals had been made promptly to a range of health professionals when people's needs had changed or they had become unwell. This included doctors, dentists and the community learning disability team. Staff told us they responded to people's needs in a timely manner, especially those related to their health and wellbeing. During the inspection staff supported one person to attend a hospital

appointment. Another person attended a dental appointment with the support from staff.

Requires Improvement

Is the service caring?

Our findings

Staff told us one person benefited from going for long walks and drives into the country. This person needed two staff to support them in the home and three staff in the community. Staff told us this person found crowds and other people generally too challenging. On the first day of our visit we saw two staff members supporting the person for the whole shift. The person appeared highly agitated and they were unsettled walking around the home pacing corridors with the staff trying to calm them. The staff that looked after the person were caring, calm and patient. The person concerned often 'grabbed' at other people as a form of expression. Both inspectors experienced this form of physical communication several times during our visit. Although the staff were caring in their approach towards the person we were told the person was unsettled due to them not going out for their morning drive. This was not caring and affected the person's wellbeing during the day. They were not given their daily continuity of care which was important to them as an individual. This was due to a lack of organisation of the shift by senior staff. There was lack of respect and regard of the person's needs.

These were breaches of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed staff were caring and supported people using attentive, warm and kind approaches. We saw this evidenced in many ways. For example, staff used a calm approach with people who were anxious and agitated in mood. Staff also used gentle humour, encouragement and distraction techniques with people. Most people responded positively to staff when they used this approach.

One relative we spoke with told us the staff were kind and caring however there was a very high turnover of staff. This had impacted on their relative because they got to know staff well and then they had left. They told us their relative was disturbed at night by the person who lived in the next flat. They had asked for soundproofing of the flat so that their relative could sleep better at night. This was being explored by the area manager who had met with the relative.

One agency staff member told us, "I like it here the staff are all very nice and so caring". Another agency staff member told us it was a privilege to work with the team. They told us they were referring to the team of staff who directly supported people with their needs.

Each bedroom was a single room and this gave people privacy. Rooms had been made to look more personalised. People had art work, photos and items of furniture in their rooms. Bedrooms were also decorated different colours to reflect the tastes of the person who occupied the room.

Requires Improvement

Is the service responsive?

Our findings

People's care records were comprehensive however staff did not always carry out the care that people had been assessed to receive. An example being was that one person had been assessed to have their observations taken twice daily. This included taking their blood pressure, oxygen levels and temperature. This was clearly recorded within their care plan which gave instructions for staff to follow. It was recorded if the person's oxygen levels fell below 92% then advice from the GP was to be sought. This was to be taken so that staff could monitor the persons health and wellbeing. We asked to see the separate observation chart in place which staff used. A senior staff member told us this was not being carried out as they were unsure why they had to take this. They told us the person was non-compliant as they wanted to stay in bed. We were shown a blank chart and were told previous records had been archived. We could not see any documentation within the person's daily records that staff had attempted to take observations. Advice had not been sought from professionals about the difficulties that staff had in taking this. Some care records may not have been a true reflection of people's need as they had not been reviewed regularly. Care records were to be reviewed monthly by staff however one person's care records had only been reviewed in January, June and October 2018. Another person's care records had not picked up changes in the person's behaviour. This meant there was a risk that the person was not receiving the care and support that they needed.

These were breaches of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the concerns we found with people's care records, staff we spoke with were familiar with people's needs and through discussion, demonstrated they knew the support people required. One staff member told us, "I work with the same people and know everything about them. I know what makes them happy and how to motivate people".

On the second day of the inspection we observed two people baking cakes in the kitchen with staff. As it was Halloween people were wearing dressing up hats. Staff interacted well with people who appeared to enjoy the activity. Later, in the day a Halloween party had been planned with party food and activities for people.

We looked at how people were spending their time and if the provider was meeting people's social, cultural and recreational needs. People living at the home participated mainly in one to one activity's due to their needs. We were told this was often going out for walks, shopping and participating in individual hobbies. The environment within the home did not provide enough sensory stimulation to meet people's needs. This had already been picked up by the area manager. They told us plans were in place to bring in sensory items into the home with some items on order. They planned to revamp the sensory room for people. The estates manager was currently assessing if one person could have a low-level trampoline in the garden. A guitar had also been ordered for the person as they enjoyed music therapy.

Complaints were listened to and dealt with in line with the homes complaints policy. The complaints policy had last been reviewed in June 2017. The policy outlined the time frame that complaints were to be

acknowledged, investigated and an outcome achieved by. The home had received one formal complaint. As a result of the complaint raised action was taken to resolve the issue. The complaint was about the use of the mobility car and having a screen behind the driver. The area manager told us a screen had been placed within vehicles and the complaint was resolved.

Requires Improvement

Is the service well-led?

Our findings

Staff told us the home was not well-led, morale was poor and there was a lack of leadership . They told us, "Things went downhill since the registered manager left in April. We have basically been left to pick up the pieces with no leadership or direction", "We have all spoken up as we feel the standards have dropped here. The home has not been managed and we need more help and support". We spoke to the area manager about the shortfalls we had identified within the home and about low morale of the staff. They told us it was unfortunate that the previous registered manager had left. They were also in the process of looking at the needs of the people they supported. This was because some people living in the home had a range of very complex needs that were challenging to meet and could be inappropriately placed.

Audits of the home had been carried out by the quality and development manager on 15 June 2018 and 19 September 2018. They had spoken with staff and people who lived at the home. Other areas focussed on included a review of complaints, staff training, random checks of people's care records and checks of the environment. The audit tool used was not effective. The provider had failed to focus on other key areas which may have led them to take necessary action. Examples included the management of medicines, accidents and incidents and safeguarding.

During the inspection we identified shortfalls with regulations that had not been recognised or addressed. This included concerns in relation to keeping people and staff safe by assessing risks, medicines were not managed safely, staff were not supported and had not received supervision, debrief meetings were not carried out after restraint was used, people's needs were not respected, people did not always receive the appropriate care and support and the provider did not have a registered manager in post which was a condition of their registration. The provider was not driving improvements and had failed to take the appropriate action to address the shortfalls of regulations. The lack of leadership of the home had led to multiple failings.

These were breaches of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was not 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 of the Health and Social Care Act 2008. At the time of the inspection a new manager had just been recruited and they were completing their induction. The service was being supported by the area manager who visited twice monthly and spoke to senior staff daily. A manager from one of the provider's other services had also been supporting the home. The home had not had a registered manager since April 2018. Another manager was previously in post after the registered manager had left. They had applied to register with the CQC however they left the service.

We spoke to senior staff about celebrating the achievements of staff. The supporting manager told us that at this time no staff awards or achievement system was in place. The area manager told us when the new manager was fully in post they wanted them to put a system in place to boost staff morale.

The ratings from the previous inspection had been displayed in the entrance hall of the home and on the provider's website. The display of ratings is required by us to ensure the provider is open and transparent with people who use the service and their relatives and visitors to the home.

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 Staff did not always carry out the care that people had been assessed for. Care records were not always reviewed. (9) (1) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect This provider was not always caring which impacted on people's wellbeing. There was a lack of respect and regard of people's needs.10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service did not always assess the risks to people and staff's health and safety. Risk assessments were not always in place to manage the risks to people and others. Medicines were not managed safely. 12 (2) (a), (b), (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Review processes which included a debrief after the use of restraint was not carried out. This meant unlawful restraint may have been

used 13 (2) (4), (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Audits were not effective and had not identified the shortfalls we found at the inspection. The leadership from the provider was not driving forward improvements. (17) (1) (2) (a) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not supported and did not receive formal supervision 18 (2) (a).