

# Blue Opal Limited

# The Meadows

## Inspection report

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### Ratings

#### Overall rating for this service

Requires Improvement



Is the service safe?

Inadequate



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

We visited the service on 7 and 9 October 2014 and the visit was unannounced. At our inspection in July 2013 we found issues with care plans and risk assessments, training and support for staff, a lack of effective systems to identify, assess and manage risks to people and record keeping. These were followed up in October 2013 and February 2014 and improvements had been made.

The Meadows provides accommodation with personal care and support for up to 14 people with complex needs who have a learning disability and/or mental health issues. At the time of our visit there were eight people receiving a service from The Meadows

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

# Summary of findings

providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

People felt safe and supported by staff but could not confirm they felt safe with other people living at the home. Staff did not know how to raise concerns if abuse was suspected and did not have up to date safeguarding training. However, although staff could not say who to report to outside of the organisation, they were aware of the safeguarding policy and procedure which they would follow if the need arose and understood what might constitute abuse.

There were not enough staff to safely support people to go out in their local community.

Staff felt, and records showed, very limited staff training had been undertaken, in respect of people's specific and complex needs.

Care plans were not personalised to show how people's pasts had impacted on them and what their likes, dislikes and preferences were. They lacked evidence that they had been completed with the people living at The Meadows. Daily records were often incomplete and task orientated. When significant comments had been documented, there was no evidence these had been followed up.

Staff did not understand the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) and how they applied to their practice. For example, the actions they would take if they felt people were being unlawfully deprived of their liberty and how to keep them safe.

The registered manager showed us a comprehensive action plan they had formulated and was actioning, which picked up all the concerns outlined in this report. For example, people's needs were in the process of being reviewed by health and social care professionals, staff were being recruited to manage staff shortages and existing staff training being updated.

They spoke about their plans to embed a vision and values in the service. These were to be centred around the people they supported to ensure they felt respected and empowered to lead fulfilled lives.

People felt well cared for by staff and relationships were caring and supportive. Staff offered care that was kind and compassionate.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this 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?

The service was not safe.

People confirmed that they felt safe and supported by staff but could not confirm they felt safe with other people living at the home.

Staff did not know how to raise concerns if abuse was suspected and did not have up to date safeguarding training. However, although staff could not say who to report to outside of the organisation, they were aware of the safeguarding policy and procedure which they would follow if the need arose and understood what might constitute abuse.

There were not enough staff to safely support people's access to the local community.

People's individual risks were identified and the necessary risk assessments were carried out to keep people safe.

People's medicines were managed so they received them safely.

Inadequate



### Is the service effective?

Some aspects of the service were not effective.

Staff felt, and records showed, they had received very limited training in respect of people's specific complex needs.

Staff did not understand the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) and how they applied to their practice. For example, the actions they would take if they felt people were being deprived of their liberty and how to keep them safe.

People were supported and encouraged to eat and drink, however there was evidence that people were not being encouraged or supported to have a healthy diet.

People were positive about the staff's ability to meet their needs.

People were able to see appropriate health and social care professionals when needed to meet their healthcare needs.

Requires Improvement



### Is the service caring?

The service was caring.

Interactions between people and staff were good humoured and caring.

Staff treated people with dignity and respect when helping them with daily living tasks.

Good



# Summary of findings

Staff relationships with people were caring and supportive. For example, staff spoke confidently about people's specific needs and how they liked to be supported.

Through our observations and discussions, we found that staff were motivated and inspired to offer care that was kind and compassionate.

## Is the service responsive?

Some aspects of the service were not responsive.

Care files did not include a history of people's pasts which would have provided a timeline of significant events which had impacted on them.

Care plans, although written as if the person had been involved in their development lacked evidence that they had been completed with the person.

Daily records were often incomplete and task orientated. Many of the entries contained basic comments, such as a description of what a person had eaten and what had been done. When possible significant comments had been documented, such as a change in mood, there was no evidence how these had been followed up.

Activities were limited for people. This was strongly linked to availability of staff to support people to undertake activities away from the home.

There were opportunities for people and people that matter to them to raise issues, concerns and compliments.

**Requires Improvement**



## Is the service well-led?

Some aspects of the service were not well-led.

A comprehensive action plan had been formulated, which picked up all the concerns outlined in this report. For example, people's needs were in the process of being reviewed by health and social care professionals, staff were being recruited to manage staff shortages and existing staff training being updated.

A monthly audit was completed by the registered manager. This was conducted on an on-going basis to monitor the quality and safety of the service provided.

There was evidence that learning from incidents and accidents took place and appropriate changes implemented. Incident reports showed that events had happened in the past and had appropriately been referred to the local authority and the Care Quality Commission notified.

Staff confirmed they attended staff meetings and felt their views were taken into account by the new manager.

The registered manager spoke about their plans to embed a vision and values in the service. These were to be centred around the people they supported to ensure they felt respected and empowered to lead fulfilled lives.

**Requires Improvement**



# The Meadows

## 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.

This inspection took place on 7 and 9 October 2014 and was unannounced.

The inspection team consisted of two inspectors and a specialist advisor who had experience of learning disability services.

Before the inspection, the provider completed 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 also reviewed the information we held about the home and notifications we had received.

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

We spoke with five people receiving a service, five members of staff, the registered manager and the provider's representative. We reviewed three people's care files, three staff files, staff training records, a selection of policies and procedures and records relating to the management of the service. Following our visit we sought feedback from health and social care professionals to obtain their views of the service provided to people. We received feedback from five professionals, which included a social worker and consultant psychiatrist.

# Is the service safe?

## Our findings

People said they felt safe and supported by staff but they also said that they did not feel safe with other people living at the home. Comments included; “If staff are not in the lounge, I feel I can’t close my eyes, just in case another service user comes and pulls my hair”, “I would prefer to live on my own as I don’t get on with the other people. One person pulls my hair and attacks staff”, “I feel safe with the staff” and “The staff keep me safe.” We did not see any evidence of people being harmed by others during our visit to the service.

We spoke with the registered manager about the comments raised by people. They explained how people’s safety was being managed. Measures had been put in place to keep people safe. For example, having staff present in the lounge, recruiting more staff and where a person was distressed they were being supported away from the lounge. In addition, care reviews were being arranged to ensure people’s needs could be met at The Meadows. Following our visit we raised our concerns with the local authority.

Staff did not know how to raise concerns if abuse was suspected. For example, they were unclear who to contact outside of the organisation if they had a concern, such as the local authority. However, although staff could not say who to report to outside of the organisation, they were aware of the safeguarding policy and procedure which they would follow if the need arose and understood what might constitute abuse. Some staff told us that they had not received safeguarding adults training whilst others said they had, but their records had not been updated. Records showed four staff had received up to date safeguarding training and the registered manager had completed advanced level training. We raised our concerns with the registered manager who explained that they had recognised that staff did not have up to date safeguarding training. They explained that all staff were to receive safeguarding training by the end of October 2014 as a matter of priority and this had already been planned.

The registered manager demonstrated a clear understanding of their safeguarding role and responsibilities. They explained the importance of working closely with commissioners, the local authority and relevant health and social care professionals on an

on-going basis. Records showed they were in the process of arranging a review of people’s care plans with other health professionals to ensure the service could maintain people’s safety.

Staffing levels were not sufficient to ensure that people could go out into their local community more than once a week. People had a designated day out per week and normally the service was able to accommodate this. However, when people requested an unscheduled trip out such as to go shopping or to the local pub, these were not usually possible because it would reduce the number of staff in the home to an unsafe level. One person commented: “There are not enough staff to escort people outside the home”. Another person told us they would like to do craft work, go out to the club/disco or do some cooking, but they tended to watch television all the time due to low staffing levels within the home to fulfil their requests. A member of staff told us a person had expressed a wish to attend a religious institution, but there were no staff to assist with this wish or even explore more of this person’s spiritual needs. The lack of activity outside of the home, due to inadequate staffing levels, impacted on people’s ability to lead a meaningful and fulfilled life which met their individual needs.

We asked staff what the current staffing levels were within the home. They explained that at a minimum, four staff were required to be on duty during the day and two at night. If people were to be supported to undertake activities both inside and outside the Meadows, at least five members of staff were required to be on duty. Skill mix was an on-going factor which was considered to ensure senior staff were always on shift to support newer members and to run the service safely. Rotas confirmed staffing levels were maintained at the levels described to us by staff.

The registered manager explained that to fully staff the home so that people could undertake activities both in and out of the home, six staff members were needed during the daytime, plus another three staff from 9am to 5pm. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People’s individual risks were identified and the necessary risk assessments were carried out to keep people safe. For example, risk assessments for managing challenging behaviours, physical health, medicines management and going into the local community. Risk management

## Is the service safe?

considered people's physical and mental health needs and showed that measures to manage risk were as least restrictive as possible, such as the use of distraction techniques when a person was becoming distressed.

There were effective recruitment and selection processes in place. Staff files contained application forms and interviews had been undertaken. In addition, pre-employment checks were done, which included references from previous employers, health screening and checks by the Disclosure and Barring Service (DBS). The provider was in the process of recruiting staff, with some new appointments just awaiting clearance from the Disclosure and Barring Service.

People's medicines were managed so they received them safely. Appropriate arrangements were in place when obtaining medicine. The home received people's medicines from a local pharmacy on a monthly basis.

Medicines were kept safely in a locked medicine trolley. The controlled drug cupboard was correctly managed in line with relevant legislation. Where a person was prescribed a controlled drug the relevant recording book had been completed accurately and signed by two members of staff. The stock of controlled drugs corresponded with the number identified in the recording book, which showed a clear audit trail.

Medicines were safely administered. The medicines records were appropriately signed by staff when administering a person's medicines. When the home received the medicines from the pharmacy that they had been checked in by staff and the amount of stock documented. Additional checks had been put in place by the home to ensure that people received the correct type and dose of medicines. For example medicines were dispensed by two members of staff, with one dispensing and the other witnessing the procedure.

# Is the service effective?

## Our findings

People were positive about the staff's ability to meet their needs. Staff told us they had received training on core subjects including first aid, food hygiene, moving and handling, medicine management and physical intervention. We were told that sometimes physical intervention was needed to ensure the safety of people when a person was displaying behaviours which challenged. Staff confirmed that they had received physical intervention training accredited by the British Institute for Learning Disabilities (BILD). This showed that staff were using up to date evidence based interventions to protect the people in their care. However, they had received very limited training in respect of people's specific and complex needs. For example staff had not received training in mental health and learning disability awareness, Mental Capacity Act (2005) (MCA), nutrition and hydration, equality and diversity and the management of diabetes. Staff expressed concerns about the level of training provided to ensure they could carry out their roles competently and confidently. For example, how to support people with mental health issues. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We raised our concerns with the registered manager who explained that they had not been able to find records of the specialist and core subject training undertaken by staff. The registered manager and the provider's representative told us that they were planning to provide training to staff to enable them to support people with complex physical and mental health needs.

Some staff had completed, and others were working on, induction training when they started work at the home. The induction required new members of staff to be supervised by more experienced staff to ensure they were safe and competent to carry out their roles. The induction formed part of a three month probationary period, so they could be assessed for their competency and suitability to work for the service.

Staff had received supervision and appraisal of their work, with the last supervision being in July 2014 conducted by the previous management team within the home.

Supervision and appraisal of staff are important ways to support effective practice and good conduct and supporting staff to address deficiencies in their performance.

Staff did not understand the MCA and Deprivation of Liberty Safeguards (DoLS) and how they applied this in practice. Staff were unsure what actions they would take if they felt people were being unlawfully deprived of their freedom to keep them safe. For example, preventing a person from leaving the home to maintain their safety. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty.

The provider had not considered or assessed people who may be at risk of being deprived of their liberty. Seven of the eight people had not had a mental capacity assessment to consider whether they were being deprived of their liberty in any way. This meant that their freedom was restricted as they required staff to support them to leave the home and there were times when there were not sufficient staff to fulfil people's wishes. There was no supporting evidence of how people's capacity to consent to restraint or restricted access to outside had been assessed and whether any best interest discussions or meetings had taken place. For example, restraint was used at times for a person's own safety and the front door had a key code to prevent certain people from leaving the home unescorted. One person had been appropriately assessed in line with the MCA, but the other seven had not. The registered manager had identified that people needed mental capacity assessments and possible DoLS authorisation. They were in the process of liaising with relevant health and social care professionals for these assessments to take place at the earliest opportunity. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were supported and encouraged to eat and drink. Staff cooked the main meals within the home. People were offered one main meal and if they did not want this, the alternative was a sandwich. This did not allow people to have choice about their dietary intake. We found limited assessment of people's risks associated with nutrition,



## Is the service effective?

putting them at risk of weight related health problems. One person had taken the decision to adopt a healthier diet to help them lose weight. However, we did not see evidence of people being encouraged to eat healthily to aid their physical wellbeing. Health and social care professionals had been involved in the past due to concerns about people's weight and the impact on their physical health. For example, how a person's diet impacted on their physical health. We raised our findings with the manager, who acknowledged that no one had a healthy eating plan and this needed to be addressed. They added that people were to choose the menu during weekly resident meetings and then how the food was cooked would be adapted to ensure it was low in fat and sugar. People were in the process of having their health and social care needs assessed, with diet being one of the areas to be reviewed.

People were able to see appropriate health and social care professionals when needed to meet their healthcare needs. Health and social care professionals were involved in people's care on an on-going basis. For example, people had had appointments with a GP and consultant psychiatrist. People did not have Health Actions Plans. A Health Action Plan holds information about a person's health needs, the professionals who support those needs, and their various appointments. The plan is based on a full health check that is kept under constant review. The registered manager was arranging reviews for people with their care managers to ensure their needs could be met.

**We recommend that the service considers the Department of Health guidance on the use of 'Health Action Plans.'**

# Is the service caring?

## Our findings

We spent time talking with people and observing the interactions between them and staff. Interactions were good humoured and caring. Interactions within the lounge involved everyone present to ensure no one was left out. Staff involved people in their care and supported them to make decisions. Comments included: “The staff are nice. I like chatting with them about my favourite things”; “They (the staff) care about me” and “I am going to the cinema later and having fish and chips to follow.”

Staff treated people with dignity and respect when helping them with daily living tasks. Staff told us how they maintained people’s privacy and dignity when assisting with intimate care, for example by knocking on bedroom doors before entering and gaining consent before providing care. Staff adopted a positive approach in the way they involved people and respected their independence. For example, one person made specific plans for their day out and went out with two members of staff that afternoon to the cinema. Staff supported people in a kind and empathetic way. Staff showed an understanding of the need to encourage people to be involved in their care. For example, how one person wished staff to talk with them about things which interested them.

Staff relationships with people were caring and supportive. For example, staff spoke confidently about people’s specific needs and how they liked to be supported. Staff were

motivated and inspired to offer care that was kind and compassionate. For example, staff spoke about how working as a team motivated them and how they gained inspiration from each other. Staff were observant to people’s changing moods and responded appropriately. For example, we heard a member of staff supporting a person who was upset. The member of staff supported them in a caring and calm manner by talking with them about things which interested them and made them happy.

Staff were involving people in their care through the use of individual cues, and looking for a person’s facial expressions, body language and spoken word. For example, when supporting a person with personal care. Staff gave information to people, such as what time their trip out was due to take place. People’s individual wishes were acted upon, such as how they wanted to spend their time within the home. However, the same did not apply when they wanted to go out due to how it impacted on staffing levels within the home.

Staff showed a commitment to working in partnership with people. Staff spoke about the importance of involving people in their care to ensure they felt consulted, empowered, listened to and valued. They recognised that care plans needed to include people’s involvement and were committed to ensure these plans were updated. Staff were able to speak confidently about the people living at The Meadows and each person’s specific interests.

# Is the service responsive?

## Our findings

Care plans reflected people's health and social care needs and demonstrated that other health and social care professionals were involved. However, the personalisation of care plans was limited. For example, people's likes, dislikes and preferences were not documented.

Care files included personal information and identified the relevant people involved in people's care, such as their GP. However, they did not include a history of people's pasts which would have provided a timeline of significant events which had impacted on them. There was very little evidence of people's likes and dislikes being taken into account, although, one person's file stated they liked particular activities.

People's care plans included information relating to their physical and mental health, personal care, medicines and behaviour. However, although they were written as if the person had written them, they lacked the evidence they had been completed with the person. For example, we did not see how people were involved in the planning of their care to show their agreement. The registered manager acknowledged that people's involvement in care planning had been limited and how the documentation could apply to anyone as the wording was similar for everyone. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Daily records were often incomplete and task orientated. For example, sections were struck through or left blank. Many of the entries contained basic comments such as a description of what a person had eaten and what had been done. When possible significant comments had been documented, but there was no evidence how these had been followed up. For example, one entry stated that one person seemed sad, but there was no explanation as to why this might have been so. Another entry stated kept

hearing voices in head and they were not saying nice things. Records did not show that this had been explored with the person or that any action had been taken as a result to ensure people's needs. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We raised our findings with the manager, who acknowledged that care files and daily records needed to be improved. They recognised people needed to be more actively involved in planning their care and support and a more personalised approach and recording needed to be implemented by staff.

Activities were limited for people and this was largely attributed to the availability of staff. People had a day out per week. However, the home was often not able to respond positively to people's unscheduled requests to go out, for example, shopping, to attend groups or go to the pub. Staff told us that at times trips were offered to people, but these had been declined. We found limited recording where a person had declined these, so staff would not be able to monitor people's involvement preferences.

There were opportunities for people, and people that matter to them, to raise issues, concerns and compliments. The complaint's policy set out the procedure to be followed by the provider and included details of the provider and the Care Quality Commission. An easy read complaints procedure had been made available around the home for people to refer to. This ensured people living at The Meadows were given enough information to help them raise concerns. Where complaints had been made, these had been appropriately followed up and actions taken to resolve the issues. For example a social care professional had raised concerns about the cleanliness and condition of a person's bedroom. The registered manager responded promptly, by implementing a daily checklist of all rooms to ensure utilities and fixtures were in good order.

# Is the service well-led?

## Our findings

The registered manager showed us a comprehensive action plan they had formulated and was actioning, which picked up all the concerns outlined in this report. For example, people's needs were in the process of being reviewed by health and social care professionals, staff were being recruited to manage staff shortages and existing staff training being updated. Staff spoke positively about the registered manager and said they felt well supported and reassured that things were changing for the better in the home.

The manager had recently registered with the Care Quality Commission, which is a legal requirement. Health and social care professionals provided us with feedback about the home. They expressed that their main concern was the management instability that had been evident over a period of time. They felt reassured that the new registered manager was competent and able to improve the overall support and running of The Meadows. They told us they had already seen improvements, with the registered manager liaising appropriately with key professionals and taking steps to action areas which needed improvement. For example, arranging care reviews and mental capacity assessments for people using the service.

People and staff spoke positively about the registered manager. Comments included: "I like (the manager), he's nice"; "The manager is approachable and I feel I can raise any concerns without fear" and "The manager is really supportive and is proactive in addressing things, such as care and support for people and training for staff."

Surveys had been completed by people using the service, relatives, health and social care professionals and staff in January 2014. However, an action plan which addressed issues raised by the survey could not be found to inform our inspection. The registered manager was planning to send questionnaires out to key people by the end of October 2014 in order to address any issues in line with the values and behaviours of the organisation. They also planned to add a resident's comments section to the daily observation records and regular key worker sessions to be implemented to increase people's involvement in their care and support.

A monthly audit was completed by the registered manager and had been in the past by the previous manager. This

was conducted on an on-going basis to monitor the quality and safety of the service provided. Areas covered included care files, risk management, medicines management, staffing arrangements, including training and support, incidents and accidents and health and safety. The most recent audit completed on 1 October 2014 outlined all the concerns we had identified during our inspection. The registered manager had developed a comprehensive action plan to address the concerns promptly. Some of the actions had already been completed, for example an easy read complaints procedure had been developed and was displayed around the home. Care reviews were being set up with relevant health and social care professionals involved in people's care.

Weekly information sheets had been completed and forwarded to the provider. These provided a summary of any specific events which had taken place. For example, accidents and incidents and staff related issues. These enabled them to keep up to date on events at The Meadows and for them to address any areas of concern. Both the weekly information sheets and monthly audit helped inform their visits to the home. We saw evidence of these visits, with the most recent being in September 2014. These visits involved meeting with people living at the home, speaking with staff, reviewing records and assessing the overall environment on the home. The visit in September 2014 documented that the atmosphere in the home was a lot more positive with people and staff interacting well with each other.

There was evidence that learning from incidents and accidents took place and appropriate changes implemented. Incident records and actions had been taken in line with the organisation's policies and procedures. Incident reports showed that events had happened in the past and had appropriately been referred to the local authority and the Care Quality Commission notified. The registered manager explained that they reviewed incident and accident forms and followed these up with staff. They told us if incidents were out of character for people, staffing levels would be reviewed and debriefs would take place with people and the staff supporting them. The Provider Information Return (PIR) completed by the registered manager outlined their plans to review incidents and accidents so they fed back more into developing people's support plans.

## Is the service well-led?

Staff confirmed they attended staff meetings and felt their views were taken into account by the registered manager. Areas covered included daily observation sheets being introduced and staffing levels and plans for the future discussed to ensure staff remained up to date and knew what was expected of them when carrying out their roles. Resident meetings had increased since the appointment of the registered manager. These were now happening on a weekly basis to ensure people were able to voice any concerns or suggestions to improve their experience of living at The Meadows.

The registered manager spoke about how they were planning to embed the visions and values of the service. These were to be centred around the people they supported to ensure they felt respected and empowered to lead fulfilled lives. They explained the methods to be used to achieve this. For example, support plans underpinned by legislation and best practice guidance and through job descriptions, supervision of staff and staff meetings. Staff supported the registered manager's visions and values, by stating that it is about encouraging choice and people taking control of their lives.

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 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	<p>Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing</p> <p>Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing.</p> <p>There was not enough suitably qualified, skills and experienced staff to safeguard the health, safety and welfare of people.</p> <p>Regulation 22</p>

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff</p> <p>Regulation 23 HSCA (Regulated Activities) Regulations 2010 Supporting workers.</p> <p>Staff were not appropriately trained and supported to enable them to deliver care and treatment to people safely and to an appropriate standard.</p> <p>Regulation 23 (1) (a)</p>

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment</p> <p>Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment.</p> <p>There were not suitable arrangements in place for obtaining, and acting in accordance with, the consent of people in relation to the care and treatment provided to them.</p> <p>Regulation 18</p>

This section is primarily information for the provider

## Action we have told the provider to take

### Regulated activity

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services

Regulation 17 HSCA (Regulated Activities) Regulations 2010 Respecting and involving people who use services.

People, or those acting on their behalf were not encouraged to express their views as to what was important to them in relation to the care or treatment.

Regulation 17 (2) (c) (ii)

### Regulated activity

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records

Regulation 20 HSCA (Regulated Activities) Regulations 2010 Records.

People were not protected against the risks of unsafe or inappropriate care and treatment because of a lack of accurate records being maintained.

Regulation 20 (1) (a)