Otterburn Health Care Limited

Otterburn

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?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 04, 05 and 18 November 2015 and was unannounced. At our last inspection in July 2014 the provider was complying with all the regulations we looked at.

Otterburn provides care and support for up to 30 people with complex health care needs including dementia, physical disabilities, mental health needs, brain injury and neurological disorders. The home is divided into three ten bed units called Otter, Fox and Squirrel.

Otterburn is required to have a registered manager in post. A manager had been recruited to the home and had been in post since February 2015, but at the time of our inspection the manager had not applied for registration. This meant that the registered provider was in breach of their conditions of registration. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like the registered provider they are a 'registered person.' Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

People were not consistently kept safe from the risk of harm associated with their health care conditions.

Summary of findings

People's healthcare needs had not all been well assessed, planned or delivered. Some essential parts of people's healthcare had been omitted, and ways of reducing risks to people were not being managed well.

People were not always being supported by enough staff, or by staff with the required skills, experiences or training to meet their specialist needs.

People were not always getting the nursing and healthcare they required to maintain good health, or achieve the best possible health outcomes.

People were not always getting the support they required to eat and drink enough. Where people were at risk of malnutrition or dehydration inadequate records were being maintained to enable staff to monitor the person's food and fluid intake to help them determine what further action or support people needed.

We found that staff usually sought people's consent before offering care and that the required applications had been made to the local authority in line with legislation to protect their legal rights.

People could be confident that the staff supporting them would always work with kindness and compassion. People's dignity and privacy was consistently maintained.

Some people had enjoyed specific activities and had been supported to go on holiday this year. However on a day to day basis most people did not have access to activities that they would find interesting, stimulating or helpful in reducing the risk of social isolation.

The provider had a complaints procedure and records showed complaints had been identified, investigated and reported. People we spoke with did not always find that their complaint had resulted in the desired changes taking place.

The service was not consistently well led.
Our observations showed that the nurses did not always provide clear leadership or that they always had the clinical skills required to lead a shift. The providers own audits used to monitor safety and quality had not all been effective at identifying areas for improvement or driving forward improvements.

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

People were not consistently safe.

People could not always be certain there would be enough staff with the required skills and experience available to meet their needs.

People could not be confident they would always get their medicines in the prescribed dose.

Staff were aware of different types of abuse and how to keep people safe, although the provider had not provided or updated all staff with this information and training.

Is the service effective?

Requires improvement

The care provided was not consistently effective.

People were not always supported by staff with the skills, training and qualifications needed to meet their nursing care needs and keep them healthy.

People were not always well supported with their nursing needs, to ensure the best possible health outcomes.

People told us they liked the food, but some people were at risk of not getting the support they needed to eat and drink enough to keep them healthy. Professional advice was not consistently sought or promptly actionned to ensure people received the support they required.

Is the service caring?

Requires improvement

The service was not consistently caring.

People were supported by staff who showed kindness and compassion.

Staff ensured that the dignity and privacy of people was upheld.

People approaching the end of their life had not been supported to plan how they wanted care and support to be provided at that time.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

The majority of people were not provided with the opportunities on a day to day basis to undertake activities they liked, which provided stimulation, or reduced the likelihood of them becoming socially isolated. Some people had been supported to go on holiday and undertake 'one off' activities that they had greatly enjoyed.

Whilst people found that complaints were dealt with promptly feedback from people who had raised concerns was that the action taken was not always effective.

Summary of findings

Is the service well-led?

The service was not consistently well led.

The registered provider had breached their conditions of registration. There had not been a registered manager in post for over six months.

The service had not benefitted from consistent or effective leadership.

The providers own audits had not all been effective at identifying areas for development or driving improvements.

Requires improvement

Otterburn

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 04, 05 and 18 November 2015 and was unannounced. It was carried out by two inspectors and a specialist advisor. The specialist advisor had specific knowledge and experience of the nursing needs of people with neurological conditions.

Before our inspection we reviewed information the provider had sent us about the home. Before our inspection we checked the notifications about the home. Providers have to tell us about some incidents and accidents that happen in the home such as safeguarding concerns and serious accidents. We used this information to plan what areas we were going to focus on during the inspection. We asked the local authority commissioners for their feedback about the service.

During the inspection we observed staff and people who were living in the home. We spoke with seven members of the staff team and met all of the people who lived in the home. We sampled the records for eight people, including records in relation to care, meals, medication, accidents and complaints. We also looked at the records relating to the home's quality audits. We sought and received the views of five relatives and sought comments from six other professional visitors to the home.

Requires improvement

Is the service safe?

Our findings

People did not always receive care which kept them safe from the risk of harm. We looked in detail, at parts of the care records for eight people. People we met were at an increased risk of developing sore skin, of becoming malnourished or dehydrated. People we met were unable to verbally share with us their experiences about the care they had received, but the records we viewed showed that people had not always been supported to change position as often as their care plan directed, to drink enough to maintain good hydration or offered a diet that followed the specific guidelines set out by a dietician.

In Fox Unit we observed that the medical equipment that would be needed in the event of an urgent choking incident had not been returned to the nurse's office. Staff we spoke with explained this is where they would expect to find the equipment, and when asked were unsure where it was. Members of staff eventually located the equipment, but were unable to establish if the equipment was clean and ready for use. We identified that the equipment had last been used four days earlier and had not been checked and left ready for use. If a person had experienced a choking incident in this period we were not confident that staff would have been able to locate or use this emergency equipment with the haste required.

Staff did not all follow the good manual handling practice given to them during training. We saw two staff use an underarm lift to support a person to stand. Research has proven that supporting people in this way can cause injury to both the person and the member of staff. Safer alternative manoeuvres have been developed which were not used. We observed two people being supported to move in a wheel chair without foot rests. Evidence is available to show that moving people without footrests increases the risk of accidents and injuries to the feet and legs of people being supported.

The failure to provide staff with predictable access to emergency equipment and the moving and handling techniques used by some staff were actions that had all placed people at risk of harm. This was a breach of the Health and Social Care Act 2008. Regulation 12.

The majority of people we spoke with raised concerns about the turn over and number of staff employed at Otterburn. People, their relatives and staff all expressed some concerns about staffing. The comments we received included, "They do change a lot, but it doesn't bother me as long as they are all nice" , "The numbers can drop down, especially at weekends", "They could do with more[staff], weekends are very hard for staffing" and "I worry about the number of night staff when I visit in the evening."

The staff rota shown to us by the manager showed that the minimum numbers of staff were usually on duty, but there had been occasions when the numbers of staff on duty had either exceeded or had dropped below the assessed minimum numbers required. We observed that people had staff support to meet their personal care needs when they required it.

During our inspection it was typical that three of the five care workers on shift within each unit were in the first week of their employment in the home. There were eight different nurses on duty during the inspection and we spoke with five of them. Of the five nurses we met three had joined the company in the 10 week prior to our inspection, and one other was a bank nurse who worked regularly in the home. In addition to working shifts as a nurse the same nurse also delivered training to staff working at the home. We spoke with the manager about this very new staff team, and asked for evidence of how risks associated with such an inexperienced team were being managed. The manager was unable to provide this at the time of inspection. Following the inspection we received further information we had requested direct from the manager confirming that they felt the risks associated with having so many new staff on duty were well managed. Staff had all undertaken an in-depth induction about the organisation, and principles underpinning good and safe care. However they were not all familiar with the specific and complex needs of the people they were supporting.

All the staff we met worked with compassion and kindness towards the people they were supporting, however the induction provided had failed to ensure that they were familiar with or could demonstrate an in-depth knowledge about the people's circumstances or the health care needs they were experiencing. The failure to ensure that there were adequate numbers of competent, skilled and experienced staff is a breach of the Health and Social Care Act. 2008. Regulation 18.

Requires improvement

Is the service safe?

Our observations showed that most people were calm and relaxed. People we spoke with told us they felt safe. Relatives told us, "I have never had any concerns about [name of person] safety."

The majority of people required staff to support them to move, and some people who were unable to stand required staff to use a hoist to lift them. Although some techniques for manual moving and handling raised concerns all the staff we observed, used the moving and handling equipment appropriately and gave people an explanation and reassurance during transfers. People were encouraged to be as independent as possible with their mobility.

Some people we met communicated their distress or needs through their unsettled behaviour. We observed the way staff supported people to stay calm, and the actions they took throughout the inspection to support and reassure people. We saw that the staff worked with kindness and patience. The plans of care to support this area of people's needs and the monitoring of incidents were not always robust. Incidents of unsettled behaviour had not always been well recorded, and the documents had not always been used to inform the review of the person's care and support needs.

The majority of systems to ensure the safe administration of medicines were robust. The stocks of medicine and records we checked provided evidence that most medicines had been administered as prescribed. However the balance of stock of some liquid medicines did not balance with the records, suggesting that people had not always received this medicine as prescribed. We identified that people who had been prescribed medicines on an, 'As required'[PRN] basis did not all have written guidance about how and when to use these medicines for each person. Nurses we spoke with did not all have a secure knowledge about the management of controlled drugs. [Those requiring extra secure storage and monitoring.] Improving the knowledge of nursing staff about controlled drugs would further ensure people benefit from safe medicines management. While in a communal area of the home we observed staff administering medicine in an injection. The practice we observed did not follow good practice guidance and increased the risk of a needle stick injury occurring.[A person being accidently injected with a needle that has already been used on another person, or was not intended for them.]

We observed the staff supporting people with their medicines at a pace and using words and techniques that people could understand. Staff responsible for administering medicines wore a tabard informing people they were administering medicines. This was a way of reducing distractions to the nurse, and subsequently reducing the risk of an error being made. The supplying pharmacy confirmed that the medicines management had only recently transferred to them, and they felt any issues recently experienced were 'teething problems.' They told us that the staff were well trained, and identified any problems which enabled them to be quickly rectified.

Staff we spoke with all had a good knowledge about the different types of abuse that could occur, and their responsibility to report this should it be witnessed or suspected. We were informed that all staff had received safeguarding training during their induction. At the time of the inspection 52 staff had received update training but a further 51 staff still required this. Increasing the number of staff who had received this training would be a further way of ensuring potential abuse was prevented, identified or reported.

Through discussion with new staff, administrative staff and looking at recruitment records we found that new staff did not start work at the home until robust recruitment and checking procedures had been completed. There were also systems in place to ensure people who had worked at the home for some time remained suitable to work in social care.

Requires improvement

Is the service effective?

Our findings

Staff did not all have the specialist skills and knowledge to meet the needs of the people they were supporting. Relatives we spoke with told us, "There is a fast turnover of staff. Always has been. They are all nice, but they don't have any specialist knowledge about Huntington's Disease" and "I am not convinced the staff have specialist knowledge about Huntington's Disease." Following our inspection we spoke with six health professionals who supported people living at Otterburn. Four of the six professionals we spoke with praised the compassion with which staff worked but raised concern about some elements of the nursing practice of staff that had not ensured that people consistently received the best possible health outcomes. Their feedback raised concern about the knowledge of staff, and included suggestions that some people had needs that exceeded the knowledge and resources that the provider could meet. They raised concern about the clinical knowledge and competency of some nursing staff. One of the health professionals praised the work undertaken with a person, and reported on the positive outcome the time they had spent at Otterburn had on their rehabilitation.

We found that the nurses recruited to work at Otterburn had been selected from across the full range of nursing disciplines and included nurses who had trained as specialist adult general health nurses, adult mental health nurses, and nurses who specialised in supporting people with a learning disability. Discussions with staff identified that their basic training and subsequent experiences had not always covered all of the health issues people at Otterburn were living with and experienced, or provided them with the skills needed to monitor people's wellbeing and identify subtle changes in people's physical health. Discussions with staff, records of training and feedback from health professionals identified that nursing staff had not always been provided with the training and support they required. At times this had resulted in a negative impact on people's care.

The training records and discussion with the manager and training co-ordinator identified that although training had been provided and more was planned this had not been delivered to all the staff team, and some training had been at an awareness level, rather than equipping staff to provide specialist care. Evidence did not support that the staff working at the home were suitably qualified, competent or experienced to meet the needs of the people they were supporting. This was a breach of the Health and Social Care Act 2008, Regulation 18.

Some people's health needs meant they were at risk of not eating or drinking enough. We were informed that food and fluid diaries were kept for these people to enable staff to accurately monitor the amount people had been offered to eat and drink to ensure their wellbeing. Records showed that some people had not eaten or taken fluids regularly or in sufficient quantities to maintain good health in the days prior to our inspection. We brought this to the attention of the staff on duty. Staff were unaware of this situation, and as a result had not taken action to encourage people to eat or drink more, or to ensure they would be brought to the attention of the appropriate medical staff. We went on to look in detail at the support given to a further two people around eating and drinking. We saw they had both steadily lost weight and had been reviewed by the dietician and relevant health professionals. Both the discussion with staff and the records we viewed showed that the people were not being offered the increased diet despite the change being dated 30 days earlier. Nursing staff on the unit and senior staff at Otterburn had not effectively communicated about this change or pursued this with the health professionals. Failing to meet the nutrition and hydration needs of people using the service is a breach of the Health and Social Care Act 2008. Regulation 14.

Meal times were not always well organised, and we observed people being offered and brought to the table for one meal only a short period after their last one. We observed people being offered the opportunity to lie in, and subsequently eating a late breakfast. We then observed people being offered lunch between 30 and 90 after their breakfast meal. We observed people not being offered the full meal they had chosen, although the correct ordered meal had been supplied by the kitchen to the unit. On one unit a bowl of salad was over-looked and then destroyed, as staff failed to offer it to people with their lunch.

The majority of people who were able to eat food required the texture of their meal to be altered. [Pureed] The menu for people to choose from did not always have foods that would puree well, for example on one day there were spring rolls and burgers to choose from. We were informed by the staff and the chef that alternative suitable meals

would be provided. While this meant people would be provided with suitable foods, a full choice of meals that reflected the needs of the people living at Otterburn should be planned and available on the menu.

We observed the support people were given around eating and mealtimes, and found that people were supported to eat and drink at a pace that suited them. Adapted cutlery and crockery was available to enable people to be as independent at meal times as possible. We spoke with the cook who had a very detailed knowledge of each person's dietary needs and preferences. People we spoke with told us the food was "Very good."

Some people would have the ability and expressed an interest in making their own drinks, snacks and meals. Each of the three units had a dining room and small kitchen, we did not observe people accessing these facilities to prepare drinks and snacks, although some people told us they would have liked this opportunity.

Some people's conditions and assessments meant they were at risk of losing weight and needed this to be closely monitored. Risk assessments showed this should be done weekly. Records we viewed showed gaps of up to four weeks between weights being taken. Failing to weigh people meant that subtle changes in the person's health and well-being had not been identified and acted on promptly to ensure the best health outcomes for the person would be taken.

Some of the people living at Otterburn had complex and multiple health conditions. We looked in detail at the care of one person with complex diabetes. Staff we spoke with and records we viewed showed that the planned action to be taken when the person's blood sugars were high had not routinely been completed. Failing to do this had not safeguarded the person, or ensured they would get the correct treatment for their condition.

We looked at the care and support given to one person who had a wound. The records failed to show that care as directed by a specialist tissue viability nurse had been given. The person had not been supported to change position, with the frequency the care plan stated. The wound had not been checked and dressed with the frequency as directed by the specialist nurse or in accordance with the directions within the care plan.

Some people were at risk of constipation. We looked at records and spoke with staff and people's relatives about how this was managed. Records of bowel movements did not show that people had used the toilet regularly, or that action such as increasing the person's laxative medicines, or increasing their fluid intake had been considered or taken. There was no oversight of this action or recording by nursing staff. The audits and checks undertaken by the manager and provider had failed to pick up these health related issues. People could not be certain they would receive safe care and treatment. This was a breach of the Health and Social Care Act 2008. Regulation 12.

Two relatives told us that their loved one received good health care. Their comments included, "Healthcare is good. They ensure she gets to see whoever she needs to see" and "I have really seen an improvement in my relative since she moved here. "

Two members of staff who had recently started to work at the service told us they had undertaken a robust induction process. We observed two daily handovers and saw staff exchanging information about people's current needs. New members of staff told us they had been given time to sit and review people's care plans. Staff told us, "I really enjoy working with the clients; I have learnt a lot and the company have sent me on lots of courses."

Some of the people using the service had needs that required staff to apply the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS).We observed staff asking people for permission to support them before they started an intervention, and care records showed that assessments of people's mental capacity had been undertaken when these were required. Staff had gone on to make the appropriate DoLS application when this had been identified as necessary. The records did not consistently show that applications had been updated or reviews applied for when the agreed period of deprivation had been reached. The manager was able to provide records of these, however the staff providing direct care had no evidence that they were supporting people in line with their wishes or the law.

We noted that the provider had followed good practice guidance and introduced consent forms for people. This policy had not been consistently followed and examples included people being photographed without there being any signed agreement for this to be used despite this being in the plan with a statement saying it was required.

Requires improvement

Is the service effective?

The provider had assessed that the doors into each unit, and in one unit the kitchen door needed to be kept locked, to keep people safe. There was no evidence that this decision had been kept under review as people's needs changed. There was no evidence that this was the least restrictive action possible. It was positive to observe that some people had been given the codes for the key pads, and were able to come and go from the unit freely as they wished.

Requires improvement

Is the service caring?

Our findings

Staff spoke affectionately about the people they supported. We observed that some staff had developed effective communication skills with people. Staff used touch, altered the tone and volume of their voice and made eye contact with people. People, relatives and visiting professionals we spoke with all reported on the kindness and compassion shown by individual members of staff. “I’m happy here. I have been here since it opened” and “I can’t say she isn’t cared for, but it’s not all good. They don’t take care of her room and property." Some staff we met had developed relationships with people’s friends and family and were able to describe people’s interests and hobbies and the occupation of the person earlier in their life. One health professional we spoke with praised the dedication of many of the care workers, and the positive bonds they had witnessed being made with the people they were supporting.

People had all been supported with their personal care. People we met were all dressed in clothes that reflected their gender, culture and their established personal style. People we spoke with told us they were pleased with the standard of cleanliness they were supported to maintain, and the help they received with their appearance.

In discussions staff were able to give examples of how they protected people’s dignity and privacy. During our observations we saw these in action. Examples of this included members of staff supporting people patiently to wash their hands before meals and to support them while they were eating and drinking.

Some of the people we met were receiving palliative care. The records we viewed showed that people had recorded the wishes of themselves or their family in the event of the person passing away, but we found no evidence that people had been offered the opportunity to plan the care they would wish to receive in the final stages of their life. Good practice guidelines identify the need to undertake end of life planning with people as early in their condition as possible, to ensure they receive care as and where they would like as far as possible. The plans in place may result in people not receiving the care and support at the end of their life in line with their wishes.

Requires improvement

Is the service responsive?

Our findings

During our inspection we observed the opportunities available for people living at Otterburn. We observed that for most people the opportunities available each day were based around their care needs. We observed people being supported extensively with their personal care and eating and drinking, but the opportunities to undertake activities that were stimulating, interesting or which related to interests the person had enjoyed earlier in their life were limited. We observed that the main activity each day for people both in their bedrooms and the communal lounges was watching television. We asked people and their relatives about this. Most people said that the opportunities were very limited. We asked one person what they would do during the day. They replied, "Sit here." Two relatives we spoke with told us, "[name of relative] is generally happy to watch TV and DVD's. There isn't much else for her to do" and, "The activities are Okay. They could be much better. There have been some great stand-alone activities such as a holiday, Drayton Manor park, cinema and bowling, but day to day there isn't much going on." One person with a specific interest told us, "They [the staff team] are all good really! I just wish I could use my telescope. I like watching the stars but I can't see them through the telescope at the moment'. Our inspection identified the person had not been supported to set up the telescope despite expressing an interest in this and having it available for some time. We looked at the occupational opportunities for people who were cared for in bed. People had no support plan to show how their social or recreational needs would be met, or how the service would manage and reduce the risk of social isolation. Our observations showed that people were left in their room for long periods between their care needs being met. Failing to provide activities to meet the assessed needs of people is a breach of the Health and Social Care Act 2008. Regulation 9.

Some of the people we spoke with told us about the activities they had been supported to plan and enjoy. Some people had enjoyed a holiday earlier in the year. People told us about specific events and shows they had been supported to attend that had given them great pleasure.

The manager was able to show us records demonstrating the action taken in response to concerns and complaints brought to their attention. The records we viewed showed the concerns had been investigated quickly and thoroughly. We spoke with people who had experience of raising concerns. We were informed that senior staff always responded positively to the person making the complaint, but the experience of people was that things did not always change. Comments we received included, "I do raise my niggles and they are always nice about it, but nothing ever changes", and "The management have dealt with my concerns. It is better but not fully resolved." People could not be confident that their concerns would always be fully explored and the action taken to address the issues would meet their expectations.

Requires improvement

Is the service well-led?

Our findings

Services registered with the Care Quality Commission are required to propose a manager to register with the Commission. Otterburn had been without a registered manager for over six months and this situation had put the registered provider in breach of their conditions of registration. The manager in post at the home informed us it was her intention to apply for registration, and she had recently commenced this process. Failing to have a registered manager is a breach of the Health and Social Care Act 2008. Registration regulations. Regulation 7.

We did not consistently observe or find evidence that leadership within the service had been effective. We observed some of the nurses on individual units failing to effectively lead the team of staff, and in one instance we observed a nurse sharing incorrect information. We identified issues with people's health or essential pieces of equipment that no one had oversight of or taken action to fully resolved.

The manager had arranged for a number of audits to be undertaken. These had not always been effective at identifying issues or driving improvements at the required level or pace to ensure people always received a good and safe service.

The feedback we received from relatives, staff and visiting health care professionals consistently identified that staff turnover and the volume of new staff was a problem. Our observations showed that a lot of new staff had recently joined the service. Some of these staff had been recruited to meet the increased support needs of people and others to replace staff that had left the service. We asked the manager how any themes or trends of staff leavers were being tracked. We were informed that staff were invited to complete exit interviews by the registered provider but that feedback or analysis from the registered provider had not been shared with the manager. Feedback from staff and relatives was varied in respect of interest from senior staff and empathy with people who used or visited the service. Comments we received included, "The management attitude to staff is poor. Another person went on to praise the management team and their comments included, " I have only been here three months but feel really supported by the manager and the staff. I feel that the manager and the staff are welcoming of ideas." The provider had undertaken an audit of staff satisfaction. Only nine percent of the staff team had completed the audit, which did not provide enough feedback to determine staff satisfaction or to determine how to maintain or improve the experience for staff working at the home.

We identified that a large number of record keeping and nursing care issues had not been picked up or identified by the provider's own audits. The failure to have effective arrangements to assess, monitor and improve systems and processes to keep people safe in the service is a breach of the Health and Social Care Act 2008. Regulation 17.

The manager was knowledgeable about their requirement to inform the Commission of notifiable events as is required by the law. This meant the Commission had been able to monitor the events occurring in the home and take action to ensure that the appropriate response had been taken by the manager.

We looked at the opportunities people and their relatives had to meet with the manager to discuss matters important to them. We found that staff meetings had been held but not for two months prior to the inspection visit. Relatives we spoke with told us, "Communication could be better. It has been a long while since we have had a relatives meeting." Although the manager informed us that there had been three meetings planned since June 2015, this was not reflected in feedback from relatives. It was welcoming to note posters advertising a forth coming meeting were on display around the home.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **People had not consistently received care and treatment that met their needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **People had not always received the support they required to eat and drink adequate amounts.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Systems in place to audit and monitor the safety and quality of the service had not always been effective.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **People had not always been supported by adequate numbers of staff with the skills and experiences required to meet people's specialist needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 7 HSCA (RA) Regulations 2014 Requirements relating to registered managers **The service was not consistently well led. There was no registered manager in post.**