Care Quality Commission

Community Integrated Care

Rosedale/Rosewood

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Good**
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

Rosedale/Rosewood is a purpose-built care home that consists of two attached bungalows with a connecting door. The service provides accommodation and personal care for six people with learning disabilities. The six people had lived there since it opened in 2001.

This inspection was carried out on 30 July and 5 August 2015. The last inspection of this home was carried out on 17 December 2013. The service met the regulations we inspected against at that time.

There had been three changes to the management of the home over the past year. At this time there was a new manager in post who had not yet 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.

During this inspection we found the provider had breached a regulation relating to the support and development of staff. This was because staff had not received supervision at regular intervals so they were not being offered support in their role or identifying the need

Summary of findings

for any additional training. Also the provider's records showed the required training for some staff had not been achieved or had expired, although updated training was now planned.

We found the provider had breached a regulation relating to care records. This was because people's support plans had not been reviewed in a timely way, some were incomplete and few staff had signed to show they had read them. This meant it was not possible to determine whether the support plans still reflected people's needs and whether staff were providing support in the right way.

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

The six people who lived at this home had learning disabilities and some people had limited communication. This meant they could not tell us their views about the service. Relatives told us people felt "safe" and "comfortable" with the staff and were "happy" at the home. One relative told us, "I have no concerns about it. My [family member] is always eager to get back so I know he enjoys it and feels safe there."

Staff were able to describe the procedures for reporting any concerns and told us they would have no hesitation in doing so. There had been some changes to staff but relatives felt there were enough staff to support people. The provider made sure only suitable staff were employed. Staff helped people to manage their medicines and did this in a safe way.

Relatives were confident that the service met the needs of the people who lived there. One relative told us, "The staff really know [my family member] and can always tell me how they have been." People were supported in the right way with their meals so their independence as well as nutritional well-being was promoted. They were encouraged to be involved in shopping and choosing meals. People were supported to access healthcare services when they needed to.

Relatives made positive comments about the "friendly" and "caring" attitude of staff. For example, a relative commented, "The staff are so nice and [my family member] seems happy with all of them."

The interaction between people and staff members was friendly and relaxed. Staff were supportive and patient, so that people could communicate and make choices at their own pace.

Relatives felt staff understood each person and supported them in a way that met their specific needs. They felt fully involved in reviews about their family member's care. Relatives told us they felt people were well cared for in the home. Each person had a range of social and vocational activities they could take part in. People were reminded how to make a complaint and relatives felt confident they could raise any issues, if necessary, with staff.

There had been three different managers running the home over the past year. Relatives felt this had had little impact on the care service to their family members. Staff felt the senior staff and manager were approachable and supportive.

The provider had a number of systems to check the quality and safety of the service including audits by staff and peer reviews by managers and people from other services. However there was an inconsistency in whether people were supported to have the same opportunities to comment on the running of the service they received. There had been few opportunities for staff to receive group instruction on expected practices or to give their views about the care service.

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?

Good

The service was safe. Relatives said people were comfortable and settled in the home and they had no concerns. Staff knew how to report any concerns about the safety and welfare of people and the provider took action to look into any reports.

Risks to people were managed in a way that did not compromise their right to an active lifestyle.

There were enough staff to meet people's needs. The provider checked potential new staff to make sure they were suitable.

Is the service effective?

Requires improvement

The service was not always effective. Some staff had not had training in necessary areas. Staff had not had regular supervision sessions so had not been supported with their professional development.

Relatives felt people's needs were met and were positive about the support they received from staff. People were encouraged to enjoy a healthy lifestyle.

People enjoyed their meals at the home and some people were involved in choosing and preparing their meals. Staff worked closely with health and social care professionals to make sure people's health was maintained.

Is the service caring?

Good

The service was caring. People enjoyed a good relationship with support staff. Relatives felt staff were helpful and kind.

People were assisted by staff in a friendly, appropriate way. Staff understood how to support people in a way that upheld their independence.

Staff helped people to communicate their choices and decisions about their own lifestyles.

Is the service responsive?

Requires improvement

The service was not always responsive. Care records were not always completed or reviewed. This meant some people might not always get the right support when they needed it.

People were offered daily activities, either individually or in small groups. People's choices about social activities were respected.

Relatives said they knew how to raise any concerns and were confident these would be dealt with. There was written information about how to make a complaint in the home.

Summary of findings

Is the service well-led?

The service was not always well led. Some people did not have the same chances to make comments and suggestions about the running of the home. Staff had had very few meetings to be instructed in expected standards of care or to give their views.

The home had a manager who was not yet registered with CQC. Staff felt the manager and senior staff were approachable and supportive.

The provider had carried out monitoring of the service and had made improvements that had a positive impact on people who used the service.

Requires improvement

Rosedale/Rosewood

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 30 July and 5 August 2015. The provider was given 48 hours' notice because the location was a small care home for younger adults who are often out during the day; we needed to be sure that someone would be in. The inspection was carried out by one adult social care inspector.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. Before our inspection, we reviewed the information included in the PIR along with other information about any incidents we held about the home. We contacted the commissioners of the local authorities to gain their views of the service provided at this home.

Some of the six people who lived at this home had complex needs that limited their communication. This meant they could not tell us about the service, so we asked their relatives for their views.

During the visit we spent time with people and observed how staff supported them. We joined two people for a lunchtime meal. We spoke with the manager, a senior staff member and three care workers. We looked around the premises and viewed a range of records about people's care and how the home was managed. These included the care records of two people, the recruitment records of three staff, training records and quality monitoring records.

Good

Is the service safe?

Our findings

The six people who lived at this home had learning disabilities and some people had limited communication. This meant they could not tell us their views about the service. They had lived at this home together since it opened in 2001. We asked their relatives for their views about whether people were safe at this service. One relative told us, "I'm sure [my family member] feels safe. He is very comfortable with the staff, especially his keyworker." Another relative told us, "I have no concerns about it. My [family member] is always eager to get back so I know he enjoys it and feels safe there."

Staff were able to describe the procedures for reporting any concerns and told us they would have no hesitation in doing so. One staff member told us, "If I thought someone was at risk I would definitely report it. With the training I feel able to do that."

The copy of the provider's safeguarding policy in the home was out of date as it referred to the Independent Safeguarding Authority which no longer existed and was replaced by the Disclosure and Barring Service. However staff understood their responsibilities to report any concerns and had done so in the past when necessary. The provider had made two safeguarding reports to the local authority over the past year. These matters were investigated, action taken and the outcome shared with the local authority, which was satisfied with the way this had been dealt with. This showed the provider took the concerns seriously and worked in collaboration with local authorities and other agencies when any concerns were raised.

Risks to people's safety and health were assessed, managed and reviewed. People's records included individual risk management plans which included information about identified risks and the action needed to take to minimise the risk. For example, people needed to be supervised when in the kitchen preparing meals, or out in the community because they lacked road safety awareness.

Most of the accommodation for people was warm, modern and comfortable. There were no health and safety hazards, although bathrooms were showing several signs of wear and tear such as the sealant to the baths and shower was perished and the bath panel was worn and scuffed. The building consisted of two attached bungalows with an internal locked door between the two units to allow access by staff. There was a small office in one part of the building which was also used as a sleep-in room. One staff member said it would be better if there was some way of requesting support, such as a call bell, between the two bungalows or to alert the sleep-in staff member in the event of an emergency.

The provider used contractors to carry out required maintenance checks, servicing and repairs. The required certificates for the premises were up to date, such as gas, electric and fire safety. The staff carried out routine health and safety checks, including hot water temperatures and fire safety.

Reports of any accidents and incidents were sent to the regional manager and were sent to the executive board each month. This meant the reports were analysed for any trends. There had been only a few minor accidents in the home over the past year. There was an emergency response file in the home which included the arrangements in the event of any type of emergency, including evacuating people from the building, what to do if someone was missing and the business contingency arrangements to make sure people continued to receive care.

Relatives felt there were enough staff to support the people who lived at the home. One relative told us, "There must be enough staff because [my family member] is always being taken out."

The usual staffing was one member of staff to one bungalow and two members of staff to the other bungalow. This was because one person needed one-to-one support, so there was a second staff member to support the other two people in that bungalow. Some staff felt it would be better if there were more staff as one bungalow had one member of staff to support the three people who lived there. The senior staff member explained that staffing was arranged as flexibly as possible so that there was always support for someone if they did not want to go to their day centre. The senior staff member also described how the rota was adjusted to make sure there were additional staffing hours at weekends when people were not at their weekday placements. Through the night there was one staff member on duty in one bungalow and a staff member on sleep-in duty in the other bungalow.

Good

Is the service safe?

The home had contingency arrangements in case of staff emergencies or accidents and there were on-call management arrangements. The manager described how there were regular bank staff and staff from a neighbouring supported living house who were familiar with people's needs and could provide cover if necessary.

There had been a number of changes to staff in the past year. Six staff members had transferred here from another care home run by the same provider which had closed. We looked at recruitment records for three staff members. The recruitment practices were thorough and included applications, interviews and references from previous employers. The provider also checked with the disclosure and barring service (DBS) whether applicants had a criminal record or were barred from working with vulnerable people. This meant people were protected because the home had checks in place to make sure that staff were suitable to work with vulnerable people.

Medicines were securely stored in a locked medicine cabinet. The home received people's medicines in blister packs from a local pharmacist. The blister packs were colour-coded for the different times of day. This meant staff could see at a glance which medicines had to be given at each dosage time. The blister packs were checked three times a day at each change of shift to make sure the right medicines and right amounts remained. Medicines were administered to people at the prescribed times and this was recorded on medicines administration records (MARs).

Staff understood what people's medicines were for and when they should be taken. Staff had liaised with GPs to review people's medicines and to make sure that people were not taking unnecessary medicines. Most staff were trained in safe handling of medicines except some staff who had transferred from another service. There were plans for them to receive this training. Staff competency in managing medicines was being checked by three observations of their practice then an annual competency check.

Requires improvement

Is the service effective?

Our findings

We looked at how the provider supported the development of staff through supervisions. Supervisions are regular meetings between a staff member and their supervisor, to discuss how their work is progressing and where both parties can raise any issues to do with their role or about the people they provide care for. We looked at the personnel files for five support staff. It was evident that those staff members had not had a supervision session with a line supervisor since January or February 2015.This was over six months ago. This was contrary to the provider's own supervision policy. This meant the provider had not made sure that the professional development of staff was supported or assessed.

The organisation used a computer–based training management system which identified when each staff member was due any refresher training. The staff training matrix record indicated that there were some gaps in required training, but training courses had been booked to address this. For example, six staff were not recorded as having had safeguarding training, although they had worked for the provider for some years. There were planned training dates for those staff to receive safeguarding training in September 2015. Also, the emergency first aid training of five staff members had expired and four other staff members had not had this training, but training dates had been booked for this in September 2015.

These matters were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff felt they had good opportunities for training. One staff commented, "We get plenty of training and I soak it up like a sponge. We're due some refresher training and this is being arranged." Another staff commented, "Generally I think we get enough training." All except three of the staff had achieved a national qualification in care (called NVQ level 2 or 3).

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS), and to report on what we find. Some staff were uncertain about whether they had had training in DoLS but understood why people needed supervision to keep them safe. DoLS applications had been made to the local authority on behalf of the people who lived there because they needed 24 hour supervision and also needed support from staff to go out. These applications had been authorised in February 2015. In this way the provider had worked collaboratively with the local authority to ensure people's best interests were protected.

We saw mental capacity assessments had been carried out to check whether people had the ability to make major lifestyle decisions or whether these would have to be made in their best interests. For example, for one person an assessment had been made around their medicines and this decision had included appropriate care professionals such as psychiatrist, social worker, and a relevant advocate to act on their behalf.

There were also records of 'best interest' decisions made by all relevant parties where appropriate. These included, for example, agreement for using a safety harness to support one person when using the minibus. Another 'best interest' decision had been made for the use of covert medicines (that is, given without the person's knowledge or consent) if a person became agitated and was at risk of harming themselves or others.

Most staff were trained in ways of helping people to manage behaviours that might challenge the service if they became anxious or upset, called 'management of actual or potential aggression' (MAPA). Staff described the positive behaviour pathways and techniques they used to support people in a safe way. These included distraction and diversion, such as a change of scenery. Some support staff who had transferred from another home did not have training in MAPA, but training dates were planned for this.

Relatives felt people were supported by staff that understood their needs. One relative told us, "The staff really know [my family member] and can always tell me how they have been." Another relative commented, "Many of the staff have worked there for a long time and they know how to look after [my family member]."

Relatives also felt people received the right support with their nutritional health and enjoyed their meals. One relative commented, "My [family member] is on a liquid diet and seems to get enough to eat because their weight is fine." Another relative commented, "[My family member] definitely enjoys their food and makes their own choices about meals."

Requires improvement

Is the service effective?

People were encouraged to be as involved as possible in choosing menus and grocery shopping. Three people were also involved in helping to prepare meals with supervision and support. Staff used a six-week menu that was based on people's preferences, and people were also asked regularly if there were any other dishes they would like to add to the menu. One staff member commented, "We make sure they get well fed. We have a menu but we always ask and if they don't want it they can have their own choice." People also enjoyed occasional meals out at pubs and cafes as part of their leisure activities in the local community.

None of the six people needed a special diet, although one person did need their food to be pureed as they had problems with swallowing. We saw that the person was offered their preferred foods, such as pasta bolognaise, but in a liquidised form. Staff dined alongside people so they could make sure people managed their meal in a safe way. One person was on a healthy eating management plan to help them reduce their weight. Staff kept a record of people's meals, a regular record of each person's weight, and their nutritional health was regularly checked. This meant people were supported with their nutritional well-being.

It was clear from discussions with staff and from records that people were supported to access a range of relevant community and specialist health care services. The six people were registered with their own local GPs and dentists. Opticians carried out home visits when required, and a podiatrist visited the home every 10 weeks. The home visits helped to alleviate the anxiety of some people who found it difficult to cope with health care appointments. Some people had input from clinical psychology service, learning disability services and the behaviour team. This meant the home staff were making sure people received support with their health care needs when this was required.

Good

Is the service caring?

Our findings

Relatives we spoke with made positive comments about the "friendly" and "caring" staff who supported their family members. One relative told us, "The staff are lovely." Another relative commented, "The staff are so nice and [my family member] seems happy with all of them."

The people we spoke with who were able to express a view told us they "liked" the staff and their house. One person requested a lot of attention from staff and this was managed in a patient and accommodating way that made sure it did not reduce the support for the other people in this bungalow. A staff member commented, "You can tell by their body language that people feel safe and relaxed here. They come first and CIC (the organisation) makes sure they are well looked after."

There was a friendly, warm atmosphere in the bungalows and people appeared calm and relaxed with the staff who supported them. We joined people in one bungalow for a lunchtime meal. Staff provided assistance in a sensitive and encouraging way. We saw one person needed staff to put the food on a spoon, so that they could then pick up the spoon and eat independently. In discussions staff were clear about making sure people's independent living skills were promoted and encouraged.

Throughout the inspection there was a lot of laughter and engagement between people and staff. People actively sought out staff members to talk about their plans for the day or to ask them about future activities. Staff were patient and supportive during discussions with people, and encouraged people to make their own decisions.

People made their own daily choices, for example about activities, menus and during personal shopping. People could also ask for a specific member of staff to support them if the staff was on the rota for a particular event. The people who lived there had a range of communication methods. Some people used Makaton or gestures to express their choices. One person was able to lead staff to show them what they wanted, and declined items that they did not want. One staff commented, "We make sure they have choices about what they want or don't want."

Staff described how they encouraged people to be as independent as possible without compromising their safety. For example, some people could carry out some household tasks with prompts, such as taking clothes to the laundry room, but other people would need support and supervision.

Staff described how they supported people with their privacy. For example, making sure people closed bathroom doors when using them. One person preferred to keep their bedroom door locked when they were out. Although they were unable to manage their own key, staff said they made sure they locked it and unlocked it on the person's behalf.

One person made frequent visits to the office to chat to the senior staff member and the manager. The person was made welcome every time and their requests were responded to in an appropriate, respectful way. In discussions, staff talked about people in a way that valued their diverse needs.

The staff we spoke with felt their colleagues were caring and supportive of the people who lived there. For instance, one newer staff member told us, "I find the staff are lovely with people. We do everything we can to make it good for them." Another staff member commented, "It's definitely a very caring place. Staff interact really well with everyone here. It's pleasure to come to work and everyone is happy living here."

Requires improvement

Is the service responsive?

Our findings

We looked at the care records for two people. Some support plans were descriptive and personalised. For example, one person's decision-making plan described how the person was able to make their own choices but that best interest decisions would be needed for any major decisions. However other support plans were incomplete, undated, and not signed as read by all except a small number of staff. This meant it was not possible to determine if all staff had accessed the information about each person's needs and goals, and how to support them in a consistent way. For example one person's behaviour plan provided detailed guidance about potential triggers and positive action to take if the person became agitated, including redirection and ultimately medication. However this had only been signed by four of the 14 staff members.

Each support plan included a 'risk assessment' that was a scoring tool to calculated when the support plan should be reviewed, for example three monthly or six monthly. For both people we saw that reviews of the support plans had not taken place at the intervals that had been set. Some support plans had not been reviewed for over 18 months. For example, one person's support plans about accessing health professionals had last been reviewed in September 2013, but should have been reviewed on a 6 monthly basis. Where reviews had taken place these only consisted of a date and the signature of the person reviewing the records. In this way the reviews were uninformative and did not evaluate how people's goals or needs were progressing.

The people who lived at Rosedale/Rosewood were not involved in their support plans because of their limited communication and the complexity of their needs. Each person was invited to have monthly meetings with their keyworkers to talk about their short-term goals for the following month, for example activities and events they would like to take part in. The meetings were recorded. However we saw for one person there were no records of any monthly meetings in January, February or March 2015. In this way it was not possible to determine if the meetings had taken place or whether any goals been met for this person. This meant it was not always possible to be clear if a person was appropriately cared for and supported because care records were not always up to date or complete. These matters were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives told us they were not involved in written support plans but were invited to annual reviews of their family member. Relatives also felt able to make comments to the care staff at any time. It was clear from discussions with staff they had a good knowledge of people's specific needs.

Relatives felt there were sufficient daytime occupations for their family member. Five people had a range of planned vocational sessions through the week. These included activities such as music, drum workshops and sports centres via nearby day centre. One person enjoyed weekly sessions at pony world and one person was also going to try gardening sessions at an allotment. The remaining person did not have any current daytime placement so was supported with activities in the house or going out with staff in the local community.

One person told us about their plans for the weekend and it was clear that staff were supportive of the person to make their own decisions about their preferred activities. One relative commented, "My family member is always out. He gets all over." Another relative told us, "They help my family member to arrange a holiday every year." People had opportunities to go out in the evenings and at weekends to social activities such as discos, local pubs and shopping for personal items and clothes. People's choices about whether to engage in these activities were respected.

The people who lived there all contributed financially towards a minibus for transporting them to activities, although some people used it more often than others and some could and did use public transport. One relative felt it was "unfair" that there were not sufficient qualified drivers to make sure that people could use their minibus whenever they wanted. Staff confirmed that there were only a small number of staff who were qualified to drive the minibus so there were days when people were unable to use it. However the manager confirmed that if people had to use taxis as a result of there being no drivers on duty, the cost of the taxi was paid for out of a social budget provided by the organisation.

People had information in picture and easy-read format for people about how to make a complaint if they were unhappy with the service. The complaints procedure was

Requires improvement

Is the service responsive?

also on display in the hallway for visitors to see. In discussions, staff were clear about recognising people's demeanour or behaviour to show if they were dissatisfied or unhappy with a situation.

Relatives told us they were confident that they could raise any concerns or comments and that these would be listened to. One relative told us, "If there was any issue I would go down and sort it out with them. That wouldn't be a problem. But he's been so happy there I've never had reason to." The staff kept a log of any complaints for analysis and emerging trends. There had been no complaints received over the past year.

Requires improvement

Is the service well-led?

Our findings

There had been three managers for this service over the past year. A long-standing manager had left and a new manager had registered with the CQC in March 2015. However that person had since left. At the time of the inspection a new manager was in post who was not yet registered with the CQC.

The relatives we spoke with knew about the recent changes of management but were not aware of any impact on the people who used the service. One relative told us, "It doesn't seem to have made a difference to [my family member]. I am aware of the changes but haven't met either of the two recent managers."

During the inspection it was evident that the six people who lived there had Deprivation of Liberty Safeguards (DoLS) in place. The DoLS authorisations were made between November 2014 to February 2015. It is a requirement that the providers submit statutory notifications to inform CQC of the outcome of DoLS applications. However these notifications had not been submitted to CQC. The new manager acknowledged this oversight and stated she would submit retrospective notifications.

Relatives said they were invited to placement reviews about their family member. They told us they had previously had a formal opportunity to give their comments and suggestions in an annual survey, but they had not received a survey in the past year. One relative told us the only thing that would improve the service was, "more staff who could drive the minibus because the people pay for it but can't always use it". Staff had supported three people to complete a survey about their views of the service, including whether they could choose what to do and whether they liked living in the house. The surveys were not dated (other than 2015) or analysed.

Three of the people who lived in one part of the home had house meetings about three times a year. At the last one in March 2015 people had discussed how to make a complaint and talked about the new hoover which people said they found easy to use. The people in the other part of the home did not have house meetings. However each person did have individual keyworker meetings to discuss their short-term plans and goals.

In November 2014 the provider's peer review team had carried out a 'quality of life' assessment of the service for two individual people at the home. The peer review team included people who used other CIC services. The assessment looked at whether Rosedale/Rosewood provided a personalised service for the two people. The peer review team recommended a number of areas that could be improved for people. These included, for example, that one person should have their own wallet rather than be given their money in a plastic money bag. One person was an avid sports fan and it was recommended that they be supported to obtain a football season ticket. The recommendations were set out in an action plan, called 'You said, we did' and it was clear that the assessment results and the actions being taken were having a beneficial impact on those people to lead a more fulfilled and personalised lifestyle.

Staff felt supported in their role. One staff commented, "I feel valued by the senior and manager." Staff described the new manager as approachable. Staff meetings were expected to be held around every two months; however the last two meetings were in November 2014 and June 2015. The minutes from the June meeting had not been typed up so were not available to the staff who had not attended. This meant there were few opportunities for staff to discuss expected standards and practices, or to give their views about the care delivered at the home.

We looked at what monitoring systems the provider used to check the quality and safety of the service. Staff carried out a number of audits to ensure the welfare and safety of the service. These included monthly health and safety checks and daily medication audits. A finance audit had also been recently carried out by the manager of another home to check a sample of people monies and records.

The regional manager had carried out an annual service quality assessment in October 2014. This was a comprehensive audit of all areas of the service. This had identified some areas for improvement that were set out in a detailed action plan. The manager was required to submit a 'monthly operational performance review' to the provider's quality team to report on the progress of the required improvements. For example, one of the areas for improvement had included the lack of warmth in terms of decoration in one lounge. The lounge had since been decorated with input from people and staff about the colour scheme and furnishings.

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 17 HSCA (RA) Regulations 2014 Good governance People were not protected from the risks of unsafe or inappropriate support because care plans were not complete or reviewed in a timely way to ensure their needs were being met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing People were cared for by staff who were not supported to deliver care and treatment safely and to an appropriate standard.