Oakview Estates Limited

Thors Park

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-519903445	Thors Park	Brightlingsea Ward	CO7 8JJ
1-519903445	Thors Park	Thorrington Ward	CO7 8JJ

This report describes our judgement of the quality of care provided within this core service by Oakview Estates Limited. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Oakview Estates Limited and these are brought together to inform our overall judgement of Oakview Estates Limited.

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

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Summary of findings

Overall summary

We did not rate the provider during this focused inspection as we did not cover all aspects of each domain. CQC last rated the provider at the comprehensive inspection, published 16 January 2018, when the service was rated as 'good.'

We found the following issues that the provider needs to improve:

- The provider had not ensured that there were sufficient staff on duty for safe care and treatment of patients. There were insufficient staff on duty and staff were not always able to take breaks during their shift. Information provided about staff allocations showed that the provider often used staff intended to relieve others for activities such as driving.
- Staff did not always complete enhanced observations correctly. They did not follow observations in accordance with patients' care plans, the provider's policy or the strategies identified in positive behavioural support plans. Staff did not always engage with patients whilst on observation and did not always use physical intervention techniques in line with their training.
- Staff did not ensure that they updated care plans and risk assessments according to their own procedure. The provider had not ensured that best interest decisions made for patients who lacked capacity under the Mental Capacity Act were decision specific.
- The provider did not complete investigations according to their agreed procedure. Descriptions on incident report forms did not always match closed circuit television footage. Two closed circuit television cameras were not working correctly. The provider did not always respond to complaints in a timely manner and the provider did not always apologise when their own investigation found them to be at fault.
- Staff did not always ensure that they monitored patients' physical health. We found that staff completed physical health monitoring of patients on admission however, they did not always update this.
- Three of the eight staff we spoke with stated that they would not feel comfortable to raise concerns without fear of victimisation, and did not feel listened to.

However, we found the following areas of good practice:

- We observed some positive interactions with patients. Staff used several different methods to communicate with patients. Patients had access to advocacy services. Patients had access to activities, escorted leave and could keep in contact with their families.
- Staff completed a two-week induction period, including shadowing other staff members, prior to working directly with patients on the wards.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

We did not rate wards for people with learning disabilities or autism at this focused inspection. We found the following issues that the provider needs to improve:

- The provider had not ensured there were sufficient staff on duty to complete patient observations in accordance with their policy.
- Staff did not always use approved physical intervention techniques in line with their training.
- Staff did not keep risk assessments and care plans up to date and there were some gaps in the records. However, staff did ensure that they updated positive behaviour support plans were following incidents.
- We found one example where the closed-circuit television footage viewed was not in accordance with the account given in the incident form. Staff did not always complete enhanced patient observations in line with patient care plans or the provider's policy.

However, we found the following areas of good practice:

- Although agency usage was high, the provider had taken steps to ensure that staff used from agencies were familiar with the service.

Are services effective?

We did not rate wards for people with learning disabilities or autism at this focused inspection. We found the following issues that the provider needs to improve:

- Staff did not always review positive behaviour support plans routinely within the agreed timescales.
- There were often inconsistencies between different shifts and how staff handed over information about patients on shift changeover. Some staff used a clear structure and some did not. Staff said handover could be improved with better structure and consistency.
- Best interest decisions made for patients who lacked capacity under the Mental Capacity Act were not decision specific.

However, we found the following areas of good practice:

- Staff completed individualised positive behavioural support plans for patients.

Summary of findings

- The provider employed a range of staff including; psychiatrists, psychologists, nurses, support workers, occupational therapists and a speech and language therapist to provide care and treatment for patients.
- Staff completed a two-week induction period prior to working on the wards. New staff then shadowed experienced staff to get to know the patients.
- Staff handed over any incidents which had occurred during their shift to the multi-disciplinary team who responded by making changes to patients' positive behaviour support plans.

Are services caring?

We did not rate wards for people with learning disabilities or autism at this focused inspection. We found the following areas of good practice:

- Staff supported patients to make decisions about the activities they participated in.
- Patients we spoke with had a good understanding of their care. They had received a copy of their care plan and staff had explained the rationale for their level of observations. Patients received information about their medicines and could access advocacy services.

However, we found the following issues that the provider needs to improve:

- Staff did not always engage therapeutically with patients whilst completing enhanced observations.

Are services responsive to people's needs?

We did not rate wards for people with learning disabilities or autism at this focused inspection. We found the following areas of good practice:

- Patients understood their care, had access to activities and escorted leave, and could keep in touch with their families.
- Staff used different methods to communicate with patients. Picture cards were available and staff could use easy read format documents to help patients to understand.

However, we found the following issues that the provider needs to improve:

- The provider did not respond to complaints in a timely manner.

Summary of findings

Are services well-led?

We did not rate wards for people with learning disabilities or autism at this focused inspection. We found the following issues that the provider needs to improve:

- The provider did not ensure that staff carried out enhanced observations safely and in accordance with policy.
- The provider had not ensured that all staff were able to take a break.
- Some staff we spoke with were not confident to raise concerns without fear of victimisation.
- Morale at the hospital was mixed. Some staff said they received high levels of job satisfaction, whilst others were frustrated by short staffing and difficulty managing aggression from patients.

However, we found the following areas of good practice:

- We saw evidence of teamwork across the wards. Staff could inform the multidisciplinary team of concerns following incidents and the team responded by reviewing positive behaviour support plans.

Summary of findings

Information about the service

Oakview Estates Limited is the registered provider for Thors Park. Thors Park is an independent hospital that provides support for up to 14 men. At the time of the inspections, there were 14 men receiving care and treatment at the hospital.

Based in Thorrington, North East Essex, Thors Park provides support and treatment for men with learning disabilities and complex needs. The provider accepts patients who have additional mental and physical health needs, and those who are detained under the Mental Health Act. The service comprises of three elements:

• Thorrington Ward is an eight-bed service that provides assessment and intervention for men with learning disabilities, complex needs and behaviours.

• Brightlingsea ward is a four-bed service for individuals who require support that is more intensive. There are also four self-contained, bespoke apartments.

• The provider also has two bespoke single person apartments that provide a more independent living environment.

The Care Quality Commission registers Thors Park to carry out the following legally regulated activities:

• Assessment or medical treatment for persons detained under the Mental Health Act 1983

• Treatment of disease, disorder or injury.

The provider has recently recruited a manager who is currently in the process of registering with the Care Quality Commission.

The Care Quality Commission last inspected Thors Park on 16 January 2018. Following this inspection, the provider received an overall rating of good. The effective, caring, responsive and well led domains were rated as good. The safe domain was rated as requires improvement. The Care Quality Commission identified breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for regulation 12, safe care and treatment, and regulation 15 premises and equipment.

Our inspection team

The team that inspected the service comprised two CQC inspectors, two inspection managers and one specialist advisor who had experience working as a social worker.

Why we carried out this inspection

We carried out a focused inspection of this location in response to several concerns shared with the Care Quality Commission and outside agencies in relation to the safe care and treatment of patients.

How we carried out this inspection

We carried out a series of unannounced visits to the hospital. To review the quality of care and treatment delivered to patients, the inspection team visited the hospital on two separate occasions during the day. These visits took place on:

- 11 October 2018
- 1 November 2018

Before the inspections, we reviewed information that we held about this service and spoke to the local authority

Summary of findings

safeguarding team. During the inspection, the team focused on reviewing the safe delivery of care to patients. The team observed interactions with the staff members caring for eight different patients. We also observed interactions using the short observational framework for inspection (SOFI is a tool developed with the University of Bradford's School of Dementia Studies and used by our inspectors to capture the experiences of people who use services who may not be able to express this for themselves. The tool records the quality of engagement between staff and patients and is appropriate for people with learning disabilities).

The team reviewed live and historical footage captured on closed circuit television, where this was available, and made comparisons to incident reporting documentation. We reviewed duty rotas to form a judgement for safe staffing levels across the hospital.

During the inspection visit, the inspection team:

• spoke with two patients who were using the service

• spoke with the registered manager and regional quality manager.

• spoke with 20 other staff members; including nurses and healthcare assistants

• looked at seven care and treatment records for patients; and

• looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with two patients. They told us the staff made them feel safe, listened to them and were caring. However, one patient told us that there were not enough staff on each shift and they were not always able to provide them with the care they needed.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff complete observations in accordance with care plans and the provider's policy.
- The provider must ensure they deploy sufficient staff to ensure safe care and treatment for patients.
- The provider must ensure that all staff are able to take a break during their shift.
- The provider must ensure staff follow practices identified in the patient's positive behaviour support plan and that staff read and follow patients care plans.
- The provider must take action to address staff attitudes towards patients.
- The provider must ensure they respond to complaints in a timely manner.
- The provider must ensure that staff are trained in, and using physical intervention techniques which are in line with safe practice.
- The provider must ensure that they complete all agreed actions when investigating incidents.
- The provider must ensure that they provide staff with sufficient training and support to identify and report poor care and treatment and raise concerns.
- The provider must ensure that staff monitor patient's physical health on a regular basis.

Action the provider SHOULD take to improve

- The provider should ensure that all best interest decisions made, are decision specific.

Oakview Estates Limited

Thors Park

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Thorrington Ward	Thors Park
Brightlingsea Ward	Thors Park

Mental Capacity Act and Deprivation of Liberty Safeguards

Best interest decisions were not decision specific. The Mental Capacity Act requires that providers should assess capacity on a time and decision specific basis. If the person is deemed to lack capacity, staff should document that a decision has been made in the patients' best interest. We reviewed the records of seven patients, staff had assessed three to lack capacity to make decisions in some areas. The provider had pre-prepared templates for best interest decisions which had been used in all three cases. These templates covered the individual's needs and showed that staff had considered the capacity of the person to make decisions. However, the templates covered broad topics, such as having their physical health checked or agreeing to all care within the service, and did not address the elements of these topics as individual decisions.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

- The provider had not ensured that all patients and staff were safe on the wards. During one inspection visit we found two CCTV cameras were not working.

Safe staffing

- The provider had not ensured there were sufficient staff on duty to complete patient observations in accordance with their policy. The provider's policy stated that staff undertaking enhanced observations within eyesight or at arm's length should do so for no longer than two hours, followed by a break from observation duties of at least half an hour. This was in recognition of the potential difficulty in maintaining concentration for more than this time. The manager and registered nurses were not able to recall the terms of their own policy and were not acting within it. Staff were completing continuous observations, changing between patients, for up to 12 hours.
- We reviewed observation allocation records spanning one month and found evidence of staff each day allocated continuous observations for their 12 hour shift without a break. This meant that workers undertaking observations were unable to take a break from observations in line with National Institute for Health and Care Excellence guidance (NG10) and the provider's policy. This was a risk to both staff and patients. We raised this risk with management and reviewed this on our return visit, however the provider had done nothing to reduce the risk.
- Shifts had an additional staff member, to support with changeover of staff between patients and to provide support during incidents. This additional staff member was regularly used as a driver or for other duties and was not always available. This meant that staff who were observing patients in pairs had to separate to changeover. During both visits we observed staff leaving patients who were on enhanced observations alone for short periods of time and not maintaining close contact as specified in their care plan.
- Staff and managers did not ensure staff took a break during their shift of 12 hours.
- The service used high numbers of bank and agency staff to cover vacant shifts. Between August and October, the service used an average of 948 hours of agency cover across all staff groups per week. However, the provider told us that they only used agency staff who were familiar with the service and had not introduced a new agency worker for seven months.
- Shifts were regularly short staffed. Staff said, at times they were unable to provide observations to patients who they had assessed to need support from two members of staff. Shift allocation records showed 29 shifts had gone without the additional support member of staff in the three months prior to inspection. Some patients required familiar members of staff to meet their needs, an unfamiliar member of staff could cause them to become unsettled. Other patients were unable to have access to outside space due to lack of staff. We were not assured, therefore, that sufficient staffing was always available to ensure safe care and treatment for patients.

Assessing and managing risk to patients and staff

- Staff completed risk assessments for patients on admission and used this to decide the level of observation the patient needed. We saw evidence that staff reassessed the patient following an incident and changed their observation level if necessary. However, staff did not update these assessments on the agreed review dates. This meant that patients whose needs had changed might not have the right level of supervision.
- Staff sometimes used unsafe physical intervention techniques that were not in line with their training. All staff we spoke with said they had completed training in physical interventions. However, we observed physical interventions through historical closed-circuit television footage from October, live footage and direct observations. We also looked at several incident forms where staff had used restraint and watched footage where this was available. Footage showed one member of staff half lifting and dragging a patient in a corridor, this was unsafe practice and is unacceptable. Some staff did not feel that the training they had received was sufficient to manage the patient group or keep them safe.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- Staff did not keep risk assessments and care plans up to date and there were some gaps in the records. Patients were risk assessed by a nurse when they were admitted to the ward who determined how often the assessment should be updated. We reviewed seven patient records and found staff had not updated three within the agreed period. This meant some patients may have been subject to more intensive observations than they needed.
- We observed one staff member behave in a way which caused a patient distress but they did not apologise or attempt to de-escalate the situation. We also viewed historical closed-circuit television footage. We saw one staff member, observing a patient on enhanced observations where their care plan stipulated that their bedroom door must remain ajar. The patient's bedroom door was shut and the staff member checked them only once in two hours; the other staff member allocated to observe this patient was not present for most of this period. We raised this with the management who acted to safeguard the patient.
- Staff did not always complete enhanced patient observations in line with patient care plans or the provider's policy. During the inspections we completed eight observations and reviewed historic and live closed-circuit television footage. On Thorrington ward and outside in the grounds, we saw staff walk away from patients who nurses had assessed to need arm's length supervision. From CCTV footage we observed one patient requiring 2:1 observations alone in their bedroom for two hours with no staff check. On Brightlingsea ward, staff left their post, leaving only one staff member together with a patient assessed to need 2:1 observations at all times.

Reporting incidents and learning from when things go wrong

- Staff did not know which incidents to report. During the inspection we observed several staff behaviours which staff should have reported but had not, for example, an incident recorded on CCTV and staff leaving their observation posts. We found one example where the closed-circuit television footage viewed was not in accordance with the account given in the incident form. Staff could identify times when the provider had reviewed practice following an incident. We found evidence that staff updated care plans following an incident, however they did not always review them routinely. Sometimes actions identified during investigations, such as reviewing closed circuit television footage, were not completed by managers.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

- We looked at seven care records across all wards in the hospital. Staff completed individualised positive behavioural support plans for patients. Overall, these plans were of good quality. They contained several proactive and reactive strategies to a variety of known triggers and early warning signs in relation to patients' behaviour and presentation. Brief copies of these plans were kept on hand in patient bedrooms and we saw they were updated regularly. However, staff told us they did not always have the time to read these plans or ensure they keep themselves updated. We found therefore, that staff did not always behave in a way that followed the patient's plan or kept the patient safe.
- Two care plans we reviewed were not updated on the agreed dates. We also saw that staff did not consistently follow the positive behaviour support plans. We observed five occasions where staff involved patients in positive activities and interactions. However, we observed four occasions where staff did not follow strategies identified in positive behaviour support plans.
- Staff did not always monitor patients' physical health. Patients had their physical health checked on admission; staff recorded blood pressure, weight and heart rate. We found one patient who had not had not had their physical health monitored for 10 months. Another patient had a medical condition which had been risk assessed, but staff had not recorded updates and progress notes.

Skilled staff to deliver care

- The provider employed psychiatrists, psychologists, nurses, support workers, occupational therapists and a speech and language therapist to provide care and treatment for patients. However, each ward had one qualified nurse per shift and staff identified it was sometimes difficult to get patients' medicines on time.
- Staff completed a two-week induction period prior to working on the wards. New staff then shadowed experienced staff to get to know the patients. Staff were positive about this process and most felt prepared for their role. Some staff said they did not feel the restrictive practice training they received was sufficient to manage the needs of the patient group.

Multi-disciplinary and inter-agency team work

- Staff handed over any incidents which had occurred during their shift to the multi-disciplinary team, who responded by making changes to patients' positive behaviour support plans. Staff could use the observation notes to hand over any concerns and we saw staff had highlighted a patient's verbally abusive behaviour resulting in a change in the support plan.
- Staff highlighted that there were often inconsistencies between different shifts and how they handed over information about patients each changeover. Some staff identified a clear structure, whereas other staff said that handover from the day to the night shift could be improved with clearer structure and more consistency.
- Staff explained how to identify abuse and knew how to report a safeguarding concern. Staff were confident that they could escalate their concerns and could give examples of when they had done so. However, it was difficult for staff to locate safeguarding records on the electronic system the provider used.

Good practice in applying the Mental Capacity Act

- Best interest decisions were not decision specific. The Mental Capacity Act requires that providers should assess capacity on a time and decision specific basis. If the person is deemed to lack capacity to make a decision, staff should document that a decision has been made in the patients' best interest. We reviewed the records of seven patients, staff had assessed three to lack capacity to make decisions in some areas. The provider had pre-prepared templates for best interest decisions which had been used in all three cases. These templates covered the individual's needs and showed that staff had considered the capacity of the person to make decisions. However, the templates covered broad topics, such as having their physical health checked or agreeing to all care within the service, and did not address the elements of these topics as individual decisions.

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, dignity, respect and support

- Staff did not always behave in a way which showed patients kindness, dignity and respect. We observed support staff giving patients options of activity and using activities identified as preferred in the patient's positive behaviour support plan. Some staff showed passion for supporting the patients in their service, they were interested in learning opportunities and demonstrated an understanding of how to support their patients. However, we also observed staff ignoring patients, and mocking them. We also saw staff talking amongst themselves whilst supporting patients and using their mobile phones when on duty.
- The patients we spoke with told us that staff were kind and respectful and that they felt safe in their care.
- Staff did not always engage therapeutically with patients whilst completing enhanced observations. We saw some examples where staff interacted with patients and provided them with activities which were written in their care plans. However, we also saw examples where staff engaged in conversation with each other and were using their mobile phone whilst completing observations. On one occasion a member of staff ignored a patient for 20 minutes.
- We completed 30 minutes of observations on Thorrington ward using SOFI (SOFI is a tool developed with the University of Bradford's School of Dementia Studies and used by our inspectors to capture the experiences of people who use services who may not be able to express this for themselves. The tool records the quality of engagement between staff and patients and is appropriate for people with learning disabilities). We observed an equal mixture of positive and negative engagement with patients during this time. Examples of positive engagement included playing board games and colouring which were included in the patient's care plan, and giving a patient a choice about what they wanted to do during the day, supporting them to make a decision by giving their options and the pros and cons. Examples of negative interactions included a staff member ignoring a patient for 20 minutes and staff not communicating with a patient to de-escalate the situation when they were agitated.
- Patients we spoke with had a good understanding of their care. They had received a copy of their care plan and staff had explained the rationale for their level of observations. Patients received information about their medicines and could access advocacy services.

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Access and discharge

- Patients had access to activities and escorted leave. During one of the visits we saw a patient receive a hand massage and staff supported several patients to access a swimming pool. Patients told us they could access a wide range of activities including religious services in their community and walks to the local shops.
- Patients had access to appointments to support their physical health such as their doctor and dentist.
- Patients told us they could see their relatives and have private telephone calls with them if they wanted to.
- Staff used different methods to communicate with patients. Picture cards were available and staff could use easy read format documents to help patients to understand.

Listening to and learning from concerns and complaints

- Complaints were not always responded to in a timely manner. We reviewed two complaints; on both occasions the response to the complaint had been delayed. On one occasion the provider had not apologised despite their investigation upholding parts of the complaint.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Good governance

- The provider had not ensured that staff carried out enhanced observations safely and in accordance with policy. We reviewed enhanced observation allocation sheets across all wards and found staff completing many hours of continuous observations, without taking breaks. This posed a risk to the health and safety of the staff carrying out the observations. All wards in the hospital used printed observation sheets divided into two-hour periods to record which staff were allocated to patients. Managers and registered nurses were not able to recall the terms of their own policy, which stated that staff undertaking enhanced observations should do so for no longer than two hours, followed by a break, and were not acting within it. There was a risk that staff would become tired, lose concentration and not provide therapeutic care for these patients. Managers had not identified the risks associated with staff completing high concentration work for long periods of time and had not taken action despite this being raised at the first inspection.
- The provider had not ensured that all staff were able to take a break. Due to the pressure to complete close observations and the lack of additional staff to support this, staff were not routinely able to access a break during their shift. Managers had not identified that it was a legal requirement to provide staff with a break and in not doing so, this was a risk to staff and patient safety.
- Staff received a two-week induction followed by a period of shadowing to ensure that they were fully prepared to work on the wards. Staff were positive about this process and most felt able to provide appropriate care to patients. However, managers did not provide staff with the training they needed to promote high quality care. We found that staff were failing to identify what poor care looked like. Managers did not follow their own processes when investigating reports of poor care and did not always complete actions. Therefore, they did not always identify when staff had behaved in an unacceptable way or produce learning from incidents.

Leadership, morale and staff engagement

- Morale at the hospital was mixed. Some staff said they received high levels of job satisfaction, whilst others were frustrated by short staffing and difficulty managing aggression from patients. Staff did not feel that their training had been sufficient to overcome these difficulties. Eight staff expressed concerns about the understaffing on wards in relation to patient safety and rehabilitation. Staff told us they often did not get a break and ate their lunch on duty whilst trying to care for patients. Most staff identified that there were insufficient staff to cover breaks and activities which took staff off site. Staff did not feel comfortable raising concerns as they said other staff had been victimised by their colleagues. They did not understand which incidents they should report, we witnessed several occasions where staff should have reported unacceptable behaviour but did not.
- Some staff we spoke with were not confident to raise concerns without fear of victimisation. We asked eight staff if they felt confident to raise concerns and three stated that they would not feel comfortable to do so or had, and did not feel listened to. Staff gave examples where they had raised concerns and other members of staff had treated them differently as a result. Evidence showed managers responded appropriately when staff raised concerns, however they had not identified that staff were not reporting poor care.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider had not ensured that systems were in place to ensure that they could deploy sufficient staff with suitable skills and knowledge. • The provider had not ensured that they completed observations in accordance with care plans and the provider's policy. • The provider had not ensured that staff had a rest break. • The provider had not ensured that staff were reading and following patient's positive behaviour support plans or their care plans. • The provider did not respond to complaints in a timely manner. • The provider did not ensure staff used physical interventions in line with their training. • The provider had not investigated incidents in accordance with their own policy. • The provider had not ensured staff could identify poor care and treatment or raise concerns. • The provider had not ensured staff were completing physical health monitoring. This was a breach of regulation 17