Regents Park Limited

47 Regents Park

Inspection report

47 Regents Park
Heavitree
Exeter
EX1 2NZ
Tel: 01392 209109
Website: EX1 2NZ

Date of inspection visit: 11 and 20 May and 2 June 2015
Date of publication: 18/09/2015

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

The inspection took place on 11 and 20 May and 2 June 2015. The first two visits were unannounced. During weekdays the people attended a day centre; therefore we visited in the evenings so that we could meet them and find out about the support they received. On the third day we visited the providers' main office where records such as staff files were held.

47 Regents Park is registered to provide accommodation with personal care for up to four people who have learning disabilities and/or physical disabilities. The property is a large terraced house and the adjacent property, 49 Regents Park, is also a registered care home run by the same provider. Although separately registered the two properties were closely linked and shared the same staff team.

At the time of this inspection there were four people living at 47 Regents Park. The property was divided into two separate units. In the basement there was a self-contained flat for one person, and on the ground and

Summary of findings

first floors there was accommodation for three people. Each unit was independently staffed although staff said they frequently worked in 49 Regents Park or other services operated by the provider

There was a registered manager in post who also managed two other care homes in the Exeter area. 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.

The registered manager was not aware of the requirement to notify the Care Quality Commission of any incidents or accidents although they told us no serious incidents had occurred since the last inspection. This meant there was a risk serious accidents or incidents may not be adequately investigated by external agencies and professionals who have a legal responsibility to ensure people's safety and well-being.

Where people were subject to restrictions, Deprivation of Liberty Safeguards (DOLS) applications had recently been submitted. The provider and registered manager had recently been made aware of changes in legislation by members of the local authority safeguarding team. This meant they had not kept up with changes in legislation designed to protect people's rights.

People were offered a range of cooked main meals, although these were not always home cooked. People were not always offered a pudding course although fresh fruit was always readily available if people wanted. Records showed each person had purchased items from their own income such as jellies, cakes and Angel Delight which they were given as a pudding course after some meals. This meant people were not offered a full choice of foods to suit their individual preferences.

During our visits to the home staffing levels were sufficient to ensure people received support from staff when they needed it. However, following the inspection we received information that indicated staffing levels sometimes fell below the levels shown in the staff rotas. This information has been passed to the local authority safeguarding team for further investigation.

Staff knew how to protect people from the risk of abuse. They had received training on safeguarding adults and knew who to contact if they suspected abuse may have occurred. Systems were in place to ensure people's cash or savings were managed safely. This meant people were protected from financial abuse.

Staff recruitment, supervision and training records showed staff had been carefully recruited by obtaining references and carrying out checks on their suitability before they were offered employment. Information provided by the registered manager showed staff received training on relevant health and safety topics, but only four staff out of a total staff team of 18 had received training on autism, challenging behaviour, or epilepsy. Information received after the inspection indicated that some shifts had been staffed by new and inexperienced staff who may not have the skills or knowledge to help them support people effectively. This information has been passed to the local authority safeguarding team for further investigation.

People were supported by staff who received regular supervision and support. Staff meetings were held regularly. Staff said they worked well together as a team.

Each person attended a day centre every weekday operated by the provider where they were offered a range of activities they could participate in. This service is not regulated by the Care Quality Commission and therefore we did not check the services or care provided to people while they attended the day centre. In the evenings and weekends they were able to choose to go out, for example to a local pub, walks in the area or the cinema, or stay at home and do activities of their choice.

Medicines were stored and administered safely, although procedures for discarding medication when no longer safe to use were not fully effective. Staff had received adequate training on safe administration of medicines.

People were supported to maintain good health. However, risks to people's health and welfare had not been assessed and reviewed regularly. Staff were given guidance and training on how to recognise and reduce risks

People had not been fully consulted or involved in drawing up and reviewing their care plans. The care plans had not been regularly reviewed or updated and some information was out of date. This meant staff did not have access to up to date information about people at all times.

Summary of findings

During our visits we saw staff interacting with people who lived there in a caring and empathic manner. Staff understood each person's individual communication methods. People were offered choices.

There were systems in place to monitor the daily routines in the home. Daily reports on all aspects of the support given to each person were completed by staff. The reports were returned to the provider's head office each month to be checked by the provider and manager. However, the registered manager did not regularly work in the home and there was a risk some poor practice or ineffective routines were not picked up or addressed. We found breeches of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).You can see what action we told the provider to take at the back of the full version of the report

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 not safe.

People were supported by sufficient staff at the time of our inspection, However, concerns received about staffing levels and the safety of the service after this inspection have been passed to the local authority safeguarding team.

Risks to people's health or safety had not been identified or managed in ways that ensured people were safe or their needs were met

Staff knew how to recognise potential abuse and the actions to take if they suspected people may be at risk

Medicines were stored and administered safely, although procedures for discarding medication when no longer safe to use were not fully effective

Is the service effective?

Requires improvement

The service was not fully effective.

People were not always supported by staff with the knowledge, training or skills to meet their needs effectively.

People were not supported with person centred care regarding food choices that reflected their individual preferences.

People's human rights were protected because the provider followed appropriate legislation.

Is the service caring?

Good

The service was caring.

Staff interacted with people in a caring and empathic manner.

Staff were able to communicate effectively with people and understood their non-verbal means of communicating choices and preferences.

Is the service responsive?

Requires improvement

The service was not fully responsive.

People had not been fully involved or consulted in drawing up and agreeing their care plans.

People's care needs had not been regularly reviewed and care plans contained out of date information which meant there was a risk people would not receive the support they needed to meet their needs fully.

People were able to participate in a range of activities and led active lives.

Summary of findings

Is the service well-led?

The service was not consistently well-led.

Systems for monitoring the quality of the service were not fully effective.

The provider did not have effective quality assurance systems in place that ensured people received a safe service that responded fully to their individual needs

Requires improvement

47 Regents Park

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.

The inspection took place on 11 and 20 May and 2 June 2015 and was carried out by one inspector. The first and second visits were unannounced and took place in the evenings because people were out during the day at a day centre. There was a delay between the second and third visits because the registered manger was unavailable during this period.

Before this inspection took place we received information that may have been relevant to this service which included concerns about the use of restrictive practices, unsafe recruitment processes, safeguarding, fire risks due to locked doors, inadequate budgets for food and activity, medication and specialism and isolation of the service. During this inspection we found no evidence of restrictive practices, unsafe recruitment practices, or fire risks due to locked doors at 47 Regents Park. However, we found some concerns relating to how food budgets were used (see Is the service effective?).

We were unable to have conversations with people because they were unable to communicate verbally. Instead we relied on our observations of care and our discussions with staff and external professionals including members of the safeguarding team, and a Speech and Language Therapist (SALT) to help us understand people's experience of the service. We spoke with four staff. We looked at three records of support given to people including support plans, daily reports, and medicines stored and administered in the home. On the third day we agreed in advance to meet the registered manager at the provider's offices to look at the records stored there. These included staff recruitment, supervision and training records, and records of cash and savings managed on behalf of people.

Before the inspection we looked at the information we had received on the service since the last inspection. We had received no notifications of incidents or accidents.

Requires improvement

Is the service safe?

Our findings

People did not receive a service that ensured they were safe or protected from harm. Risks to each person's individual health and safety had been assessed but these had not been regularly reviewed. Care plans explained the potential risks for each person including choking, dehydration and malnutrition but when we discussed the care plans with staff we heard that some risks had changed and the records were incorrect. Staff told us none of the people living at 47 Regents Park were at risk of choking although this differed with information in one care plan we saw. This meant staff did not have up to date information about the risks to each person's health and safety, or the actions staff should follow to reduce or eliminate those risks.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

People could not be confident there were always sufficient staff on duty with the skills and experience to meet their needs. During each of our two unannounced visits we found the support needs of the four people living at 47 Regents Park were met by three staff. Staff rotas showed that when people were at home in the evenings and weekends there were two staff on duty in the main part of the home supporting three people, and one member of staff supporting one person who lived in a self-contained flat in the basement. Overnight there were two staff on duty, one in each part of the house. During our visits we saw staff were attentive to the three people, and people received support promptly when they needed it.

However, after the inspection staff told us there were times when staffing levels had fallen below safe levels, leaving people with insufficient staff to meet their needs. They also told us there had been occasions when the only member of staff on duty did not have the knowledge or experience to meet the needs of each person fully. This information was passed to the local authority safeguarding team for their attention.

Many of the staff who worked in 47 Regents Park also regularly worked in other services run by the provider including the adjacent home at 49 Regents Park.

We were unable to have conversations with people living in the home due to their lack of language skills associated with their learning disabilities. We relied on our observations of care and our discussions with the staff to help us understand people's experience of the service. We saw people were smiling and relaxed when staff were supporting them.

During our visits we spoke with four members of staff. They told us they had received training on topics relevant to people's health and safety, and on safeguarding adults. They were confident they knew how to identify and report any potential abuse. They explained the signs they would look for, and how to recognise changes in behaviour or mood.

We looked at staff employment records for all care staff recruited by the provider since the last inspection. These included records of staff working in other services operated by Regents Park Ltd. The records were neatly filed and contained clear evidence of checks carried out before new staff were suitable to work with vulnerable adults. Staff were not allowed to begin working with people until satisfactory checks and references had been obtained. This meant the risk of abuse to people who used the service was reduced because effective recruitment and selection procedures were followed.

Before our inspection we received a concern that indicated people may not have received an adequate diet and had lost weight. Daily records showed each person was weighed regularly. Their weights had remained stable and were within healthy limits.

People received their medicines safely from staff who had received training and were competent to carry out the task. Medicines were safely stored and administered. The service used a monitored dosage system supplied by a local pharmacy. Staff had signed the medicines administration records each time they had administered a medicine and there were no unexplained gaps. There were systems in place to record the amounts held in the home at the end of each month and carried forward to the next. Staff told us they had received training on the safe administration of medicines and we saw certificates to confirm this.

Creams and lotions had not been dated when opened. This meant staff did not know when medicines should be discarded.

Staff explained how they recognised the signs of pain in each person and knew when to offer pain relief. Care plans gave information to staff about most medicines prescribed

Requires improvement

Is the service safe?

to each person, including how to administer them safely, and how to administer them according to each person's individual needs and preferences. Information on staff training provided by the registered manager showed that all staff had received training on the safe administration of medicines.

We looked at records in the provider's main office of cash and savings held by the provider and managed by staff on behalf of people using the service. The records showed regular checks and balances were carried out that ensured people's money was managed and held safely.

The premises were well maintained and safe. Each person had a comfortable bedroom that had been decorated and furnished to suit their individual preferences. The registered manager provided us with information about regular safety checks carried out on the premises, for example gas and electricity equipment checks.

We recommend the provider reviews the support needs of each person living at 47 Regents Park to ensure that at all times there are sufficient staff with the knowledge, skills and experience to meet people's needs safely.

We recommend the provider ensures there are safe systems in place to ensure all medicines are discarded when out of date or no longer safe to use.

Requires improvement

Is the service effective?

Our findings

People did not receive a service that was fully effective. People were able to make choices about their main meals and drinks but were not offered a choice of puddings. Fresh fruit was available in the dining room. The main meals were varied, although included some shop-bought meals such as pies and pizzas which staff heated, rather than homemade meals. People took packed lunches with them to the day centre. On our first visit people had faggots with rice and vegetables for their evening meal. Staff told us they sat down with people on a Sunday and helped people choose the menu for the following week using picture menus.

A member of staff told us the food budgets were good and they had plenty of stocks of food. However, when we looked at the records of money spent by staff on behalf of people we saw people had purchased items such as packets of jellies, cakes and Angel Delight. We spoke with the provider about this and they told us if people wanted extras or 'treats' such as puddings or cakes they were expected to purchase these out of their own personal money. This meant that, although people were offered a variety of main meals, they were not offered a varied choice of pudding courses. The purchases of jellies and Angel Delight showed that people would request a pudding course if this had been offered.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 Regulated Activities) Regulations (2014).

During our visits people were offered drinks regularly and staff encouraged people to help prepare the drinks where they were able to do so safely.

We were given a copy of the provider's training matrix that showed there were 18 staff employed. Of these, nine staff held relevant qualifications in care, while nine staff held no relevant qualification. All staff had received training and regular updates on all required health and safety related topics. Four staff had received training on autism in the last year and more training was planned for eight staff for March 2016 on this topic. Five staff had received training on non-abusive psychological and physical intervention, and more training was planned for the future for a further four staff. No staff had received recent training on epilepsy awareness of epilepsy medication, although training on this topic was planned for some staff in the future. This meant that a high number of staff had not received training on topics relevant to the support needs of the people living at 47 Regents Park.

Staff told us they had received training on safeguarding adults, but had not yet received training on the Mental Capacity Act 2005 (MCA) or Deprivation of Liberty Safeguards (DOLS) although they were aware this training had been booked for the near future. The MCA provides the legal framework to assess people's capacity to make certain decisions at a certain time. The training records showed three staff had received this training. We discussed one person for whom restrictive practices had been agreed in the past through a 'best interest' decision making process. The staff were unsure if the person's capacity to agree to this practice had recently been reviewed and they said this highlighted the importance of the MCA training about to be provided.

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

During our two evening visits to 47 Regents Park we met four staff. On the first evening we met one staff who had worked there for one year and one staff had worked there for three weeks. On our second evening visit we met two staff who told us they had been employed at the home for approximately three months. One staff had five years relevant previous employment caring for people with similar needs to those living at 47 Regents Park.

All staff said they enjoyed their jobs and felt well supported. The newest member of staff told us they had received a good induction covering a range of topics including care planning, report writing, safeguarding and medicine administration. They said the induction had mainly been provided by watching DVDs and afterwards they had to complete a handwritten test. They said the induction had been interesting and of a good standard and they had learnt new things from the training. Staff told us the induction also included instructions on daily routines for people in both 47 and 49 Regents Park.

Two staff told us they had received a good range of training. They said "We do lots here." They were keen to do as much training as possible. One staff was in the process of completing a nationally recognised qualification in care,

Requires improvement

Is the service effective?

and the other staff said they hoped to sign up for this training in the near future. However, one staff said felt they would have benefitted from more training on autism and challenging behaviour at the start of their employment.

A Team Leader had responsibility for supervising staff in 47 and 49 Regents Park. Staff told us they were well supported by the team leader who provided regular supervision. They told us new staff received supervision every week until their probation period was completed, and from then on supervision was received every six weeks.

Staff were knowledgeable about people's individual support needs. For example, one person was able to communicate using sign language. We saw one member of staff communicating with them using sign language. They told us they had picked up some basic sign language skills while working in the home and had requested further training to improve their skills. Staff also explained each person's daily routines including getting up, going to bed, sleeping and eating.

Before this inspection took place checks were carried out through the safeguarding adult's team that showed that no Deprivation of Liberty Safeguards applications had been submitted for people living at 47 Regents Park. The provider was advised to submit applications where applicable. This was needed because people were unable to leave the home without staff support. Deprivation of Liberty Safeguards (DoLS) provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. During this inspection we were assured by the registered manager that they had submitted applications for each person a few days before our inspection.

Reports were completed by staff about each person regularly throughout each day. The report sheets had been specially printed for each person to include any tasks specific to their needs. The reports were bound in monthly books that provided a complete record of the person including risks assessments. The reports covered all aspects of each person's daily routines and provided good information about their health and welfare, the activities they had participated in, times of getting up and going to bed, the foods they had eaten, and their mood. The reports showed that each person's health and wellbeing had remained stable, and they were happy and contented.

Support plans provided good information about each person's medical conditions including signs and symptoms and how it affected the person. The plans also explained each person's communication methods, including sign language such as Makaton, or use of pictures to help them express their needs.

Suitable arrangements were in place to ensure people attended medical appointments. Staff told us there were always two members of staff on duty if people needed to attend medical appointments. Appointments were written in the daily communication diary and in care notes to ensure staff were aware of the appointments. They told us some relatives chose to take people to medical appointments. We discussed the possibility of missed medical appointments with the registered manager. They told us that in response to a previous mix-up over an appointment for influenza inoculations they had decided to introduce a monthly appointments sheet which would be added to the front of each person's daily recording book.

We looked around the house and found all areas were well maintained and homely. Bedrooms were bright and attractively decorated to reflect individual interests. All areas were comfortably furnished. The people living at 47 Regents Park were able to move around safely without the need for adaptions or specialist equipment.

Good

Is the service caring?

Our findings

During our visits we saw staff interacting with people who lived there in a caring and empathic manner. For example, one member of staff offered to plait a person's hair. The person enjoyed having their hair brushed and styled. The member of staff told us people enjoyed having 'pamper sessions'.

Another member of staff explained how a person needed reassurance when they became anxious. They told us about the things the person liked to do, and they offered the person choices, for example "Would you like to play a game?" The person chose a game and we saw them laughing and smiling.

Although people were unable to communicate verbally staff understood their non-verbal communication methods including sign language. For example we saw people taking staff by the hand and showing them the things they wanted to do by pointing. Staff responded positively and reassuringly. Where two people wanted to do different things, for example one person wanted to watch their choice of DVD while another person wanted a different choice; the staff were able to confidently support people to reach a compromise.

Care plans explained people's capacity to make choices and also explained how staff should support them. For example, one care plan said "I do have capacity to make choices between two objects and I have the ability to choose not to engage." Throughout our visits we saw staff offering people choices and respecting their decisions.

When a person became excited and showed signs of agitation staff were firm but also caring, saying clearly "No, this must stop." They suggested the person helped them to make a drink and this helped the person to become calm again.

A key worker system was used to ensure each person had a member of staff who had been given the responsibility for ensuring their needs and preferences were known and respected by all staff. Staff explained how they helped people purchase clothing by taking them on shopping trips either in the evenings or at weekends. Each person was dressed in attractive clothing to suit their personalities. Staff had taken care to ensure their hair was attractively styled.

Staff treated people with dignity and respect. For example, when people were supported with personal care such as assistance to use the toilet this was carried out discretely and respecting people's privacy and dignity. Each person had their own individual bedroom where they could spend time in private if they wished.

Daily reports completed by staff were factual and non-judgemental and showed staff understood each person's needs and were meeting these in a caring manner.

Requires improvement

Is the service responsive?

Our findings

People did not receive a service that was fully responsive to their individual needs. Care plans were not always reflective of people's up to date needs and wishes. This could potentially place people at risk of receiving inappropriate care and support. On our first visit to the home we found care plans had not been fully updated. One care plan was not available and staff told us this had been taken to the providers' office to be updated. Two care plans had lots of handwritten amendments, but some of these were out of date. On our second visit to the home all care plans were in place but some information remained out of date. For example, one care plan contained information about a person's continence, support needs with food and drink, and their sleeping pattern. Staff told us that all of these areas had improved since the care plans had last been updated.

People had not been fully involved in drawing up or reviewing their care plans. Some photographs were used, but plans were otherwise drawn up using text. This meant that people who were unable to read did not have access to information about their care and support needs in a format they were able to understand. We spoke with the provider and the registered manager about the care plans. They told us they were aware the care plans needed updating and they were in the process of carrying this out urgently. They planned to introduce a new electronic system of recording all information using tablet and desktop computers. They expected this to take a little time to implement and they planned to run both systems of care planning and recording until the new system was fully established. They also told us they planned to give people greater involvement in the care planning process by incorporating more photographs and symbols into the plans.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

Staff told us about the activities people enjoyed doing. The provider ran a day centre which people attended on weekdays. The day centre provided a range of activities including arts and crafts, cookery, animal care, and a cinema.

Support plans provided information about the activities each person enjoyed and the places they liked going to, including activities during the evenings and weekends. For example, one person enjoyed sitting down with staff in the evenings and playing games. One person enjoyed reading books in their bedroom, and another person enjoyed watching films, gardening and animal care.

Where possible people and their families were encouraged to participate in house meetings. Satisfaction surveys had been sent out to all families in December 2014 to gather their views of the service. The registered manager told us that responses had not been received from every family member. However, the completed surveys we were shown included positive comments such as "Very satisfied" and "Extremely positive." The registered manager told us families, visitors and staff have been encouraged to use the CQC website to view Regents Park's reports and use the "Share your experience" section where people were encouraged to give their views on the service.

Although people who used the service were unable to make formal written or verbal complaints staff understood the things that made them unhappy. Staff told us they were confident they would recognise any signs of distress and these would be reported to their line manager, the registered manager or the provider. Staff told us they thought the people living there were all happy and contented.

Requires improvement

Is the service well-led?

Our findings

The home was not well-led. The home was managed by a person who was registered with the Care Quality Commission as the registered manager for the service. This person also managed two other care homes owned by the provider. During our inspection we found the registered manager was not fully aware of some issues or concerns relating to the home. They told us they were unaware of some of the decisions that had been made by the provider, for example the decision not to provide a pudding course after the main meal. This meant there was a lack of communication between the manager and provider. This also indicated the management roles and decision making procedures between the provider, registered manager and team leaders were not clearly defined or fully effective.

We asked how they monitored the service to make sure all aspects were running smoothly. Daily reports completed by staff which contained detailed information about and monitoring checks on their health and welfare were returned to the provider's main office each month where they were checked by the manager and provider. The provider visited the service regularly and took a keen interest in each person's welfare. The provider carried out informal monitoring of the service and had a good awareness and close involvement with all aspects of the day to day running of the service. However, there was no overall quality assurance system in place to show how the provider and manager monitored the quality of the service.

A team leader provided supervision and support to the staff team in both 47 and 49 Regents Park. Staff told us they only saw the registered manager "as and when we need him".

Each week the registered manager told us they met with staff team leaders individually and also as a group on a monthly basis. They attended all monthly house meetings and where people living in the home were also present. The registered manager told us they carried out weekly spot checks on the service, where they checked areas such as staffing, accidents and incidents, cleanliness of the home, medications, petty cash, activities, and any safety checks including fire safety. They also checked that staff had read and signed any updates of policies and procedures. After the inspection the manager told us they will review their methods of communicating with every member of staff to ensure they have contact with every member of staff regularly. This will include those staff who were unable to attend staff meetings, and who were not present during spot check visits.

The registered manager had not kept themselves updated on changes in legislation relevant to the service. For example, they had been unaware of the need to submit DOLS applications for each person using the service until they had been requested to do so by the local authority safeguarding team. Applications had not been submitted promptly to comply with a change in legislation.

Since the last inspection no notifications of serious incidents had been submitted to the Care Quality Commission. The registered manager told us they had been unaware of the current procedures to notify the Commission of incidents, accidents or deaths. They told us there had been no serious incidents or accidents at 47 Regents Park. This was also confirmed by the staff we spoke with.

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

Staff meetings were held regularly and these were a useful opportunity to share information or discuss any issues. Staff said the meetings were helpful and gave them opportunity to discuss individuals and their support needs. They were able to make suggestions for changes or improvements to the service.

After the inspection the manager told us they planned to improve communication and monitoring procedures through the introduction of new computer equipment for staff to record all information relating to the day-to-day running of the houses

We recommend that the provider reviews the management of service and the roles of the management team to ensure there are clear job descriptions and job specifications for each member of the management team including the registered manager.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).** People's care was not person-centred. Care needs including potential risks to their health had not been fully assessed, monitored or reviewed and people had not been fully consulted or involved in drawing up or agreeing how their care needs should be met. **Regulation 9(3)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).** People were not offered a choice of food that met their needs and preferences as far as reasonably practicable.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).** The registered manager failed to evaluate and improve their practice, or ensure they were aware of all changes in legislation and good practice recommendations relevant to the services people received. The provider has failed to establish clear and effective management systems and monitoring of the service that meets the changing needs of people who use the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Action we have told the provider to take

Regulation 18(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014).

Staff had not received appropriate supervision, support, training or professional development to enable them to carry out the duties they were employed to perform.