

# Community Integrated Care Rose Vale

## Inspection report

15 Rose Vale  
Hoddesdon  
Hertfordshire  
EN11 8NR

Tel: 01992443189

Date of inspection visit:  
14 September 2022  
22 September 2022

Date of publication:  
01 November 2022

### Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

# Summary of findings

## Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

### About the service

Rose Vale is a residential care home providing personal care and support for five people at the time of the inspection. The service can support up to eight people.

### People's experience of using this service and what we found

#### Right Support

The provider had not ensured the staff team was appropriately trained to meet the needs of people and keep them safe. This resulted in people being put at risk of potential harm.

The provider had introduced some improvements to the environment people lived in to help ensure it was clean, well maintained and appropriate equipment was in place. People were able to personalise their rooms; however, these were due for refurbishment.

People received their medicines when they needed them, and staff were mindful when people needed medicines. However, not all staff were trained to safely administer medicines and competency assessments had not been undertaken to ensure those staff who had received training were sufficiently skilled and able.

The provider had not ensured people had care plans in place to support end of life care. We have made a recommendation for the provider to access current guidance on end of life care planning and take action to update their practice accordingly.

#### Right Care

The provider had systems in place to report and respond to accidents and incidents. However, not all accidents and incidents in the home had been referred to the local authority safeguarding team for further consideration.

Staff had training on how to recognise and report abuse, however staff actions did not always show they understood how to raise concerns appropriately either to the provider or to external agencies.

People said staff were kind to them and we observed staff interact with people in a caring and appropriate way.

People's care and support plans did not always reflect their full range of support needs. Care plans were

being reviewed and uploaded to the provider's digital care planning system. Neither the staff team or the manager were fully adept with the digital system and did not always know where to find information.

### Right Culture

People had assessments to identify and manage risks they faced in their daily lives and how staff should support with these. Staff were not always knowledgeable about the content of these risk assessments.

People were supported by staff who were not all appropriately trained to meet their care and support needs. People were not always supported by staff who understood best practice in relation to supporting people with a learning disability or autism.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

The provider's quality assurance system did not effectively manage improvements across the service. Where improvements had been identified by external agencies including the local authority and CQC actions were not always taken in a timely manner. This had an impact on people's care and support.

Further improvements were needed to create an open and transparent culture in the home where all staff felt valued, engaged in the running of the home and consulted.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

### Rating at last inspection and update

The last rating for the service under the previous provider was requires improvement, published on 12 February 2020 and there were breaches of regulation.

### Why we inspected

We carried out an unannounced focused inspection of this service on 08 January 2020. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment, response to complaints, staffing, the duty of candour and good governance.

We undertook this inspection to check the provider had followed their action plan and to confirm they now met legal requirements. The overall rating for the service remains requires improvement based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Rose Vale on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

### Enforcement and Recommendations

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to people safety, staff training and quality assurance systems in place at this inspection.

Please see the action we have told the provider to take at the end of this report.

#### Follow up

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not always safe.

Details are in our safe findings below.

**Requires Improvement** ●

### Is the service effective?

The service was not always effective.

Details are in our effective findings below.

**Requires Improvement** ●

### Is the service caring?

The service was caring.

Details are in our caring findings below.

**Good** ●

### Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

**Requires Improvement** ●

### Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

**Requires Improvement** ●

# Rose Vale

## Detailed findings

### Background to this inspection

#### The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

#### Inspection team

This inspection was conducted by one inspector.

#### Service and service type

Rose Vale is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement dependent on their registration with us. Rose Vale is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

#### Registered Manager

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post. The previous registered manager had left the service but had failed to cancel their registration. The current manager has been in post since June 2021 and had not yet submitted their application to register

#### Notice of inspection

This inspection was unannounced.

### What we did before inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used information gathered as part of monitoring activity that took place on 30 August 2022 to help plan the inspection and form our judgements. We used all this information to plan our inspection.

### During the inspection

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with two people who used the service and received feedback from 10 staff members including the manager, regional manager and the provider's head of operations. We received feedback from two external professionals about the care and support provided for people.

We looked at a variety of documents relating to the care and support of people who use the service. These included (but not limited to) two people's care plans and risk assessments, a range of audits and monitoring tools, staff recruitment records, accident and incidents and complaint records.

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. (This was with a previous provider.) The rating for this key question has remained requires improvement: This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse; Using medicines safely; Learning lessons when things go wrong

- Staff training records indicated 55.5% of the staff team had received up to date training in safeguarding people. Some staff confirmed they knew how to identify when a person may be at risk of harm and knew who to report concerns to outside of the service. However, some staff told us where incidents had been reported to the manager but had not been referred to the local authority safeguarding team for guidance and external oversight.
- The manager advised there had been no accidents or incidents deemed necessary to report to the local authority safeguarding team since they had started to work at the home in June 2021. However, we found two examples where the manager had failed to refer minor injuries of unknown origin to the local authority safeguarding team for further investigation.
- Staff reported concerns appropriately to the management team. The manager advised they consulted staff whilst looking into any incidents reported and used various methods to share lessons learned from accidents, incidents or other events to help improve care practices in the home. However, some staff members advised they were not consulted about any incidents happening in the home nor were they updated with any outcomes of internal investigations.
- Some staff had not received up to date training to give them the skills to safely transfer people who were unable to mobilise independently. There had not been any competency assessments undertaken to assure the provider that these staff could provide this support safely. Staff who had not received this training told us they had support from skilled and competent staff 'Most of the time' to enable them to support people's needs.
- A person's care plan stated, "All staff giving me medication must be medication trained and have a completed medication competency assessment." However, records showed us 55.5% staff were medicines trained and only one staff member had their competency to administer medicines checked.

We found no evidence people had been harmed. However, appropriate action had not been taken when there was a suspicion people may not be safe. This placed people at risk of harm. This was a breach of Regulation 13 [Safeguarding service users from abuse and improper treatment] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

- People said and indicated to us they felt safe in the home. One person said, "I am happy here, I like living here."
- People's medicines administration records were completed accurately and the sample of medicines we



counted tallied with the amount recorded.

- People's medicines were administered as the prescriber intended, and any errors were identified and reviewed. People's medicines were regularly reviewed, and staff contacted the prescriber if any issues occurred.

#### Staffing and recruitment

- The provider operated a safe system of staff recruitment.
- We viewed recruitment records for two staff members employed in recent months and found the necessary checks had been undertaken to help ensure the suitability of staff for the roles. This included a Disclosure and Barring Service check (DBS). The DBS helps employers make safer recruitment decisions.
- A recently recruited staff member confirmed the recruitment process and said they had waited a long time for the DBS check to be completed before they were able to start work at the service.
- The service has relied heavily on agency staff in recent months. However, the management team advised a successful recruitment campaign had resulted in new members of staff starting to work at the home. The manager reported this had been positive in terms of improving staff morale and stated the service should be fully staffed by the end of September 2022 reducing the need for temporary staff.

#### Assessing risk, safety monitoring and management

- Risks associated with people's care were assessed and risk management plans directed staff how to manage and reduce risks. Risk assessments covered all aspects of people's needs including, but not limited to, areas such as mobility, epilepsy, eating and drinking, safeguarding and fire. However, some staff were not clear about who lived with significant risks such as choking.
- Assessments were undertaken in relation to areas including fire safety, legionella, electrical testing and actions arising from these were completed. Staff had received training and knew what to do if the fire alarms sounded and regular fire drills were carried out.
- The senior care worker on duty was the designated fire marshal for the shift and was responsible for fire safety whilst on duty. The staff rota did not confirm this was the case, the manager undertook to amend the rota so it clearly indicated who was fire marshal for each shift.

#### Preventing and controlling infection

- Effective infection, prevention and control measures were in place to help keep people safe, and staff supported people to follow them. There were systems in place to keep the home clean and hygienic.
- Staff used personal protective equipment (PPE) effectively and safely.
- The provider ensured infection outbreaks could be effectively prevented or managed. Training was provided for the staff team to give them the skills and knowledge needed to promote people's safety and wellbeing in this area.
- People were able to see friends or relatives if they wanted to and there were no restrictions on visiting.

# Is the service effective?

## Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question Requires Improvement. (This was with a previous provider.) The rating for this key question has remained Requires Improvement: This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- People were not always supported by staff who had received the relevant training to meet their specific health and support needs. Not all staff had training for epilepsy, positive behaviour support and communication tools.
- The provider did not ensure they met best practice guidance when supporting people with a learning disability and autistic people. Not all staff had training in supporting autistic people or people living with a learning disability. The provider stated they were looking to further develop training provision in this area.
- There was a shortfall in staff refresher training and competency assessments in basic core training. Staff training and refresher training were identified at the previous inspection of this service and by the local authority quality monitoring team as areas requiring improvement. The manager advised this was being addressed as an area for improvement and told us all basic core training would be up to date by the end of October 2022.
- Staff did not always feel they had adequate skills or training to support people. One staff member said, "I don't have the training and support I need." Another staff member said, "No-one checks my practice."
- The manager advised staff now received regular 1:1 supervision, team meetings and group supervisions. However, some staff told us they did not receive the management support they needed.
- External professionals advised training opportunities had been offered to the service but had not always been acted upon.

We found no evidence people had been harmed. However, the provider had failed to support staff to develop their skills or have effective training. Staff did not always receive updates to their training. This placed people at risk of harm. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider's management team acknowledged they needed to upskill the staff team. This included checking staff competency to ensure they understood and applied their training.

Supporting people to eat and drink enough to maintain a balanced diet

- People were supported to maintain a well-balanced diet and were provided with meals they enjoyed. People were provided with specific equipment they needed to enable them to eat independently.
- People were supported to participate in their meal planning, food shopping and meal preparation. During the inspection we saw a person helping to prepare vegetables whilst sat in the communal dining area chatting with staff.

- Staff understood people's specific dietary requirements and eating plans and supported people to follow them. People's weights were monitored regularly if this was necessary.
- Allergies were recorded and specialist guidance from health professionals was followed particularly around risk of choking. However, one person's care plan stated, "I must be supervised closely at all times when I am eating and drinking. All staff must be first aid trained and know what to do in the event of a choking incident." The training matrix for Rose Vale stated 55.5% staff had received training in emergency first aid.

#### Adapting service, design, decoration to meet people's needs

- Rose Vale is a purpose-built care home to support people's needs. Some refurbishment of communal spaces had taken place since our previous inspection however, people's bedrooms had scuffed walls and cracked tiles around wash hand basins.
- The management team told us about the plans to improve the environment. This included refurbishment of people's bedrooms, the kitchen and toilet and buying furniture for the communal lounge/dining spaces. However, timescales had not yet been agreed for this work to take place.

#### Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- Staff demonstrated they understood the principles of MCA, although not all staff had received refresher training. Staff asked people for their consent before providing care and support.
- Capacity assessments and best interest decisions had been completed for areas including medicine administration, use of bed rails, use of lap belts in wheelchairs and living at Rose Vale.
- Deprivation of Liberty Safeguards (DoLS) authorisations had been applied for as required. For example, where people were not free to leave the building independently. Where DoLS authorisations were awaiting assessment by the local authority a plan to manage the deprivation was in place and kept under review.

#### Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were assessed before they started using the service to help ensure staff understood people's needs and preferences and the service could meet their needs.
- All aspects of a person's needs were considered during the initial assessment including the characteristics identified under the Equality Act and other equality needs such as people's religious and cultural needs.
- Staff worked with external health professionals to routinely assess and review people's care. This helped to ensure people were supported in line with current best practice guidance to promote safety and well-being.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- Staff supported people to attend planned health appointments and referred people promptly to their GP or other specialist health services as needed.
- Staff worked with local and specialist health services to ensure people received effective, timely care. The advice given by external professional and specialist healthcare services was included in people's care records. This helped to ensure staff had access to up to date and relevant advice and guidance to support them to care got people safely and effectively.
- An external professional told us, "People have always appeared comfortable and supported during my visits. [Staff member name] in particular is always able to share up to date information and calls me for advice/support when needed."

# Is the service caring?

## Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question Requires Improvement. (This was with a previous provider.) At this inspection the rating has changed to Good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People received respectful and caring support from a committed staff team. Some staff had worked with the same people for a significant time and had developed strong and meaningful relationships. We observed warm interactions between people and staff.
- Staff were patient and used individual styles of interaction with people. We observed staff bending down to engage with people at their level and at their own pace.
- Staff understood people's emotions and support needs such as sensory sensitivities and knew how to support people according to their needs and wishes.
- An external professional commented, "During my visits to Rose Vale I have always found the staff to be kind and compassionate towards the residents."

Supporting people to express their views and be involved in making decisions about their care

- Staff supported people to make choices for themselves and helped to ensure they had the information necessary to make meaningful choices. For example, when offering people choices for their meals or drinks, what clothes to wear and options for social engagement.
- People's relatives were involved in their care where appropriate. Staff kept relatives updated about people's health and well-being with regular telephone calls and at visits to the home.
- Information about advocacy services was available to people and their relatives. This helped to ensure that people were able to seek independent support to help them make decisions about their care. An external advocate was involved in supporting a person to make decisions about their life and health.

Respecting and promoting people's privacy, dignity and independence

- Staff promoted people's dignity. This was demonstrated by the way they spoke with people, gave them time to respond and listened to them.
- Staff respected people's privacy and dignity. For example, when providing personal care and helping someone use the bathroom. They also explained how they helped people to make independent decisions about their daily living, such as by using different objects, food items and clothing to encourage people to make choices. Professionals told us staff promoted people's dignity and privacy.
- People's care records were kept securely; information was protected in line with General Data Protection Regulations.

# Is the service responsive?

## Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question Requires Improvement. (This was with a previous provider.) The rating for this key question has remained Requires improvement: This meant people's needs were not always met.

### End of life care and support

- There were not always sufficiently planned arrangements in place to support someone to experience good end of life care.
- People's end of life care plans gave basic details about potential funeral arrangements but lacked personalised information to help make sure staff could support people to experience a comfortable, dignified passing, informed by their known preferences. This was not in line with national practice guidance on end of life care. We raised this with the manager and signposted them to practice guidance resources.

We recommend the provider consider current guidance on end of life care planning and take action to update their practice accordingly.

### Planning personalised care

- People's support plans provided guidance and information for staff about what was important to people and how best to support them safely and effectively. Some staff were confident in using the provider's digital care planning system, but others said they were not as confident and asked colleagues for any information they needed. This meant that staff may not always have access to the up to date information they needed to provide people with appropriate care and support to meet their needs.
- People's care and support plans set out some simple outcomes their support aimed to help them to achieve. This was in areas including eating and drinking, health needs and entertainment and stimulation.
- Staff supported people according to each person's preferences, needs and wishes. Staff spoke knowledgeably about how they personalised their approaches to support people's individual needs.
- An external professional told us, "The care plans have been slowly improving over time."

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant

- Staff supported people to maintain relationships with people important to them. For example support with email and video contact for relatives who did not live close by and physical support to enable a person to visit with their relative in person.
- Staff supported people to join in their chosen social and leisure interests and activities that were meaningful to them. These included country walks, visits to parks, trips to the seaside, eating out, watching a variety of films, listening to music, BBQs, birthday and Christmas parties, musical instruments, shopping and a wide variety of indoor crafts.

### Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- The service supported people to meet their communication needs.
- People's support plans set out basic information about how people communicated, such as when a person didn't use words to communicate with others. For example, one care plan stated: "I am able to communicate my needs and wants through facial expressions, noises and how I present overall. I need my team to understand me to avoid me becoming frustrated and not listened to."
- Staff demonstrated a good awareness of people's individual communication needs, how to facilitate communication and understood when people were trying to tell them something.
- Staff used objects, pictures and gestures to help people communicate and know what was likely to happen during the day and who would be supporting them.

Improving care quality in response to complaints or concerns

- The provider had systems in place for receiving and responding to complaints. The manager told us no formal complaints had been received since they had started in post.
- The provider monitored complaints as part of their quality assurance processes. This meant they could confirm any concerns had been resolved and identify any trends or themes and learning for service improvements.

# Is the service well-led?

## Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- This care home was taken over by the new provider (Community Integrated Care) in June 2021. The provider had meetings with the local authority and the Care Quality Commission to share their plans for bringing about the improvements needed to benefit the people using the service. However, at this inspection we found improvements had not been made and people continued to receive care that put them at risk of potential harm.
- The provider had failed to identify improvements needed in the service. We found examples where incidents had not been reported, routine audits and monitoring exercises were not detailed so it was not clear what actions had or had not been taken to safeguard people.
- Lessons learnt from accidents, incidents were not clearly identified or shared with the staff team. This meant changes were not made to improve people's experiences and care.
- The provider had not ensured people were supported by staff who had received the relevant training to meet their specific health and support needs. For example, not all staff had received training for epilepsy, positive behaviour support and communication tools.
- The provider had not ensured they met best practice guidance when supporting people with a learning disability and autistic people. Not all staff, had training in supporting autistic people or people living with a learning disability. The provider stated they were looking to further develop training provision in this area.
- There was a shortfall in staff refresher training and competency assessments in basic core training. Staff training and refresher training were identified at the previous inspection of this service and by the local authority quality monitoring team as areas requiring improvement. External professionals advised training opportunities had been offered to the service but had not always been acted upon. The manager advised this was being addressed as an area for improvement and told us all basic core training would be up to date by the end of October 2022.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- We found the morale in the staff team was low. Some staff did not feel listened to and felt they could not share their ideas about the service. The senior management team advised they felt this was due to previous historical and cultural issues within the home that had not been properly addressed and shared plans to address this immediately.
- The provider and manager did not always consider people's holistic needs when reviewing the support they provided. For example, there was no consideration about how to meet people's end of life care and support needs.
- The provider had failed to identify the failing in relation to the safety of people, staff training and competency assessments and the need to improve the culture of the service.



We found no evidence people had been harmed. However, the provider had failed to implement robust governance systems to ensure the quality and safety of the care provided met people's needs. The provider failed to ensure action was taken to improve the care people received. This was a breach of Regulation 17(Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider had not sought recent feedback from people, those important to them, external stakeholders and staff. The manager advised a satisfaction survey was due to be completed soon.
- Team meetings were held to share information and learning. However, the minutes from these meetings and staff feedback confirmed these were not used as an opportunity to engage staff views and opinions in order to help improve people's experiences of living at Rose Vale.

Working in partnership with others

- The manager gave examples of how they had regular input from other professions to achieve good outcomes for people. External professionals confirmed they were involved with people's care and support needs however; they reported the quality of their engagement with the service depended significantly on the staff members they spoke with.
- One professional told us how some staff were always able to share up to date information and called for advice when needed. However, other professionals reported communication with the service had been difficult and had impacted on their ability to progress work or gather important information.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing  The provider had failed to support staff to develop their skills via effective training. Staff did not always receive updates to their training. This placed people at risk of harm. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.