Reed Care Homes Limited

Nayland Lodge

Inspection report

44 - 46 Nayland Road
Mile End
Colchester
Essex
CO4 5EN

Tel: 01206853070

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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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Nayland Lodge is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Nayland Lodge provides rehabilitation and support for up to eight adults who have a mental health disorder. Nayland Lodge is a large two storey house situated in Colchester and close to all amenities. The premises provide each person using the service with their own individual bedroom and adequate communal facilities for people to make use of within the service.

At the last inspection on 10 November 2015, the service was rated 'Good'. At this inspection we found the service was now rated overall 'Requires Improvement'. This is the first time the service has been rated 'Requires Improvement'.

This inspection was completed on 20 June 2018 and there were eight people living at Nayland Lodge.

A new manager was appointed since our last inspection to the service in November 2015. The manager commenced employment on 3 August 2017, however they were not formally registered with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Improvements were required to the service's governance arrangements to assess and monitor the quality of the service. These arrangements had not identified the issues we found during our inspection. The registered provider lacked oversight as to what was happening within the service to make the required improvements and provide suitable support to the manager to ensure compliance with regulatory requirements and the fundamental standards. Improvements were required to ensure lessons were learned and actioned when things go wrong.

Improvements were required to the recruitment practices at the service to ensure these were robust. There was limited evidence to show staff employed at the service had received and attained suitable training. Improvements were required to ensure newly employed staff received a robust induction, formal supervision and an annual appraisal of their overall performance; with aims and objectives set for the next 12 months.

People were protected from abuse and people living at the service indicated they were safe and had no concerns about their safety and wellbeing. Policies and procedures were being followed by staff to safeguard people, apart from safeguarding concerns not being notified to the Care Quality Commission. People received their prescribed medication as they should, however minor improvements were required to

ensure the correct codes were recorded on the Medication Administration Records. Risks to people were identified and managed to prevent people from receiving unsafe care and support. Staffing levels and the deployment of staff was suitable to meet people's needs. People were protected by the registered provider's arrangements for the prevention and control of infection.

Staff understood and had a good knowledge of the key requirements of the Mental Capacity Act [2005] and Deprivation of Liberty Safeguards. Suitable arrangements were in place to ensure that people's rights and liberties were not restricted and people's capacity to make day-to-day decisions had been considered and assessed.

People were treated with kindness, dignity and respect. People received a good level of care and support that met their needs and preferences. Support plans were in place to reflect how people would like to receive their care and support, and covered all aspects of a person's individual circumstances. Staff had a good knowledge and understanding of people's specific care and support needs and how they wished to be cared for and supported. Social activities were available for people to enjoy and experience both 'in house' and within the local community.

People's nutritional and hydration needs were met and they received appropriate healthcare support as and when needed from a variety of professionals and services. The service worked together with other organisations to ensure people received coordinated care and support. Suitable arrangements were in place to support people who required end of life and palliative care.

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.

Improvements were required to ensure recruitment checks for staff were robust.

Whilst people told us they were safe, safeguarding concerns had not always been notified to the Care Quality Commission.

Medication arrangements were safe and ensured people received their prescribed medication as they should. Minor improvements were required to ensure records were consistently completed.

The deployment of staff was suitable to meet people's care and support needs.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Improvements were needed to ensure staff received appropriate training, a robust induction and the opportunity for formal supervision including an annual appraisal.

Suitable arrangements were in place to meet people's nutritional, hydration and healthcare needs.

Staff demonstrated a good understanding of the Mental Capacity Act 2005 and how to apply these principles. Improvements were required in relation to staff's understanding of Deprivation of Liberty Safeguards.

Is the service caring?

Good

The service was caring.

People were positive about the care and support provided by staff. People told us staff were good and their needs were met.

Staff demonstrated a good understanding and awareness of how to support people to maintain their dignity and independence

and how to treat people with respect.

Is the service responsive?

Good

The service was responsive.

Care plans provided sufficient detail about a person's care and support needs and how this was to be promoted and delivered by staff.

People who used the service were engaged in social activities that suited their needs and interests.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Improvements were required to ensure quality assurance arrangements at the service were improved, particularly in relation to the registered provider's oversight of the service.

The service worked in partnership with other agencies.

Nayland Lodge

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 inspection took place on 20 June 2018 and was unannounced. The inspection was undertaken by one inspector.

We reviewed other information that we hold about the service such as safeguarding information and notifications. Notifications are the events happening in the service that the provider is required to tell us about. We used this information to plan what areas we were going to focus on during our inspection.

We used the Short Observational Framework for inspection [SOFI]. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with three people living at the service, two members of staff, the manager and the team leader. We reviewed three people's care files and four staff personnel files pertaining to recruitment practices and a further three staff files relating to staffs supervision and appraisal arrangements. We also looked at a sample of the service's quality assurance systems, the registered provider's arrangements for managing medication, staff training records, staff duty rotas and complaints records.

Requires Improvement

Is the service safe?

Our findings

We asked people whether they felt safe living at Nayland Lodge. People told us they had no concerns and the service was a safe place to live. One person told us, "Yes, I feel safe, if I didn't I'd be out of here, gone." Another person told us, "Yep, I'm safe, I make sure that I am." Staff demonstrated an awareness of the different types of abuse, how to respond appropriately where abuse was suspected and how to escalate any concerns about a person's safety to the management team. Staff told us they would not hesitate to report any concerns to external agencies such as the Local Authority or the Care Quality Commission if they felt the manager or registered provider were not receptive or responsive.

Prior to the inspection we reviewed the service's safeguarding information that had been forwarded to the Care Quality Commission as required by regulation. We found there was a discrepancy between the number of safeguarding concerns reported to us. There was no evidence available to show that three safeguarding concerns dated August 2017, October 2017 and May 2018 had been forwarded to the Care Quality Commission. The manager told us they were unaware of their responsibility to notify us of any allegations or incidents of abuse. There was also a lack of evidence to show the actions taken to safeguard people had been completed as stated within the investigation reports. For example, one action in August 2017 and May 2018 recorded all staff were to receive medication training. However, when we reviewed the staff training matrix provided, this had not been provided. We discussed this with the manager and they confirmed the records were accurate and staff had not received up-dated training.

Staff recruitment records for four members of staff [including the manager] were viewed and showed improvements were required. References received for one member of staff were not from their most recent employer, one written reference only had been received for two members of staff, one of which was received eight months after the employee had commenced employment. The latter was discussed with the manager. They told us a verbal reference had been sought by the registered provider but evidence to confirm this was not available. The Disclosure and Barring Service [DBS] certificate for one member of staff was received after they commenced in post and had not been risk assessed to ensure they were suitable for the role. A recent photograph had not been sought for any of the staff employed. The manager was sign-posted to Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which provides reference to the recruitment checks and documents required when appointing staff.

We recommend the registered provider and manager familiarise themselves with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which provides reference to the recruitment checks and documents required when appointing staff.

A written record was not completed or retained to demonstrate the discussion had as part of the interview process and the rationale for staff's appointment. This showed robust measures had not been undertaken to retain information recorded to enable the registered provider's representative to make an initial assessment as to the applicant's relevant skills, competence and experience for the role and; to narrow down if they were suitable.

Suitable arrangements were not as robust as they should be to review incidents and to learn from these. For example, two safeguarding concerns relating to medication were identified in August 2017 and May 2018 respectively. One incident resulted in a person accessing and swallowing another person's medication and another person accessing one of their own medications and taking an overdose. Although both incidents had not resulted in 'actual' physical harm and an investigation completed, lessons had not been learned and the appropriate action taken to improve safety for people using the service.

At this inspection medicines were securely stored for people using the service. The temperatures for storing medicines were monitored each day and within recommended guidelines. Each person's Medication Administration Record [MAR] was viewed. Whilst records and random sampling of people's medicines, against their MAR forms showed people had received their prescribed medication, staffs use of codes on the MAR form for medication prescribed as PRN [when necessary] was inconsistent. For example, some staff left the MAR form blank if no PRN medication was required, others recorded 'A' [refused] or 'N' [prompt but not required]. The latter was highlighted within the latest 'Visiting Managers Audit' completed on 17 March 2018 by the deputy manager from another of the registered provider's 'sister home'. No information was recorded detailing the actions to be taken to rectify this.

Risk assessments were in place and information recorded within people's care plans identified the risks associated with people's care and support needs and how to mitigate them. These related to the risks involved in enabling people to access the community independently and safely and risks related to specific healthcare conditions.

Environmental risks for the service were viewed, particularly those relating to the service's fire arrangements. The manager confirmed that records relating to the monitoring of the service's fire alarms and emergency lighting could not be located and had been recommenced since the 15 June 2018. Essex County Fire and Rescue Service completed an audit of the service in May 2018. The outcome of the audit detailed the service was not fully compliant and improvements were required to the service's fire risk assessment and the fire alarm system was not adequately maintained. Information to evidence the required improvements were not available at the time of our inspection. The registered provider was contacted by the manager and we were advised the service had been visited by an electrician and a copy of the certificate would be forwarded to the Commission within 48 hours. A copy of the service's electrical installation certificate dated 21 June 2018 and emergency lighting inspection certificate dated November 2017 was forwarded to us. However, it remained unclear if the required improvements had been made to the fire risk assessment as the fire risk assessment had not been updated since the Essex County Fire and Rescue Service's visit in May 2018. The registered provider must notify the Commission in writing and provide evidence that the fire risk assessment has been updated and is now fit for purpose.

Specific information relating to people's individual Personal Emergency Evacuation Plans (PEEP) had been completed. This is a bespoke plan intended to identify those who are not able to evacuate or reach a place of safety unaided in the event of an emergency.

People using the service told us there were always sufficient numbers of staff available to provide the support required to meet their care and support needs. Our observations showed that people received care from a consistent staff team. The deployment of staff was suitable to meet people's care and support needs in line with information documented within their care plan and this included carrying out or supporting people with their chosen activities.

The service's infection control and principles of cleanliness were maintained to a good standard and staff understood their responsibilities for maintaining appropriate standards of cleanliness and hygiene; and

following food safety guidance. However, only 50% of staff had attained infection control training.

Requires Improvement

Is the service effective?

Our findings

The staff training matrix provided to us at the time of the inspection showed significant shortfalls in training. For example, the training matrix indicated for two members of staff employed in February and March 2018 respectively, no evidence of training. This was not strictly accurate as both members of staff had attained medication awareness training on 29 March 2018. The manager confirmed the latter was accurate and this was the only training attained to date for both members of staff. Although both staff members had previous experience within a care setting, evidence of previous training attained was not available or sought. The training matrix for another member of staff showed the only up-to-date training achieved related to fire safety and health and safety. Their personnel file demonstrated mandatory training in 14 subjects was completed in one day on the 6 February 2017 and this was valid for 12 months. The manager confirmed up-dated training had not been provided.

The manager had attained a Level 3 award in education and training in 2015. The manager confirmed they delivered medication training to staff. However, although the manager had many years' experience, they confirmed they did not have up-to-date knowledge in specific subjects to deliver effective training to staff in line with current legislative requirements. The manager had not trained as an accredited trainer to enable them to provide staff with training relating to medicines management. Therefore, we could not be assured staff had been trained by a skilled and competent person. We discussed this with the manager and they confirmed prior to us completing the inspection that they were booked to undertake 'train-the-trainer' medication training in July 2018. Additionally, there was little evidence to show that staff had received specific training relating to the specialist needs of the people being supported and despite not all staff having experience of working with this group of people.

The manager told us staff received an induction, including where appropriate the Skills for Care 'Care Certificate'. Staff were required to undertake and complete the Skills for Care 'Care Certificate' induction programme where they had not attained an appropriate National Vocational Qualification [NVQ] or qualification in line with the Qualification and Credit Framework [QCF] and where they had little or no previous experience within a care setting. The Care Certificate is a work based assessment of competency and is made up of 15 minimum standards that should be covered if an employee is 'new to care'. It enables the registered provider and manager to assess if an employee is competent in their role. Out of four staff personnel files viewed for staff employed between 3 August 2017 and 16 April 2018, two staff [including the manager] had not received an induction, one member of staff's 'in-house' induction was only partially completed and one member of staff had not commenced the 'Care Certificate' despite not having completed a NVQ or QCF qualification.

Staff told us they received good support from the manager and team leader and felt valued. Though this was positive, staff had not received formal supervision in line with the registered provider's policy and procedure. Out of five staff personnel files viewed for staff employed between 29 February 2016 and 13 March 2018, one member of staff had received two supervisions over a 14-month period. Two members of staff had only received one supervision since 31 January 2017 and 21 September 2017 respectively and two members of staff employed in February and March 2018 had yet to receive supervision. The manager had

not received supervision since the commencement of their employment in August 2017. The manager confirmed annual appraisal arrangements were not in place for staff. Following the inspection the manager confirmed staff received informal supervision through regular verbal discussions.

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

Staff told us and people confirmed they were consulted by staff to plan and inform the weekly menu and were offered the opportunity to participate with grocery shopping. One person told us, "The food is fine." Another person told us, "The food is alright." Our observations showed people received sufficient food and drink of their choice throughout the day and where people were competent, they were encouraged and supported to make their own drinks and snacks. At the time of the inspection, no-one had any cultural and religious requirements relating to their nutrition and hydration needs. Where people were at nutritional risk or required support and advice from a healthcare professional, this had been sought.

Staff worked well with other organisations to ensure they delivered good joined-up care and support. The manager and staff team knew the people they cared for well and liaised with other organisations to ensure the person received effective person-centred care and support. This was particularly apparent where people's healthcare needs had changed and they required the support of a range of external organisation's and agencies. For example, the manager told us and information recorded in one person's care plan reflected their healthcare needs had declined over recent months, because of this the person now received on-going support from the dementia nurse specialist team.

People's healthcare and mental healthcare needs were well managed. People had regular support from social worker's, Community Psychiatric Nurses [CPN] and six-monthly reviews with consultant psychiatrists. Care records showed people's healthcare needs were clearly recorded, including evidence of staff interventions and the outcomes of healthcare appointments. Each person had a hospital passport, although for one person this document had yet to be completed. The latter provides hospital staff with important information about the person at the time of their admission either to the hospital or A&E department. One person confirmed they attended healthcare appointments independently and without staff support. They told us this was very important to them.

Compliments from healthcare professionals were available and positive. One compliment recorded, "I've never visited such a lovely home. I visit frequently to complete activities of daily living assessment with a resident. Each time I visit the staff are positive, professional and extremely friendly. The staff communicate in a respectful and appropriate manner with each other and most importantly all service users. Each person's needs appear to be taken into account. It makes it a lovely place to visit. The service promotes independent living skills and encourages service users to thrive." Other compliments were equally positive and confirmed staff were helpful, knew the needs of the people they supported and were professional in their manner.

The Mental Capacity Act 2005 [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 the mental capacity to make 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards [DoLS]. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff had a good knowledge and understanding of MCA and Deprivation of Liberty Safeguards (DoLS). Staff were observed during the inspection to uphold people's rights to make decisions and choices. Information available showed each person who used the service had had their capacity to make decisions assessed. However, where restrictive practices were in place to keep people safe, for example, where people had restricted access to their personal lighters and cigarettes because it was deemed a fire hazard, this was not clearly recorded to demonstrate the person had consented to this arrangement and this was in the person's best interests. Where people were deprived of their liberty, the manager had made an appropriate application to the Local Authority for DoLS assessments to be considered for approval.

Good

Is the service caring?

Our findings

People told us they received appropriate care and support that met their needs. One person told us, "It is alright here. I get the help I need from staff and when I need it." Another person told us, "I don't require much support from staff, I try to be as independent as I can. If I want staff help, I know that I can request it. The staff are alright."

Our observations showed people received person-centred care and had a good rapport and relationship with the staff who supported them, including newer members of staff employed at the service. During our inspection we saw that people and staff were relaxed in each other's company and it was clear staff knew people well. Staff understood people's different communication needs and how to communicate with them in an effective and proactive way. People were addressed by their preferred names and staff interacted with people in a caring and considerate way, taking the time to listen to what people were saying to them. Staff confirmed no-one at the time of the inspection required specific assistive technology to help them to communicate.

Most people using the service were judged as having the capacity to make decisions and choices about their care, treatment and support. People were involved in their care planning as much as they were able and people were supported to participate in reviews. The manager confirmed that people's relatives advocated on their behalf and at present no-one had an independent advocate. An advocate supports a person to have an independent voice and enables them to express their views when they are unable to do so for themselves.

People told us they were treated with respect and dignity and their privacy upheld and maintained. People confirmed they could spend private time in their bedroom if they wished and this was respected by staff. Staff encouraged people to do as much as they could for themselves according to their individual abilities and strengths. People could go out independently to maintain links with their local community. People were also encouraged to participate in activities within the home environment, such as cleaning their bedroom, completing personal laundry and making snacks and drinks.

Good

Is the service responsive?

Our findings

People using the service told us they received good personalised care and support that was responsive to their needs. People's support packages were funded by the Local Authority. An initial assessment of people's needs was completed by the Local Authority and together with the registered provider's assessment, this was used to inform the person's care plan.

Care plans covered all aspects of a person's individual care and support needs, including information relating to the person's mental healthcare needs. Additionally, the care plans focused on the care and support to be delivered by staff, what was important to them and their personal preferences. Information available showed that people's care plans were reviewed and updated to reflect where their needs had changed and/or their mental healthcare needs deteriorated. For example, one person's care plan had been updated following a deterioration in their healthcare needs. Staff were aware of the changes and the specific care and support to be provided to ensure the person's health and welfare.

People confirmed to us they could spend their time as they wished and wanted. Suitable arrangements were in place to ensure people using the service had the opportunity to take part in leisure activities of their choice and to maintain their independence as much as possible. One person told us they attended a local club each week as it gave them the opportunity to meet others away from the care home setting and to form friendships. The person also confirmed they regularly accessed their local community for personal shopping and to go out with family members for lunch. Another person advised they were independent and were enabled to follow their interests and to take part in social activities relevant to their chosen interests. One person was supported by staff to attend bowling and trampolining.

People could maintain relationships that mattered to them, such as with family members. The manager confirmed suitable arrangements were in place to enable people to spend time with their families. One person told us they visited their family most weekends and did this independently without staff support.

The service had an effective complaints procedure in place for people to use if they had a concern or were not happy with the service. No complaints had been raised since our last inspection to the service in November 2015. Staff were aware of the complaints procedure and knew how to respond to people's concerns and complaints. People told us they would either speak to a family member or the manager if they had any worries or concerns.

Although no one living at the service was receiving end of life care, the manager provided an assurance that people would be supported to receive good end of life care to ensure a comfortable, dignified and pain-free death. Furthermore, they told us that they would work closely with relevant healthcare professionals and provide support to people's families.

Requires Improvement

Is the service well-led?

Our findings

Since our last inspection to the service on 10 November 2015, the management arrangements at the service had changed. A new manager was appointed and commenced in post on 3 August 2017. The manager was not formally registered with the Care Quality Commission. In discussions with the manager they confirmed an application to be registered with us had not yet been completed or submitted. A rationale for this was not provided, however an assurance was given by the manager that the application would be completed and submitted. The manager was asked to notify the Commission in writing once done.

The manager told us information was collected and recorded in a variety of ways to regularly assess and monitor the quality of the service provided. This included the completion of audits at regular intervals to help identify and manage risks to the quality of the service and to help drive improvement. The manager confirmed they completed a monthly 'Overview Audit' for Nayland Lodge. The purpose of this was to provide a broad overview of the service, identifying areas of good practice and where improvements were required. The manager told us the report was not forwarded to the registered provider, however it was available for them to view when they visited the service. Additionally, a 'Visiting Managers Audit' was completed by another home manager and the outcomes shared with the manager of Nayland Lodge. A substantial number of remedial actions were highlighted within both reports [March 2018]. No information was recorded confirming if these actions had been completed or if these remained outstanding. The visiting manager commented that the remedial actions were primarily due to the service not having had a manager for several months and compliance with fundamental standards and regulatory requirements had therefore suffered because of this.

Quality assurance arrangements had identified the areas for improvement we found as part of this inspection. However, these arrangements were not as robust or effective as they should be as most of the improvements required remained outstanding. This referred specifically to most staff not having attained mandatory or refresher training or other training relating to the specialist needs of people using the service. Suitable arrangements were needed to ensure all newly appointed staff received a robust induction following their appointment, particularly where they did not have previous experience within a care setting or attained a National Vocational Qualification [NVQ] or qualification in line with the Qualification and Credit Framework [QCF]. Supervision and appraisal arrangements were not in place and did not ensure staff received formal supervision or an appraisal of their overall performance. The manager and registered provider were not aware of their legal requirements to notify the Care Quality Commission of safeguarding concerns. No information was evident to show how the above was to be addressed, who was responsible and the dates for completion.

It was evident the registered provider lacked oversight as to what was happening within the service to make the required improvements. They had not provided suitable support to the manager to ensure arrangements were in place to achieve compliance with their own quality assurance arrangements and the fundamental standards highlighted above. This demonstrated that the governance arrangements in place were not reliable or effective to ensure a quality service and ensure regulatory requirements were fully understood and managed to make the required improvements.

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

The views of people using the service and those acting on their behalf had been sought in 2016, however a report detailing the findings and actions was not available. The manager told us one satisfaction survey had been received from a person's relative, one from a visiting adult social care professional and one from a member of staff in February and March 2018. Positive comments were received from the relative and adult social care professional and included, "As a family, we have found a vast improvement in the care and needs of [Person] since the change of staff. [Person] is very happy living in Nayland Lodge and has friends there as well as getting on with the very thoughtful staff. The staff are also very supportive of us as a family' and, 'I have observed good practices."

The manager advised that ideally, they would like staff meetings to be held four to six weekly. Records showed the last meeting was held in August 2017 and this was confirmed as accurate by the manager. When we discussed this with the manager they told us although meetings had been planned, they had been cancelled due to unforeseen circumstances emerging at the service which centred around the needs of people using the service.

Staff were complimentary about the manager and told us they were approachable and received good support. Staff told us they enjoyed working at Nayland Lodge and that morale amongst the staff team was encouraging and positive. The manager knew the people they supported well and had a good relationship with them and the staff team. We saw that people using the service and staff were very comfortable with the manager and spoke freely with them during the inspection.

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
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Improvements were required in relation to the provider's quality and assurance processes to ensure these are operated effectively to guarantee compliance.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Improvements were required to ensure staff were appropriately trained, received a robust induction, supervision and appraisal.