St Anne's Community Services

St Anne's Community Services - Shady Trees

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

Overall summary

We carried out this inspection on 21 October 2014. This was an unannounced inspection. At the last inspection, the service was found to be fully compliant.

Shady Trees offers a nursing respite service for up to four adults at any one time, aged 18 and over who have learning disabilities and other complex physical health needs. The home is registered to provide accommodation for people who require personal or nursing care. Shady Trees is part of St Anne's Community Services, a Voluntary Sector Service.

It is a condition of registration that the provider has a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. The provider had previously sent us a notification form to inform us that the registered manager would be absent from the service for some time

Summary of findings

and had identified an interim manager, who would manage the service until the registered manager returned. The interim manager was present on the day of our inspection.

We found people were safe and protected from abuse. Staff we spoke with were knowledgeable about safeguarding and abuse and were able to tell us the steps they would take, should they have any concerns.

We found staffing levels at the service were adequate and staff were appropriately skilled and qualified to carry out their roles. We found people's care was provided effectively by staff who were knowledgeable and kind, having built up positive, caring relationships with people who lived at the service. However, we found there were some issues around staff training, where required refreshers were overdue.

We looked at medications at the home and found they were managed appropriately. We carried out a stock check of four medications and found these to be correct. However, we did find some issues with medications and the recording of.

We carried out observations and saw that staff sought consent from people when carrying out tasks or activities. However, we found issues around consent, where people were, at times, deprived of their liberty.

We saw that people were supported to maintain a healthy lifestyle, including adequate nutritional intake and regular, appropriate access to health services. We saw in care records that people, their relatives and relevant healthcare professionals were involved in care planning.

We found regular questionnaires were sent out to people who used the service and their relatives to obtain feedback about the service. However, we saw that there was no formal recording of complaints, however large or small. This meant we were unable to evidence the service listened to and learned from people's experiences.

We found staff felt well supported and managed. Staff said they felt confident speaking with the interim manager and were able to raise any issues or concerns they had. However, we found issues with how the service was managed and monitored through the use of auditing and governance procedures. We found several auditing records were incomplete or had not been carried out.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was safe. However, improvements were required.

We found people were protected from bullying, harassment, avoidable harm and abuse as staff were able to identify signs of possible abuse and explain the procedures they would follow, should such concerns have arisen.

We found there were sufficient staffing levels at the service, who were adequately trained and qualified.

We found there was no formal trend analysis of safeguarding concerns, late or incomplete auditing and issues with the recording of medications.

Is the service effective?

Requires Improvement

The service was effective. However, improvements were required.

We found staff had the appropriate knowledge and skills to provide effective care to people who used the service. However, we found some staff were not up to date with training or refresher training.

We found issues around consent, where the service was unlawfully depriving someone of their liberty as they had not followed the correct process to ensure that the Deprivation of Liberty Safeguard principles were adhered to.

People who used the service were supported to maintain a balanced diet, good health and access to ongoing healthcare support.

Is the service caring?

Good

The service was caring.

We saw evidence that positive, caring relationships had been developed between staff and people who used the service.

We also saw that people and their relatives were actively involved in making decisions about their care and support and people's privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was responsive. However, improvements were required.

We found that people received personalised care that was responsive to their needs. However, we found that risk assessments did not always reflect information in care and support records.

We found evidence that people, their relatives and other healthcare professionals were asked for feedback on the service.

Summary of findings

We were unable to evidence how the service used complaints, concerns and compliments for continuous service improvement as there was no official trend analysis carried out and no complaints had been recorded.

Is the service well-led?

Requires Improvement

The service was well led. However, improvements were required.

We found the service promoted a positive culture, that was person-centred and open, with care provided by staff who felt well-managed and supported.

We found issues around auditing and governance at the service with some audits being overdue and some issues we identified during our inspection having not already been identified as part of audits.

St Anne's Community Services - Shady Trees

Detailed findings

Background to this inspection

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

This inspection took place on 21 October 2014 and was unannounced. The inspection was carried out by one Adult Social Care inspector.

Regulations of the Care Quality Commission (Registration) Regulations 2009 make requirements that the details of certain incidents, events and changes that affect a service or the people using it are notified to CQC. Prior to our inspection, we looked at previous notifications that CQC had received from the provider.

During our inspection, we spoke with one person who used the service, one support worker who was on duty, the interim manager and the area manager. We carried out observations of staff interaction with people during the morning, before people who used the service went to their day services. We also reviewed records kept by the home.

We looked at the care records of three people who used the service and the staff personnel records of three staff members.

Requires Improvement

Is the service safe?

Our findings

During our inspection, we spoke with one support worker about safeguarding at the service. The staff member told us they protected people from abuse that may have resulted in psychological harm by ensuring an open and transparent approach was taken. The staff member told us; "There are risk assessments in place for everything. If I had a concern, I would go straight to my manager or report it to safeguarding." The staff member was able to tell us the different types of abuse and the signs to look for, as well as the procedure for reporting such concerns. They also told us they had received training in this area. This demonstrated the service ensured people were protected from abuse and avoidable harm

We asked the staff member about the use of restraint at the service. They told us restraint was not used. We asked the staff member if the front door of the service was unlocked for people to come and go as they pleased, as a locked door would be considered a use of restraint. They told us it usually was unlocked, however, when certain people used the respite facility at the service, the door was locked due to risks associated with absconding. The staff member then went on to say that if people wanted to go to the shop, for example, a staff member would go with them. We asked if there were appropriate assessments in place for this and the staff member confirmed there were risk assessments in place to explain the rationale behind this. We checked in care files and found this to be the case.

We asked the interim manager how they encouraged people to raise any concerns they had about keeping safe. The interim manager told us they operated an 'open door policy', where their office door was left open so people were able to enter and leave as they wished and discuss any concerns they may have had.

We looked at the care records for three people who used the service. In all care records we looked at, we found there were risk assessments in place to ensure that risks were managed appropriately. We saw evidence that risk assessments and care planning involved family members of people who used the service.

We looked at the safeguarding log kept by the service. We saw evidence that all safeguarding concerns were investigated and concluded appropriately, including working with a multi-agency approach. We also saw evidence that the outcomes of these investigations were communicated appropriately to the relevant people. We asked the area manager what arrangements were in place to continually review safeguarding concerns, accidents and incidents. The area manager told us they carried out an analysis of these on an ad-hoc basis, but no formal trend analysis was conducted.

We looked at the records in place to manage the premises and equipment at the service to keep people safe. We found a 'Premises safety survey report' was completed monthly and, although issues had been identified, we found this report had not been completed since July 2014. This meant the premises and equipment were not always checked and serviced in the required timescales in order to keep people safe.

We asked the interim manager what the staffing levels at the service were. They told us that the service was closed between 10am and 2.30pm due to the funding they receive and during this time, people who used the service attended day services or had alternative arrangements. They told us there was a nurse and two support workers on duty from 2.30pm until night staff arrived and one staff member would be at the service overnight. The night staff member remained at the service until 8.30am the following morning, when the interim manager and one support worker came on shift until 10am.This demonstrated the service ensured there were sufficient numbers of staff on duty at all times.

We looked at three staff personnel files and found all pre-employment checks had been carried out, including reference checks from previous employers, proof of identification and Disclosure and Barring Service (DBS) checks. This meant the service ensured safe recruitment practices were followed. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. It replaces the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA).

We asked the interim manager to show us the medicines at the service. We saw these were kept in a locked facility, to which the interim manager held the key. We saw evidence that temperature checks were taken to ensure the safe storage of medicines. We asked the interim manager if there were any cooling mechanisms in place, should the temperature exceed the maximum for storing medicines.

Requires Improvement

Is the service safe?

The interim manager was able to tell us how they would reduce the temperature of the room in which medicines were stored. This meant the service managed and monitored the storage of medicines.

We carried out a stock check of four different medicines, stored in the medicines trolley and found these all tallied with the amounts shown on the Medication Administration Records (MAR).

We asked the interim manager about 'as required' (PRN) medication. They told us these would be listed on the MAR chart as well as on a 'PRN sheet'. We carried out a stock check on these medications and found some discrepancies. The interim manager told us this was due to medicines not being checked in and out when people who came for respite arrived and left the service. We asked the interim manager how they could ensure PRN medication amounts were correct, using this PRN sheet and MAR chart. The interim manager told us it was not possible to ensure this, due to the discrepancies between MAR and PRN sheets. The interim manager told us they would remove the PRN sheet with immediate effect and ensure all medication was now 'booked in' on the MAR charts.

In care files we looked at, we found details of people's medicines on a 'medication profile'. This included details of the name, frequency and dose of medicines required. There were also instructions on how to administer medicines. For example, in one care record we looked at, we found; "Give [person] her tablets in her hand and she then takes them with a drink of water." We also saw on the 'medication profile' a section to list all known allergies. This demonstrated the service managed the administration of medicines safely.

The staff member we spoke with told us they had been trained in medicines, but that medicines were administered by the nurse, when they were on shift and trained staff when a nurse was not on shift. In one staff personnel file, we found evidence that the staff member had undertaken an NCFE qualification in the safe handling of medicines. This demonstrated the service made training available for staff from outside organisations to effectively and safely carry out their roles.

Requires Improvement

Is the service effective?

Our findings

We looked at the care records of three people who used the service. We found that people's needs were assessed and included their preferences and choices. We asked the staff member we spoke with how they ensured that people's needs, preferences and choices were met. They told us they had received training in all relevant areas to delivery of care, including any training relating to people's conditions, such as epilepsy.

In staff personnel files we looked in, we saw evidence of monthly supervisions (called 'Monthly Competency Framework Assessments') and annual appraisals. These supervisions and appraisals identified areas for improvement or training required. One of the staff personnel files we looked in was for a member of staff who had recently started working at the service. We found evidence in this file that the person had completed their induction, on commencement of their employment.

We asked the interim manager how they ensured they monitored the day-to-day culture in the service, including staff attitudes, values and behaviour. They told us this was done through regular, monthly supervisions. We saw evidence of this in staff personnel files we looked at. We found that feedback given to staff during these supervisions was constructive and focussed on ensuring the service maintained and improved the quality of care and support provided.

In one staff personnel file, we found evidence that the staff member had undertaken an NCFE qualification in the safe handling of medicines. The Awarding Organisation 'NCFE' was established in the 1990's and provides a wide range of general and vocational related Qualifications and Credit Framework (QCF), Competency Based Qualifications, National Vocational Qualifications (NVQ) and Functional Skills Qualifications. This demonstrated the service sourced training with outside organisations to enable best practice in the delivery of care.

We found evidence in one staff personnel file that the staff member had undertaken further training titled 'Developing community connections for people with learning disabilities' and another training course titled 'learning disabilities communication'. This demonstrated the service ensured staff had the skills to communicate effectively with people and carry out their roles and responsibilities.

We looked at the staff development plan for the service. We saw the plan identified areas for staff training the following year. However, we found some training was out of date, with seven staff members overdue refresher training in moving and handling, five staff members overdue refresher training in health and safety and four staff members overdue refresher training in safeguarding. We also found refresher training was overdue for some staff members in emergency first aid, equality and diversity, positive behaviour support (PBS) and communication. This meant staff knowledge and skills were not up to date, as required by the service and Regulation 23 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at the staff development plan and saw that all staff members had been trained in Mental Capacity Act 2005: basic awareness (MCA), Deprivation of Liberty Safeguards (DoLS), assessing MCA capacity and best interest. This demonstrated the service made training available for staff to understand the Mental Capacity Act 2005.

We asked the staff member what they understood about MCA and DoLS. They were able to explain the Mental Capacity Act 2005 and the main principles behind DoLS. They also told us that people who use the service could access an advocate, should they wish to do so.

In one care record we looked at, we saw the person was at risk of absconding from the service. We saw a 'client positive risk assessment' that stated the front door should be locked, keys removed and staff to supervise the person. We asked the interim manager if a DoLS authorisation had been obtained for this. The interim manager told us there had been no assessment completed. We found evidence in this file that the person's relative had extensive input into their care planning, including risk assessments in place regarding absconding. However, the 'Deprivation of Liberty Safeguards; Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice' states; "A managing authority must not, except in an urgent situation, deprive a person of liberty unless a standard authorisation has been given by the supervisory body for that specific situation, and remains in force". The code of practice also states; "Authorisation should be obtained from the supervisory body in advance of the deprivation of liberty, except in circumstances considered to be so urgent that the deprivation of liberty needs to begin immediately. In such cases, authorisation must be obtained within seven

Requires Improvement

Is the service effective?

calendar days of the start of the deprivation of liberty." This meant the service was unlawfully depriving someone of their liberty as no authorisation had been sought in line with Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw food and drink available in the kitchen area of the service and, during our morning observations, we saw people were offered a choice of food and drink. In care records we looked in, we saw evidence of care plans to enable people to meet their nutritional and dietary needs. In one care file we looked at, we saw the person's religious beliefs meant they were unable to eat certain types of foods and we saw the person's family had had input into this care plan. We also saw a section in the care file that outlined the routines to be followed for the person who used the service, including routines around mealtimes. We spoke with the staff member about this, who told us the person was "very particular" about the food they ate, so were involved in the preparation and cooking of meals, to reduce any anxieties over food that the person had.

We saw evidence in care records of multi-agency work, including joined-up working with the local authority, clinical commissioning groups and the South and West Yorkshire Partnership NHS Foundation Trust (SWYPFT). This demonstrated the service ensured relevant health services were involved in care planning in order to get a clear, accurate view of people's needs.

Good

Is the service caring?

Our findings

When we arrived at the service, we carried out observations of staff with one person who used the service, whilst they waited for their transport to day services. Observations were limited due to people who used the service attending day services. We saw staff spoke to the person with kindness and compassion. We asked the person who used the service if they liked being there. They told us they did.

In one care record we looked at, we found evidence that the service used Picture Exchange Communication system (PECs) to communicate with the person so they understood the information presented to them. PEC is a system used for developing full communication through the use of pictures and imagery. This demonstrated the service made available accessible, tailored and inclusive ways of communicating with people.

We asked the interim manager how they ensured people's views of the service were actively sought and acted upon and if there was any formal recording of people's opinions of the service. The interim registered manager told us there was no formal recording of opinions from people who used the service but that people were able to discuss any issues or concerns on an ad-hoc basis.

We asked the interim manager how they obtained the views of friends and relatives of people who used the service. They told us an annual questionnaire was sent out to relatives. We saw the latest results of this survey, which were all positive. On one of the returned questionnaires, the person had written; "Bowel/urine chart is sometimes left blank – particularly at weekends." We asked the interim manager about this, who told us they would address the issue as they had not already seen the comment.

We asked the staff member on duty about people who used the service. The staff member we spoke with clearly knew people well and was able to give a brief explanation of people's needs, wants, likes and dislikes. This demonstrated staff knew people well.

We asked the staff how they ensured people who used the service were involved in making decisions at the service. The staff member told us they would always ask for people's consent before carrying out a task. They said they would ask people what activities they would like to partake in and they would assist in personalising the person's own space. We saw evidence in care files that people were asked for their input, where they had capacity to understand.

We saw no evidence at the service during our walk around or whilst looking through care files of advocacy services that were available at the service, although staff told us people would be given information about advocacy, should it be required.

We asked the staff member how they ensured people's privacy and dignity was respected. The staff member told us people were able to go into their rooms and shut their doors. They also told us that, before entering a person's room, they would always knock and ask if they could enter. The staff member told us, when giving personal care to someone at the service, they would always ensure doors were closed in order to maintain people's privacy.

We observed people were able to access all relevant areas of the home, including the kitchen area, where they were able to get food and drink as they pleased. The interim manager told us people's relatives could visit the service when they pleased, although this did not usually occur due to the short-term nature of the respite service. This demonstrated the service encouraged people's independence and friends and family were able to visit with no restrictions.

We looked at the minutes from staff meetings and saw the monthly meeting agenda contained 'dignity', where items were discussed such as how to maintain people's dignity both inside and outside of the service. This demonstrated the service ensured staff understood how to respect people's privacy and dignity.

Requires Improvement

Is the service responsive?

Our findings

During our inspection, we looked at the care records of three people who used the service. We saw evidence that people and their relatives were involved in the person's care planning, where possible. In all care records we looked at, we found a document titled 'Important things to me' that detailed information including the person's likes, dislikes and favourite pastimes. This demonstrated the service respected people's choice and control.

We carried out observations on the morning of our inspection and saw that people were supported to follow their interests. For example, we saw one person at the service awaiting transport to a day centre they liked to attend.

We saw people were supported to develop and maintain relationships with people and avoid social isolation. For example, in the lounge area of the service, we saw there was ample seating for people to use and board games to play with each other. We looked in the garden area and saw it was maintained to an acceptable standard, with flower beds inside large vehicle tyres. We asked the interim manager if people who used the service had been involved in creating and maintaining a suitable garden area. The interim manager told us people had been involved when creating the garden and people often went out to the garden to water plants.

We asked the interim manager how they ensured people's views were listened to and taken into account. The interim registered manager told us they held quarterly family and carer meetings, where people were invited to attend and discuss any issues they may have had. This included issues around care, support, activities and the service itself. We also saw evidence in care files that the service catered to people's communication needs so that they could get people's views when planning their care. For example, in one care file we looked in, we saw evidence of a Picture Exchange Communication system (PECs) being used. PEC is a system used for developing full communication through the use of pictures and imagery.

We looked in care records to see how people had their individual needs regularly assessed, recorded and reviewed. We found several 'support plans' in each file that contained details of the support required in different areas, including; eating & drinking, choices, hearing, height & weight, exercise, mobility, medication and relationships. We saw these 'support plans' were regularly reviewed and updated with input from the person themselves, relatives and other professionals. We saw a sheet titled 'Review of clients file before they access the service', that had details of any changing needs the person had before the person accessed the service for respite. This information included any changes to medication and support. We also saw another sheet titled 'Review of clients when they have returned home after respite stay'. These sheets were completed with the input of the person's relative. This meant the support needs of people were regularly reviewed with ample personal and professional input with information of the person's day to day needs.

In all care records we looked at, we found risk assessments in place to corroborate with the support plans. However, we found there were no review dates recorded on these risk assessments. This meant it was not possible to evidence that risk assessments were carried out and reviewed with appropriate frequency.

During our inspection, we conducted a walk around of the service and found a 'sensory room'. This room contained coloured lights, large upright tubes filled with water and plastic fish, large beanbags and speakers to play music. Sensory rooms are typically designed to develop people's sense through lighting, objects and music and can help create a safe space, facilitate a therapeutic atmosphere, provide opportunities for crisis prevention and de-escalation and promote self-care, resilience and recovery. We saw evidence that this room was well-used and was being updated with newer décor and facilities. This demonstrated the service made reasonable adjustments to cater to people's physical, sensory or learning disability needs.

We asked the interim manager how complaints were encouraged, explored and responded to. The interim manager told us they sent out the complaints policy to people and their relatives on an annual basis but that they had received no formal complaints at the service. The interim manager told us that, if anyone had any issues, they usually phoned the service. We asked the interim manager if a log was kept of the informal complaints/ issues, where people had called the service to raise an issue. The interim manager told us these issues were not recorded. This meant it was not possible to evidence that

Requires Improvement

Is the service responsive?

complaints and concerns were dealt with appropriately and we could not evidence that information and concerns received about the quality of care were thoroughly investigated and recorded.

We asked the interim manager if relatives and friends of people who used the service were given opportunity to provide feedback. The interim manager told us an annual relative questionnaire was sent out. We looked at the results from the latest relative survey and found they were all complimentary about the service.

We asked the interim manager if they carried out any trend analysis of concerns, complaints and incidents as an opportunity for learning or improvement. The interim manager told us they had not carried this out as they had not received concerns or complaints. However, the interim manager told us the area manager carried out trend analysis of concerns, complaints and incidents regionally. We spoke with the area manager about this, who told us they carried out trend analysis on an ad-hoc basis and there was no formal recording. This meant we were not able to evidence that trend analysis was carried out to inform service development in line with Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Requires Improvement

Is the service well-led?

Our findings

We asked the interim manager how they ensured people who used the service and staff were involved in developing the service. The interim manager told us service development was discussed at quarterly family/carer meetings and at monthly staff meetings. We looked at the minutes of staff meetings and saw an item on the agenda titled 'opportunities for service growth and development'. This demonstrated people, relatives and staff were actively involved in service development.

We asked the interim manager how they ensured there was an open and transparent culture at the service. The interim manager told us they operated an 'open door policy', where staff or people who used the service were free to come and go as they pleased to discuss any issues or concerns they had. We found no policies pertaining to maintaining an open culture at services. The interim manager told us that people were able to enter their office, 'even if they just wanted a chat'.

We saw the service enabled accessible, tailored and inclusive ways of communicating with people. In care records we looked at, we saw evidence of PECs being used. This evidenced the service made resources available to aid in communication with people. We also observed staff speaking with people clearly, avoiding complicated sentences and words. This demonstrated staff knew people well and were able to cater to their individual communication needs. We saw evidence of 'nurses meetings', which took place every four months. These 'nurses meetings' were used to discuss people's care needs, including communication needs and techniques used to cater to these. These meetings were attended by the service and facilitated by the National Health Service (NHS).

We asked the interim manager if they received appropriate support from higher management. The interim manager told us they felt well supported and knew how to contact their manager. During our inspection, the area manager visited the service and offered support to the interim manager.

We asked one member of staff if they felt supported by their manager. The staff member told us they felt very well supported and were confident that, if there was an issue, they could approach their manager and would be supported. We asked the staff member if resources were available for their personal professional development. The staff member told us there was ample training available at the service and that they were due to attend a training course that afternoon. However, we were unable to evidence this due to some staff training being out of date and requiring refresher courses.

We asked the interim manager how they ensured that quality assurance at the service was effective and used to drive continuous improvement. The registered manager showed us audits the carried out at the service. We saw evidence that audits had been carried out at the service. However, we found several areas where audits had not been carried out for some time. For example, we looked at a 'Premises safety survey report' that had been completed monthly up until July 2014, but not after. We saw issues had been identified on the latest audit but no further information had been recorded to state whether the issues had been resolved. This meant it was not possible to evidence that audits were carried out regularly and effectively. We spoke with the interim manager and area manager about this, who told us the identified issues had been resolved but not recorded.

During our walk around of the service, we noticed several breaches in the paintwork and plasterwork at the service. However, when we looked at a 'Property maintenance request record', held with other audits at the service, we found there had been no information recorded since October 2012. This meant the service did not record when areas of the service and premises required improvement.

We saw evidence that bi-annual bath and hoist servicing took place at the service. However, we found that some of the servicing dates had passed their 'required' date. We found that both bath and hoist servicing was due in February 2014 but had not been carried out until June 2014. This meant that, although servicing of baths and hoists was carried out, governance and auditing at the service was not always conducted within the required timescales in line with Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers 10.—(1) The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to— (a)regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this Part of these Regulations; and (b)identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity. (2) For the purposes of paragraph (1), the registered person must— (a)where appropriate, obtain relevant professional advice; (b)have regard to— (i)the complaints and comments made, and views (including the descriptions of their experiences of care and treatment) expressed, by service users, and those acting on their behalf, pursuant to sub-paragraph (e) and regulation 19, (ii)any investigation carried out by the registered person in relation to the conduct of a person employed for the purpose of carrying on the regulated activity, (iii)the information contained in the records referred to in regulation 20, (iv)appropriate professional and expert advice (including any advice obtained pursuant to sub-paragraph (a)),

This section is primarily information for the provider

Action we have told the provider to take

(v)reports prepared by the Commission from time to time relating to the registered person's compliance with the provisions of these Regulations, and

(vi)periodic reviews and special reviews and investigations carried out by the Commission in relation to the provision of health or social care, where such reviews or investigations are relevant to the regulated activity carried on by the service provider;

(c)where necessary, make changes to the treatment or care provided in order to reflect information, of which it is reasonable to expect that a registered person should be aware, relating to—

(i)the analysis of incidents that resulted in, or had the potential to result in, harm to a service user, and

(ii)the conclusions of local and national service reviews, clinical audits and research projects carried out by appropriate expert bodies;

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment 18. The registered person must have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff 23.—(1) The registered person must have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard, including by— (a)receiving appropriate training, professional development, supervision and appraisal; and

This section is primarily information for the provider

Action we have told the provider to take

(b)being enabled, from time to time, to obtain further qualifications appropriate to the work they perform.

(2) Where the regulated activity carried on involves the provision of health care, the registered person must (as part of a system of clinical governance and audit) ensure that healthcare professionals employed for the purposes of carrying on the regulated activity are enabled to provide evidence to their relevant professional body demonstrating, where it is possible to do so, that they continue to meet the professional standards which are a condition of their ability to practise.

(3) For the purposes of paragraph (2), "system of clinical governance and audit" means a framework through which the registered person endeavours continuously to—

(a)evaluate and improve the quality of the services provided; and

(b)safeguard high standards of care by creating an environment in which clinical excellence can flourish.