The Disabilities Trust

Gregory Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Gregory Court on 11 September 2018. The service is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Gregory Court provides personal care and accommodation for up to 10 people living with a physical disability and some people have a learning disability. It is one of a number of homes run by the charity The Disabilities' Trust. The service is a predominantly a single storey building, and has 10 flats within it, each of which has an ensuite bathroom and a kitchen area. All of the flats, with the exception of one, are on the ground floor. On the day of our visit, eight people were living at the service.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen." Registering the Right Support CQC policy.

At the last inspection in January 2016, the service was rated 'Good' in all the key questions. At this inspection, we found the fundamental care standards were not being fully met, resulting in the rating for the service changing to 'Requires Improvement.'

At the time of our inspection there was a registered manager in place and present during the day of the inspection. A registered manager is a person who has been registered with the Care Quality Commission (CQC) to manage the service. Like registered providers they are "registered persons". Registered persons have the legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how the service is run.

Staff had not consistently followed recommendations made by an external a healthcare professional and this had impacted negatively on a person's health.

Risks associated with people's needs had not always been effectively assessed. Information to guide staff of how to manage risks lacked detail or was not consistently followed. The system used to monitor accidents and incidents and consider lessons learnt, were not being used effectively to ensure risks to people were reduced.

The management of medicines did not follow national best practice guidance. Two staff signatures were not used consistently for transcribing hand written entries. Medicines were not always dated when opened and there was no stock balance record kept, to audit medicines were being managed safely. The checks in place for infection control, had not identified equipment that was not in good order, impacting on cleaning and causing a risk of cross contamination.

People were protected from the risk of abuse as far as possible because staff had received safeguarding training and followed the provider's policies and procedures to protect them. The deployment of staff required reviewing to ensure staff were effectively used. The provider followed safe staff recruitment checks.

Staff received an induction and ongoing training, but had not received regular opportunities to formally review their work, training and development needs at the frequency the provider expected. Training opportunities did not fully cover people's care needs is relation to their health conditions.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the provider's policies and systems in the service supported this practice. People's capacity to consent to their care and treatment had been considered where required.

People received a choice of meals and their nutritional care needs had been assessed and planned for, but information available to guide staff was not consistently documented. The internal and external environment met people's individual needs.

Staff were aware of people's needs, routines and what was important to them. Staff were kind, caring, and they supported people ensuring their privacy, dignity and respect was met. Independence was encouraged and supported. Information about independent advocacy services was available.

People's care plans were not consistently detailed. Staff were aware of people's needs but there was a risk new staff, would not have sufficient written information to provide responsive and effective care and support. People's diverse needs had been assessed and were met, this ensured people did not experience any discrimination.

Improvements were being made to the social activities and community opportunities available for people. The provider's complaint policy and procedure had been made available to people who used the service. However, this was not available in alternative formats to support people's communication needs. People's end of life wishes in relation to their care and support had been discussed with them but staff had not received end of life training.

People received opportunities to share their views about the service they received. The systems and processes in place to check on quality and safety, identified the fundamental care standards were not being fully met and an improvement plan was in place that showed what had been completed and what further work was required.

During this inspection we found one breach of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Information about risks associated with people's needs was not sufficiently detailed or up to date. The system to monitor accidents and incidents were not used consistently.

Medicines were not managed in accordance with nationally recognised best practice guidance.

The deployment of staff required reviewing to ensure it was fully effective in meeting people's care needs.

Infection control prevention and control measures were not fully effective.

Safeguarding procedures were in place and used by staff when required.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's healthcare needs were not effectivity managed and recommendations made by healthcare professionals consistently followed.

Staff had not received training that fully reflected people's care needs. Staff had not received supervisions and appraisals at the frequency the provider expected.

People received a choice of meals and their needs had been assessed with eating and drinking.

People lived in an environment that met their needs and safety.

People's rights had been considered in line with the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

Staff were kind and caring in how they supported people.

People were involved as fully as possible in their care and treatment and independent advocacy information had been made available.

People's privacy and dignity were respected by staff and independence was promoted.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The information and guidance to support staff to provide a person centred approach in the delivery of care lacked detail in places.

Improvements were being made in social activities and community opportunities people received.

People had access to the provider's complaint procedure, but this was not available in alternative formats to support people's different communication.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The fundamental standards in care were not being fully met but the provider's action plan showed what improvements had been made and what was still required.

People received opportunities to be involved in the development of the service. Staff were consulted in their experience of working at the service.

Gregory Court

Detailed findings

Background to this inspection

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

This comprehensive inspection took place on the 11 September 2018 and was unannounced. The inspection team consisted of two inspectors.

To assist us in the planning of the inspection, we used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We sought the views of the local authority care commissioners who support people to find appropriate care services, which are paid for by the local authority or by a health authority clinical commissioning group. We also contacted Healthwatch Nottingham, who are an independent organisation that represent people using health and social care services. We also reviewed information that we held about the service such as notifications. These are events that happen in the service that the provider is required to tell us about.

During the inspection, we spoke with four people who lived at the service, to gain their views about their experience of the care and support they received. We also spoke with a visiting community nurse. We spoke with the registered manager, assistant manager, the cook, two care staff and two team leaders. We looked at all or parts of the care records of four people and checked that the care they received matched the information in their records. We also reviewed other records relevant to people's care and the management of the service. This included medicines, staffing, and complaint records, management audits and policies.

After the inspection, we contacted two relatives and two external professionals for their feedback about the service. We received information from one relative.

Requires Improvement

Is the service safe?

Our findings

Accidents and incidents were not consistently reviewed and action taken to reduce further risks. The provider had an electronic system called datix, used by staff to record all accidents and incidents. These were informed by the completion of body maps used to record bruises, marks and skin tears. Datix records were reviewed by the registered manager and senior staff within the organisation to review what action had been taken to reduce further risk. We found four body maps that were not recorded on datix and there was no record to confirm what action had been taken to reduce further risks to people. For example, one body map had recorded marks on the person's skin was due to incontinence wear incorrectly fitting the person. However, no action had been taken such as discussing this with the community nurse. This meant the procedures in place to report and review accidents and incidents for lessons learnt and action were not fully effective.

Risks assessments associated with people's care needs did not consistently provide staff with guidance of how to provide safe care and support. This was due to either not being updated to reflect changes in care needs or guidance lacked detail. For example, one person's professional health notes stated a visiting healthcare professional in June 2018, had introduced food and fluid supplements to a person's diet, due to risks with weight loss. Whilst staff were aware of this and the supplements were available, this person's care plan and risk assessment had not been updated to reflect this change in need. We also noted that this person did not receive a morning drink as per the instruction from the community nurse. This meant staff had insufficient recorded and up to date information, on people's care needs which could put them at unnecessary risk.

Another person's care records stated the person was vulnerable to financial abuse. However, there was no risk assessment that provided staff with guidance of what this meant and what support was required. We discussed this with the registered manager who told us they were not aware this was a risk. This showed guidance provided to staff was insufficiently detailed or incorrect that could impact on people's safety.

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

Individual plans were in place to support people in the event of an emergency requiring people to be safely evacuated from the service. For example, in the event of a fire. Safety checks were completed on the internal and external environment and premises, including equipment. This included fire, health and safety and the protection from legionella. This is bacteria that can be found in the water supply and can cause serious illness.

People told us they had their needs met at the times they required. People wore pendants or wrist alerts, to call for assistance when required. A person told us that staff responded promptly when they requested staff support. Another person said, "In general there's enough staff, but if someone is ill they don't always get cover." A relative said, "It is our experience that staffing levels are appropriate."

Staff told us they felt an additional member of staff was required. A staff member said, "We need two people to support people to go out and two left in the building." The management team told us they had assessed staffing levels were sufficient for the current care needs of people. New staff were also being recruited with the addition of domestic staff, which would reduce the amount of time care staff were required to complete domestic tasks. The management team told us they provided care support when required. Staff told us they did not always request this support, but acknowledged they could ask for management support. We observed people received support from the staff team when required. We considered people's care needs and the role and responsibilities of the staff team. We concluded there were sufficient staff employed, but the deployment of staff needed to be reviewed. Communication between the staff team and management team also needed to be improved upon.

People's medicines were not consistently managed. For example, hand written entries of prescribed medicines instructions on medicine administration records (MARs), were not routinely signed by two staff. This is recognised good practice to help ensure accurate transcribing and reduce the risk of a medicines administration error. Liquid medicines were found to have not been dated when opened. This is important because these medicines have an expiry date once opened. There was no system that could monitor the stock balance of medicines, to ensure medicines were being administered and managed correctly.

People told us they received their medicines at regular times and we observed people received their medicines safely and in the way their care records stated they preferred. Staff responsible for the management of people's medicines had received appropriate training and competency assessments.

Infection control risks had not been managed effectively. For example, we identified a person's toilet seat had a tear in the waterproof fabric. This was a concern as it could cause an infection control risk because the effectiveness of the cleaning was compromised. Cleaning schedules and the management team's daily walk around that included health and safety checks, had not identified this. We discussed this with the management team who agreed to take action to have the toilet seat replaced and to ensure their checks were more robust.

Staff were aware of the prevention and control measures in place to manage infections and cross contamination. This included the use of wearing aprons and gloves when required and having good hand hygiene. People and visitors had access to liquid soap, paper towels and hand hygiene posters were on display advising of the importance of hand washing.

The provider had robust staff recruitment procedures in place. Checks were carried out on potential staff's identity, their work history and whether they had a criminal record that would prohibit them from working with vulnerable people. This contributed to keeping people safe.

People told us they felt safe living at Gregory Court. A relative also confirmed they felt their relation was cared for safely. Information about how to report safeguarding concerns had been made available to people. This meant people were aware of what action they could take, if they had concerns about their safety. Staff told us they completed safeguarding refresher training and were aware of the provider's safeguarding procedures. We were aware when safeguarding allegations and incidents had occurred, staff had taken appropriate action in reporting these to external agencies and CQC. This meant people were protected from the risk of harm or abuse.

Requires Improvement

Is the service effective?

Our findings

People did not consistently receive the care and treatment they required, to manage known health care needs. For example, one person's health condition and mobility needs, meant their skin was vulnerable to developing pressure sores. At the time of our inspection, this person had a pressure sore. A visiting community nurse told us the person's pressure sore had deteriorated. They were concerned a contributing factor to this, was that staff were not consistently following their recommendations in the care and treatment required by the person.

This person's pressure care, care plan and risk assessment, detailed the frequency staff were required to reposition the person. During the day this was every two hours and whilst in bed four hourly. However, the pressure relief care record showed staff were not consistently following the recommendations made. For example, the three days prior to our inspection showed gaps of up to five hours between being repositioned and on one day, nothing was recorded after 11am. In addition, this person's eating and drinking care plan stated they were required to have six to eight cups of fluid a day. People's fluid intake is particularly important in the management of pressure care, as a precautionary measure of pressure sores developing and or, in the healing process of a pressure sore. This person's fluid intake record did not inform staff what recommended level of fluid was required. For three days prior to our inspection, the fluid intake record was inconsistently completed and showed the person had not received the recommended fluid intake. This meant we could not be sufficiently assured this person was receiving the care and treatment they required and recommended by external healthcare professionals.

This person had a history of developing pressure sores and in May 2018 the provider identified staff were required to receive pressure care management training. The registered manager told us they had trouble in sourcing this training and had provided staff with a DVD on pressure care management to view. Information fact sheets had also been provided as an additional method to support staff's knowledge. It was identified by staff training records, talking with staff and the management team, that staff had not viewed the DVD as required. This showed a lack of accountability by staff and the management team, in meeting this person's needs effectively.

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

The staff training plan identified by the provider as required, did not reflect the healthcare needs of people using the service. For example, training did not include learning disability and mental health awareness or health conditions such as multiple sclerosis and alcohol dependency. We found staff were aware of people's routines and what was important to them, but their understanding of health conditions were variable. This meant the provider had not provided staff with training and support to meet people's needs effectively.

Staff received an induction and opportunities to review their work, training and development needs. However, staff records did not show staff had received meetings at the frequency the provider had identified as required. Neither were there annual appraisals to confirm staff had received a review of their

performance. Staff told us they felt communication from the management team could be improved upon. They reflected on the different management styles of a recent manager no longer in post, and the current management team. This showed inconsistences in the support provided to staff that could impact of how people's care needs were met.

People told us they had a choice of meals and drinks and we saw the cook offered people a choice of breakfast and lunch, drinks were also served throughout the day of our inspection. One person said, "The meals are lovely." The cook told us the menu was based on people's preferences and was reviewed with them and changed accordingly. A person confirmed this by saying on a Friday the menu was fish, but they had steak instead. The resident meeting records dated May 2018 confirmed people were consulted about their preferences. The menu was presented with pictures of meals available, to support people with any communication needs. Food stocks were in good supply and stored in accordance with food hygiene standards.

Two people were at risk of choking due to swallowing difficulties and we saw staff provided support that matched the guidance in the person's care records. One person required food supplements due to concerns with weight loss. These were seen to be available and staff were knowledgeable about how these were given. However, information in the kitchen of people's specific support needs in relation to eating and drinking did not clearly reflect information in their care records. This meant new staff or agency may not fully understood people's support needs. We discussed this with the management team and after our inspection, they forwarded us information that confirmed what action they had taken to address this.

Independence was promoted using adapted crockery or cutlery, such as the use of lipped plates and plate guards. We noted a person ate independently and the cook told us this could take between 30 to 60 minutes to complete. We were concerned that no consideration had been made in to ways of keeping the food warm. After discussion with the cook they told us they would follow this up.

People's care needs in relation to their physical, social and mental health needs had been assessed. The registered manager told us assessments were informed by the provider's policies and procedures that were in line with current legislation and best practice guidelines. Assessment of people's diverse needs included the protected characteristics under the Equality Act 2010 and these were considered in people's care plans. For example, the adaptation and design of the service met people's physical needs and preferences. People did not experience any discrimination due to their mobility needs. Corridors were sufficiently wide enough for people to use their wheelchairs independently. People had electric doors to their flat to aid easy access and the kitchenette work surfaces, were lowered to meet people's physical needs. Ceiling track hoists were in place in people's flats to support them with their transfers from their wheelchair to bed.

Important information was shared across organisations to ensure people's needs were known and understood by others. For example, NHS Hospital Passports', were used to record and share information with ambulance and hospital staff, about a person's health and social care needs in their ongoing care.

Staff understood and followed the Mental Capacity Act 2005 (MCA) when required for people's care. The MCA provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. At the time of our inspection the management team told us people could consent to their care. Where concerns had been identified about people consenting to specific decisions, this had been assessed and concluded

people did have mental capacity. The registered manager was aware of the importance of regularly reviewing people's ability to consent.

Good

Is the service caring?

Our findings

People received consistent care from all staff who were kind, caring and promoted their dignity and rights. People told us they liked the staff that cared for them. One person said, "I like the staff." Another person said," I love it – living here." A third person described the staff as, "Always helpful."

A relative spoke very highly of the staff. Comments included, "We find staff at all levels at Gregory Court are compassionate, caring and competent, and they work hard to cater for my relation's complex and changing needs, in terms of their mental, emotional and physical needs." This relative was also positive about communication and being kept informed of any changes.

Staff were knowledgeable about people's needs, routines and what was important to them. From people's interactions with staff and their laughter and light-hearted exchanges, it was apparent people were relaxed and comfortable in the company of staff and positive relationships had been developed.

Throughout our inspection we saw staff treated people with respect and ensured their dignity and rights when they provided care. This included protecting people's privacy and dignity by closing doors or speaking quietly with people in communal areas. Staff supported people's choices and preferred daily living routines. For example, in relation to meal choices and how they chose to spend their time. We saw a person requested to have a cigarette and a staff member made themselves available to support the person.

Staff supported people to maintain their independence. Some people could access the community independently and came and went as they pleased, with no restrictions placed upon them. They could gain access in and out of the building independently without relying on staff. Some people did their own laundry with minimum support from staff.

People were involved in their care. People had monthly meetings with their keyworker. This is a staff member that has additional responsibility for a person using the service. This gave the person an opportunity to discuss the care provided and to review their care plan for any changes that were required. For example, one person's monthly keyworker meeting showed there had been a discussion about social activities which they had enjoyed in the past and they were asked if they would like to try them again. A relative told us they were confident their family member was fully involved in their care. Comments included, "We have witnessed the patience of staff in explaining matters to my relation, and equally important making sure that they have fully understood what had been said to them."

People were informed of how to access independent advocacy services if they needed someone to speak up on their behalf. Information about people's needs were treated confidentially and in line with the General Data Protection Regulation that states how personal information should be managed.

A relative told us they had no restrictions of when they visited their relation. Comments included, "Gregory Court has told us that we are welcome to call in at any time, and this open-door policy is evident, whenever we visit. We have encountered no restrictions on visiting."

Requires Improvement

Is the service responsive?

Our findings

The level of detail about people's life history and other important information was inconsistent. This is important information for staff to be aware of to support them in providing individualised care. Whilst staff we spoke with understood people's needs and preferences, the concern was that new staff, would not have a consistent understanding of people's needs based on the written information available. The provider used a document referred to as 'Things I would like you to know about me'. One person's document included helpful and informative information. However, another person's document was blank. However, staff signed a record to confirm they had read and understood what was recorded. This was a concern because staff had not reported the document was blank. This showed a lack of accountability of staff and that the checks in place on record keeping was not effective.

The management team told us they were aware that social and community activities needed to be improved upon. The assistant manager showed us a file they had started to develop that identified different community activities available for people that were based on people's interests and hobbies and opportunities they may wish to try. The management team also told us they had plans to explore volunteer opportunities for people. This showed a commitment in developing an increase in meaningful activities and opportunities for people.

The service was in a short distance to community facilities. One person told us how they liked to go to the local supermarket with staff. Another person told us how they enjoyed gardening and how they had taken some responsibilities in the upkeep of the garden that had raised beds with flowers. They also told us they attended a community pottery class. Another person attended a community day service and another person enjoyed going swimming. Within the service there were a good selection of arts and crafts and board games. On the day of our inspection a staff member was seen to organise a game of dominoes which people enjoyed. Other people were seen to being sewing, one person was using their iPad. Some people accessed the community independently. Staff told us that some people were supported to go on holiday, but this was dependent on people's personal finances.

People's religious and cultural needs had been assessed and planned. For example, one person attended a weekly place of worship. Staff were aware of how this person's religious faith was important to them and they acknowledged and respecting their wish for bible study. People's preferences in relation to their daily living routines, such as when they liked to bath or shower, go to bed and get up was recorded and known by staff.

A staff member told us about people's different communication needs, this included a person whose speech was significantly impaired due to their health condition. They said how the person used a 'speech image booklet' to support them to communicate their needs. However, we did not see staff support the person to use this. Neither were we informed about this communication tool when we engaged with the person about the care they received. This meant we were not sufficiently assured that people were fully supported with their communication needs. The provider was therefore not meeting the Accessible Information Standard. This standard expects providers to have assessed and met people's communication needs, relating to a

person's disability, impairment or sensory loss.

People told us they felt confident to raise any concerns with the staff. A relative told us, "We have been made aware of how to make a complaint. If we have had any infrequent concerns, these have been addressed promptly and effectively, to our complete satisfaction and to my relations benefit."

The provider had a complaints policy but this was not available in alternative formats such as large print or easy read. The registered manager said they would ensure it was provided indifferent accessible formats. One complaint had been received in the last 12 months and this had been responded to in a timely manner and in line with the provider's complaints procedure.

We saw an example that a person's end of life care wishes had been discussed with them. The registered manager told us some people had refused to discuss their wishes. However, the registered manager was aware of the importance of this information. The staff training plan did not include end of life care, this meant this gap in training could impact on the quality of care people received at the end stage of their life.

Requires Improvement

Is the service well-led?

Our findings

The service had been managed by a different manager for a period during 2017 and 2018, due to the registered manager being on a break from the service. This had some impact on the effectiveness of how the service was managed, due to a difference in leadership styles. Staff were not clear about their role and responsibilities and this impacted on their accountability. Communication between the management team and staff team was fragmented impacting on the service people received. However, this had already been identified prior to our inspection by the management team. Action was in place to develop the staff team in understanding fully, their role and responsibilities. Improved communication systems had also been implemented but further time was required to be fully imbedded for improvements to be sustained.

It was also apparent from viewing the internal systems and processes that monitored the quality and safety of the service that the care standards were not being consistently met. The audits and checks completed in June and July 2018 by a members of the provider's senior management team and quality assurance team, showed where improvements had been made and what further actions were required. From discussions with the management team, it was apparent they were fully aware of the action required to make improvements and had plans in place to complete this work. Where this inspection identified new shortfalls to the management team, following our inspection they forwarded us an action plan detailing what they had done to make improvements. We were therefore sufficiently assured the provider and registered manager, had oversight of the service and had a commitment to develop the service in fully meeting the care standards people should expect.

People were positive about living at the service and told us they were happy with the level of care they received and the environment they lived in. A relative gave positive feedback about how the registered manager managed the service. Comments included, "The registered manager leads in an effective and thorough manner, ensuring that the ethos of compassion and care associated with Gregory Court is upheld." Additionally, they said, "My relation thinks highly of them as a kind, friendly person on whom they can depend and to whom they can go, if necessary."

People who used the service, relatives and staff were invited to share their experience about the service. The results of the 2017 survey for people who used the service was presented in a poster with the title 'you talked, we listened'. An example of action taken in response to feedback included, the menu being reviewed to take account of people's preferences and the purchase of inhouse arts, crafts and games. The outcome of the staff survey completed in 2018 resulted in an action plan that the registered manager told us was being developed.

People who used the service were also invited to participate in regular resident meetings, used by the registered manager as an additional method to seek the views about the service people received. Examples of people being included in the development of the service was in relation to the refurbishment plan. People were also informed of any changes such as staffing.

The provider had submitted written notifications to the Care Quality Commission when required to do so,

about important events that happened at the service. We saw policies and procedures were in place and these were regularly reviewed, to make sure they met with legislation and relevant national guidance for staff to follow. It is a legal requirement that a provider's latest CQC inspection report is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed this in the home and on their website.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks associated with people's needs had not been fully assessed and or staff were not following guidance to mitigate risks. Regulation 12 (1)