Life Style Care (2011) plc

Clarendon Nursing Home

Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Good**

Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

We carried out this unannounced inspection on 8th July 2014 and returned on 9th July 2014.

At the last inspection in August 2013 the service had met the regulations we looked at.

Clarendon Nursing Home provides nursing care for up to 51 people who have various complex needs including mental health, learning disabilities and dementia. There were 47 people living at the home when we visited. There was a registered manager in place. 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.

Most people we spoke with were positive about many aspects of the care they received at Clarendon Nursing Home and thought they were well looked after. People

Summary of findings

told us they felt safe at the service, but said they often had to wait a long time for staff to assist them. They told us care staff were very busy and often did not have the time to talk with them.

We saw some people's call bells were out of reach or not working and some people had to wait for long periods before staff attended to them. The provider confirmed call bell response times were not recorded or routinely monitored. Without regular recorded checks, the provider was unable to confirm staff attended to people in a timely way. This was a risk to people's welfare and safety and you can see what action we have told the provider to take at the back of the full version of the report.

We found that people's healthcare needs were assessed. However, we saw care was mainly based around completing tasks and did not take account of people's individual preferences. We were concerned that some people may have felt isolated as there was not enough meaningful activities for people that took into account their social needs, interests and wishes. You can see what action we have told the provider to take at the back of the full version of the report.

Systems and processes were in place to protect people from foreseeable harm, and act on concerns in order to keep people safe. CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes and hospitals. We found there were no DoLS authorisations in place at the time of our inspection.

People told us they felt safe at Clarendon Nursing Home. The staff we spoke with understood the procedures they needed to follow to ensure that people were safe. They were able to describe the different ways that people might experience abuse and the correct steps to take if they were concerned that abuse had taken place.

Staff were up-to-date with a range of core training and received regular supervision and support. Staff told us they felt supported by the manager.

Staff supported and assisted people in a kind and helpful manner treating them with dignity and respect. We saw that people's healthcare needs were attended to and healthcare professionals were contacted as and when necessary.

Staff felt supported by their manager and said the registered manager was open to suggestions from staff and visiting professionals on how to improve the service. We saw that appropriate action was taken in response to incidents and steps were taken to reduce the risk of incidents reoccurring.

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?

Some aspects of the service were not safe. People sometimes had to wait for long periods for staff to assist them. Some call bells were not working or were out of peoples reach.

People told us they felt safe and did not have any concerns about their safety or that of others. Staff knew how to recognise and respond to abuse correctly. Health risks had been assessed with guidance for staff. The provider met the requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS) to help ensure people's rights were protected.

The service followed safe recruitment practices .There were adequate systems in place to protect people from the risk or spread of infection.

Requires Improvement

Is the service effective?

Some aspects of the service were not effective. People had access to food and drink throughout the day but some people were not given a choice of food or offered alternatives if they changed their mind.

There was an on-going programme of training for staff to ensure they had the skills and knowledge required to meet people's needs.

People were supported to maintain good health and have access to healthcare services. Care records were in place which showed staff had assessed people's care needs. Care records gave staff clear instructions that enabled them to meet people's needs through delivering appropriate health care and support.

Requires Improvement

Is the service caring?

The service was caring. People told us most staff were caring but were very busy. Staff had a good knowledge about people's health care needs and preferences. We observed staff supporting and assisting people in a kind and helpful manner for example at mealtimes.

People told us staff respected their privacy and dignity and we saw some staff had been appointed as dignity champions to help promote people's dignity and respect.

Good

Is the service responsive?

Some aspects of the service were not responsive. People told us sometimes they felt their care fitted into the homes routine, not their own. People did not always have choice, control or engagement in meaningful activities that were important or relevant to them

Care records we looked at were mostly health and risk-based with very little information about people's preferences or personal history.

Requires Improvement

Summary of findings

Systems were in place to ensure complaints were encouraged, explored and responded to in a timely manner. People told us they knew how to make a complaint if they were unhappy about the home and felt they were listened to.

Is the service well-led?

Good

The service was well-led. People who used the service and their relatives said the manager was approachable. Staff members told us they felt confident in raising any issues and felt the manager would support them.

There were systems in place to monitor and review accidents, incidents and complaints. There was evidence that learning from incidents took place and appropriate changes were implemented.

Processes were in place to monitor the quality of the service and action was taken when it was identified that improvements were required.

Clarendon Nursing Home

Detailed findings

Background to this inspection

The inspection team consisted of two inspectors and an expert by experience who had experience of older people's care services and dementia care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

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 improvements they plan to make. We reviewed the information included in the PIR along with information we held about the home.

We made an unannounced visit to the home on 8 July 2014. We used a number of different methods to help us understand the experiences of people who used the service. We spoke with 16 people living at the home, four relatives, six care staff, the activities co-ordinator, the cook, the registered manager and the regional director.

We observed care and support in communal areas and also looked at the kitchen and some people's bedrooms and bathrooms. We looked at nine care files as well as a range of records about people's care and how the home was managed.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us they felt safe at the service, but explained they often had to wait a long time for staff to assist them. They said, "The attitude of some of the staff isn't sometimes how it should be but they're so busy", "Staff are too busy doing other things" and "The staff treat you alright here, it's just sometimes they take so long to answer when you need them." A relative told us, "The staff don't do [my relative] any harm and try their best".

People told us the staff were too busy to talk with them as they were "doing other things." We observed staff were always active and there was constant movement between the rooms and floors of the home. Staff were efficient in carrying out their duties, but we noted they were often task focused and had little time to talk with or involve people in their care. One staff member told us, "There is no time to get to speak with people because we are all so busy."

We saw call bells were available in most people's rooms and looked at a sample of rooms to see how the call systems and emergency call bells worked. Some call bells were not accessible to people. For example, one call bell was placed out of reach, another had fallen behind a piece of furniture and another was tucked behind one person's bed. Some people told us their call bells were answered quickly however, others said, "Sometimes you have to wait quite a while when you ring your buzzer for someone to come", "It's worse at weekends when they ring in sick… they could do with more staff. It's noticeable then that you have to wait longer" and "When I've had a shower and they're busy I have to wait for a while for them to see to me". One person needed assistance and their call bell was out of their reach so we rang the call bell and waited with them for 10 minutes before a member of staff responded. We were concerned about call bells being out of people's reach and the length of time it took for staff to attend to people. We spoke to the manager about our findings and the consequences for people's care and safety.

The manager explained there was no system in place to ensure staff responded to call bells in a timely manner and response times were not monitored. During the second day of our inspection we saw the provider had fixed the faults we had identified and had ordered longer leads so call bells would not be out of people's reach. We were also informed that those people who were unable to reach their call bells had been given a pendant that allowed them to call staff as and when required. However, we still had concerns that the welfare and safety of people using the service were not always being met. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The home was staffed 24 hours a day by nurses and care staff. They were supported by a range of domestic and catering staff. We were shown how the registered manager had arrived at the staffing numbers required on each floor and saw that this was assessed based on the number of people in residence but not on people's individual needs. For example, additional staff were required to assist one person while their en-suite toilet was out of order. We did not see that staffing had been temporarily increased to deal with this situation.

People and their visiting relatives told us they felt safe at Clarendon Nursing Home, one relative told us, "I've been coming here most days for a long time to visit and there are no dark bits. It's all open and above board with a nice atmosphere and I think residents are safe here." Another relative said, "I come every day until 6pm and there is no danger here for [my relative], [they are] protected."

All the care workers we spoke with confirmed they had received training in safeguarding awareness and had a clear understanding of how they would respond to and report any concerns they had about the treatment and care of people using their service. We looked at the provider training records and noted that nearly half the staff at the service had received training in the last twelve months. We saw the provider's policies on safeguarding vulnerable adults and noted a copy of Pan London multi-agency policy and procedures to safeguard adults from abuse, which was available in the main office. We saw the whistleblowing policy, which was also contained within the staff handbook. Staff we spoke with knew about the policy and said they felt comfortable raising any issues with the manager.

The Care Quality Commission (CQC) has a legal duty to monitor the use of the Deprivation of Liberty Safeguards in all care homes in England, and to check on their use when we inspect how well the service is meeting the requirements of the Mental Capacity Act 2005 (MCA). Managers and staff demonstrated a good understanding of the MCA and Deprivation of Liberty Safeguards (DoLS). The manager described the procedure they had followed in applying for a DoLS authorisation for one person who lived

Requires Improvement

Is the service safe?

in the home. Although there were no DoLS authorisations currently in place, we saw the previous application and noted guidance had been followed, timescales adhered to and best interests meetings had been recorded involving relatives and various health and social care professionals.

We saw risk assessments that related to people's medical conditions, moving and handling and how to prevent people from falling. There were bed rail assessments for those people who were immobile. Skin integrity, diet and weight charts were also maintained. Where risks had been identified we saw the plans put in place to reduce that risk. For example, one person was at risk of developing pressure sores. Their care plan identified that staff needed to regularly turn the person to redistribute the pressure on their body. We saw that staff were doing this and documenting it in a turning chart.

There were adequate systems in place to protect people from the risk of infection. We found the home to be clean and free from odours. We observed domestic staff cleaning people's rooms, toilets and shower rooms. We noted that care staff wore uniforms and had access to tabards and gloves when assisting people with their personal care. Staff we spoke with also told us that they had received training in infection control.

The manager told us that they were the infection control lead. The service had an infection control policy which included guidance on hand washing, laundry and included procedures for staff to follow if someone had an infectious disease. A copy of the Department of Health's infection control guidance "prevention & control of infection in care homes" was available for staff. We saw an infection control audit had been completed during April and no issues had been identified.

We observed maintenance was required in some areas. For example, some bed rail protectors were ripped and there were areas of dampness on some walls and worn flooring in some people's rooms that could hinder the cleaning process. We were shown the maintenance program for redecorating people's rooms, starting with those most in need and heard that Clarendon was part of a five year refurbishment project set up by the provider.

The service followed safe recruitment practices. We looked at the personnel files of four members of staff. We saw each file contained a checklist which clearly identified all the pre-employment checks the provider had obtained in respect of these individuals. This included an up to date criminal record check, at least two satisfactory references from their previous employers, photographic proof of their identity, a completed job application form, a health declaration, their full employment history, interview questions and answers, and proof of their eligibility to work in the UK (where applicable).

Requires Improvement

Is the service effective?

Our findings

Staff attended a three day induction when they started working for the service. This covered subjects such as the service's philosophy of care, safeguarding adults, whistleblowing, emergencies, food safety, and health and safety. On the day of our inspection some care workers were attending a training session in the homes training room. Staff told us they had access to enough training to enable them to effectively carry out their roles and responsibilities. One staff member told us, "I found the induction training very helpful." Another said, "We are up to date, the training matrix tells us when our training is due." Staff training records were kept centrally by the provider. The manager monitored the system to ensure all staff had completed their mandatory training. This included fire safety, moving and handling, infection control, food hygiene and safe handling of medicines. We saw some staff had received additional training such as dementia awareness, bed rail safety, pressure care and challenging behaviour.

Staff received one to one supervision with their manager. We saw records of staff supervision and noted these were held six times a year. The manager confirmed staff appraisals were also being conducted annually and she showed us completed appraisal forms.

People had mixed views about the food at Clarendon Nursing Home. Comments included, "The food's lovely", "We have nice cakes here", "You get what they give you" and "The foods ok but I don't like the spicy food we have… I like traditional English food. We did have roast beef and Yorkshire pudding last Sunday and that was lovely".

Staff told us people were asked the night before what meal they would like the following day. We asked staff how effective this was for people with dementia or learning difficulties because some people had told us they did not know what the main meal was going to be until it arrived. Staff told us they did not really know and were vague with their responses.

Although we saw menu's in the dining rooms giving the two options of lunch for that day it was not always apparent that people were given a choice or offered alternatives if they changed their mind. For example, we observed one person had asked for their meal to be taken away because they did not like the food offered, but staff did not offer an alternative. One person said, "If you want something different you have to ask for it, there's no choices offered beforehand." During our lunchtime observations we saw staff did not always ask if anyone wanted anything different or if people were still hungry and wanted a second helping.

We looked at the way people received meals and drinks throughout the day. We saw that meals were prepared in the main kitchen and then transferred by heated trolleys to each floor. Some people had their meals in their own rooms and others made use of the dining facilities.

We observed staff assisting people in the dining room. People were offered their meal in a quiet and unhurried manner. However, we noted there was little social interaction between people and staff. Staff were focused on serving the meal and then assisting those who needed them without entering into any conversation. For example, we saw people were automatically dressed in tabards which were referred to as "bibs", they were not asked if they needed one or wanted one.

Staff told us how they catered for people with special dietary requirements. For example, people with diabetes were provided with biscuits in their room in case of low blood glucose and people experiencing weight loss had their meals fortified with higher calorific food. Staff explained how sandwiches and tinned soup were available for people when the kitchen was closed. People's weight and fluid intake were monitored and where necessary nutritional screening tools were used to identify people's needs and involve other healthcare professionals as necessary.

People had access to healthcare services and received on-going healthcare support. People and their relatives told us that they felt confident that medical treatment would be sought promptly. One person said, "When I had terrible pain they did get the doctor to me, and they come and check if I need pain relief. A relative said, "I have no concerns about immediate medical care." We looked at one person's care records and noted they had difficulty swallowing their medicine. Staff told us the GP had been called out earlier that week and had made recommendations and prescribed alternative medicine. We saw the GP's visit and advice had been recorded in the person's records.

Good

Is the service caring?

Our findings

Most people using the service and their relatives were happy with the level of care and support provided at the home. They told us, “Some of the [staff] here are very nice and they all keep the place lovely”, “It’s very nice here I like it, the carers are nice”, It’s not like home but I’m happy enough and am well looked after” and “They do their best to cope with everyone.” Relatives told us, “The staff work very hard” and “It’s a happy place to come and visit.”

Staff told us about people’s health needs and preferences. They were able to describe how people wanted to be supported. For example member of staff explained that one person needed a special cup to drink from and another person required at least two members of staff to assist them with personal care that needed to be carried out in a certain way to avoid any pain. Some people told us that they thought carers knew them well and how they liked things to be done. One person said, “I’m an early riser and they do get me up early.” People told us they could choose if they wanted to stay in their rooms or go to the lounge and where they would prefer to eat their meals.

During our visit we observed staff supporting and assisting people in a kind and helpful manner. They took care to provide prompting to those people who needed it, for example, when it was meal times, or to encourage someone to engage in an activity. For example, we observed how the activities coordinator positively engaged with people, encouraging them to be involved in the activity at that time. We heard staff being courteous and polite when addressing people. For example, “Hello [name] can I give you your tablets now please”, “I’ll help you to your chair”, “Is the food OK, take your time” and “[Name] where is your tray? Do you want me to get it for you?”

Staff respected people’s privacy and dignity when they were supporting people with personal care. We saw staff using ‘do not disturb’ notices for people’s doors when attending to them. People told us staff would close doors and curtains when delivering care. One person said, “They knock on your door and address you politely.”

The manager explained three staff had been identified as dignity champions to promote dignity and respect at the service and they helped complete a dignity in care audit every six months. This audit looked at the environment and if it supported people’s privacy and dignity, and how staff respected people’s privacy and dignity during day to day activities. We were shown the last completed audit and noted the service had not identified any issues.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive the care and support they needed and when they needed it. People told us they sometimes fitted into the homes routine rather than having their individual choice and preferences considered. They told us, "They wake me to have my pad changed at 5am and then I'm awake. I might get a cuppa, it all depends who's on and how busy they are, but then I wait for my breakfast at 9.00am, don't get anything to eat until then", "I'm going to get changed at 2pm … that's my time … they won't do it before then, that's my time" and "I have my supper in bed. They like you to be in bed early. I'm in bed at 4.15pm ready for my tea at about 5.00pm."

People did not always have choice, control or engagement in meaningful activities that were important or relevant to them. People told us how they spent their day, they said, "I don't go out and about, they're too busy to take us anywhere" and "There is a garden, but none of us go out …how could they take 20 people out in wheelchairs?" People in their rooms told us, "I don't do much" , "Nothing really", " They [the staff] don't have time to come and chat to you they're too busy", " I don't go downstairs much because [the other people there] all just sit around and don't speak" and "The activities down there aren't for me so I choose to stay in my room."

We spoke to the activities co-ordinator who spoke positively about their position and displayed enthusiasm for the role. During the morning we observed them presenting a reminiscence type quiz. They were skilled at engaging people gently to recall their memories and encouraging those on the edge of the group to join in. We noted their manner was respectful and polite and they spoke to people on their level, following the thread of the conversations that resulted. However, we noted activities were limited to the people who wanted to be engaged and were able to attend the downstairs lounge area. As a result, few people at any one time were able to make use of this resource.

On one floor we observed a person with learning disabilities seated at a table during the morning with five pieces of Duplo. This was the person's activity until lunchtime and also for a period after lunch. We saw this person's care records did not provide information or advice for care staff about how to stimulate them or to involve them in social activities. Another person was unable to speak English, staff told us they had access to an interpreter when they needed to communicate with them. Although the person was mobile we noted they stayed in or around their room for most of the day. When we looked at their care records there was very little information concerning their preferences and choices of care. We saw this person had mental health issues and we were concerned that their lack of social stimulation and isolation would result in deterioration in their condition. We discussed our concerns with the manager who explained they would look at ways of involving this person in their care choices and social activities.

On the second floor the TV channel was playing pop music. People were unable to change the channel as staff kept hold of the remote control, "In case it goes missing", one staff member reported. This was an indication that the TV was used as a distraction or background, rather than a useful resource to help meet the needs of people in relation to their age, culture or interests. We saw there was little social interaction between staff and people on this floor.

Care records we looked at were mostly health and risk-based with very little information about people's preferences or personal history. We saw some people had a document named "my life story" in their care records. We noted some of these had been completed with details including life history and information about close relatives and friends. However, in the sample of records we looked at, these life histories and preferences were blank so staff had limited information available to treat people as individuals.This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Consent forms were in people's care plans. For example, consent to take photographs of any injury or bruising and consent to receive vaccinations. Staff told us they would always ask for people's consent before providing care and they routinely explained what they were going to do. In some care records we saw people's wishes for end of life care had been expressed.

People were able to maintain relationships with their friends and relatives. Visitors told us they were made to feel welcome and could visit at any time. People who had

Requires Improvement

Is the service responsive?

family and friends came to take their relatives out on occasions. One person told us, "My husband and daughter come and take me out. I go to my daughter's house for the day from time to time."

We saw how the service recorded and acted upon complaints. We saw the complaint procedure was available in the home and clearly outlined the process and timescales for dealing with complaints. The home had received four complaints in the last 12 months and we were shown how the manager had recorded and responded to these with details of what action has been taken and by whom. All the people we spoke with and their visiting relatives told us they would speak to the manager or their deputy if they were worried or concerned about anything. One person told us, "Oh I've not got any worries but [the manager] is very nice …. I know I could speak to her if I needed to." Another person told us, "I'd speak to [the manager] or [the deputy], you can talk to either of them and, yes, they listen to what you say."

Good

Is the service well-led?

Our findings

There was a registered manager in post. During our visit we saw that family and friends were encouraged to visit and were made to feel welcome to stay as long as they wished. Discussions with the manager and care staff indicated that there was a culture of openness at the home, and that people were enabled to maintain contact with friends and family.

People were encouraged to be involved in the development of the service. Residents' meetings were held every three months. We saw minutes of the meeting held in May 2014 and noted the topics discussed included activities, staffing and the refurbishment of the home. We saw the results from the customer satisfaction survey for 2013/14 and told this was sent yearly to people and their families by the provider. We noted the responses were mainly positive and, where comments had been made about improvements needed, we were shown the action plan put in place for the manager to resolve any issues.

Staff felt comfortable with the management structure of the home, and all staff we spoke to told us they would feel able to report any concerns about the care of people to the manager or the nurse in charge. We saw the service had a whistle blowing policy and that this was also documented in the staff handbook. Staff we spoke with were able to demonstrate understanding of the duty upon them to report any concerns about people's care and welfare. Most staff we spoke with said they would discuss any issues with the nurse or manager in the first instance.

Staff we spoke with told us they felt well supported by the home's management. One care worker told us, "We have a good team, if I don't know I ask." Another said, "My manager is very supportive, I never have a problem telling her anything."

Bi-monthly staff meetings were held and we saw the minutes of the meeting held in May 2014. We noted discussion points included people's quality of life, showing compassion and dignity, documents and records, broken equipment, observations from the commissioning team and people's portion sizes for evening meals.

We saw evidence of monthly managers' meetings and saw how these offered support and guidance to managers and gave the opportunity to share best practice.

There were systems in place to monitor and review accidents, incidents and complaints. There was evidence that learning from incidents took place and appropriate changes were implemented. We saw how the service had acted upon a recent incident at the home and how this had been recorded, together with details of staff actions at the time to reduce the risk of any reoccurrence.

We saw a monthly report which provided an analysis of accidents, pressure ulcers, people's dependency levels, complaints and staffs sickness. We also saw regular audits were carried out by the provider covering subjects such as care planning, staff files, staff training, staff supervisions and privacy and dignity. Other regular audits included fire safety, medicines, infection control and health and safety. We saw that checklists had also been completed by staff to show that fire and other health and safety checks had been carried out. We saw where areas of improvement had been identified these had been addressed.

We were shown the provider's central risk register for the service and noted some identified such as incomplete care records and staffing issues. We saw actions taken to reduce risk had been taken together with the person responsible and the date action was taken. For example, a high level of shift cancellations by staff had been highlighted and as a result the service recruited more staff to bank to cover those shortages.

The regional director explained the central risk register was relatively new and enabled the provider to monitor risk both at provider level and at each location and ensure actions are taken to reduce the risk identified. They explained new risks such as the identified issues with call bell monitoring would be added to the central risk register for action.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered person did not always meet people's individual needs. Regulation 9 (1) (b) (i)** **The registered person did not always protect the welfare and safety of people who used the service. Regulation 9 (1) (b) (ii)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **The registered person did not always enable people to make decisions relating to their care and treatment. Regulation 17 (1) (b)** **The registered person did not always ensure people were provided with appropriate opportunities, encouragement and support in relation to promoting their autonomy, independence and community involvement. Regulation 17 (2) (g)**