Your Choice (Barnet) Ltd

Barnet Supported Living Service

Inspection report

2 Quartz Court, Pellow Close, Barnet, EN5 2UP.
Tel: 020 8359 4621
Website: www.barnet.gov.uk

Date of inspection visit: 6 and 7 August 2014
Date of publication: 03/03/2015

Ratings

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

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.

This inspection was announced. The provider was given 48 hours' notice because the locations provided care to people who needed to be prepared that we were inspecting and we were visiting their home. The service met all of the regulations we inspected against at our last inspection on 9 September 2013.

The service has five units across the London Borough of Barnet, which provided care and support to people with a learning disability, mental health needs and autism. Three of the units were self-contained flats and the remaining were two shared houses. All units were staffed 24 hours a day. On the day we visited we saw there were 35 people using the service. A registered manager

Summary of findings

oversaw all of the services. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law, as does the provider.

People's safety was being compromised in a number of areas. This included how medicines were stored and recorded and infection control related to personal care.

Staff did not understand the Mental Capacity Act 2005 (MCA) and had not received training to support people who lacked capacity to make decisions. For example, the provider had not made an application under the Mental Capacity Act to the Court of Protection for one person, when their liberty may have been restricted.

The registered manager investigated and responded to people's complaints according to the provider's complaint procedure. However, relatives said the complaints procedure had never been explained to them.

Staff had not received training in areas such as MCA, DoLS and dementia. Staff had received training in medicine, food hygiene and understanding people's physical health such as epilepsy. However, they did not put this training into practice. People who used the service and their relatives had concerns about the low numbers of staff. People said that their needs were sometimes not met as they could not attend activities they enjoyed.

People were provided with a choice of food and were supported when needed. In communal fridges we saw food that was out of date and not stored correctly. People were at risk of food poisoning.

Although people had care plans and risk assessments, these did not clearly document people's current needs and risk. They were not always personalised or written in a way that people could access, such as using pictures for people who were unable to read.

The provider ensured people had access to their GP and other health professionals, however records were not kept up to date and most people did not have health passports. These help professionals in hospital understand how people communicate and their physical and mental health needs. Therefore, professionals may not have had the most up to date information to ensure they provided the most appropriate care.

People told us that staff were caring and kind. We did see some staff that were caring however, others were not and did not have the skills or understanding to care for people who had different needs effectively.

Although systems were in place to monitor the quality of the service, we saw these were not effective. Audits had not picked up issues that were observed on the inspection, such as missed medicines and lack of equipment to prevent the spread of infection.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. People were at risk of infection as staff access to personal protective equipment was restricted. Some people's medicines were not managed safely.

People and relatives were concerned with the levels of staffing at all the services. Relatives said that people's individual needs were not being met due to staff not being available to support people to attend their chosen individual activities.

The service had not completed capacity assessments to determine if people's liberty was being restricted at the service.

Is the service effective?

Requires Improvement

The service was not always effective. People had access to food and drink they liked. However the provider did not always store food appropriately.

Staff did not receive the training they required to ensure they understood their responsibilities and had the skills and knowledge to support people.

People were supported to attend appointments, however these were often not recorded in peoples care files.

Is the service caring?

Requires Improvement

The service was not always caring. People were positive about the care they received, but this was not supported by some of our observations such as staff not always treating people with dignity and respect and not knowing people's needs.

People had access to independent advocacy should they need support to make decisions.

Is the service responsive?

Requires Improvement

The service was not responsive to people's needs. Care plans did not always show the most up-to-date information on people's needs, preferences and risks.

The service managed complaints that had been raised. However, not everyone knew how to make a complaint or raise a concern.

People had access to activities, but told us that at weekends there were not enough staff to support them to attend activities they enjoyed.

Is the service well-led?

Inadequate

The service was not well-led. People were put at risk because systems for monitoring quality were not always effective.

Summary of findings

Computer systems installed by the provider did not enable staff and management to access information that would have assisted to improve accessibility to care records for people at the service.

Barnet Supported Living Service

Detailed findings

Background to this inspection

The inspection team consisted of two inspectors and two specialist advisors, one of whom had experience of learning disability in a social care and health setting and one who had a background of financial auditing in health and social care.

We visited all the units that made up this service on 6 and 7 August 2014 and spoke with ten people living at the service. We also spoke with ten relatives, three managers, eight care staff and the registered manager. We observed care and support in communal areas and were invited to look at the kitchen and six people's bedrooms as well as ten people's care records. We reviewed staff training and induction records for ten staff employed at the service. We also reviewed ten people's medicines records and quality assurance audits the managers had completed.

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.

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.

Before our inspection, we reviewed the information included in the PIR along with information we held about the service. We contacted the commissioners of the service to obtain their views about the care provided in the service.

After the inspection we reviewed the information the registered manager had given to us, spoke with learning disability professionals who visit and review people's care at the service and asked the registered manager some further questions.

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.

Inadequate

Is the service safe?

Our findings

The service was not safe as we found that people using the service were exposed to significant risk to their safety.

We looked at people's medicines in all five properties and the supported living service. We saw that most people managed their own medicines with support from staff. Medicines were stored in people's bedrooms in locked cupboards. All the medicine cupboards we looked at were dirty and sticky from medicine that had been spilt. Medicine administration charts (MAR) were not always completed by staff. We saw one person whose MAR chart was blank for four days. Staff told us that the medicine had run out, and staff had not ensured more medicines were obtained. The person's MAR chart had not been signed to reflect they had not received their medicines. Therefore this person did not receive important medicines for four days. Five other MAR charts had not been fully completed after medicines had been given to people. Another person who received as required medicine (PRN) was receiving this regularly twice a day. Staff said they always asked the person if they needed it, however, staff had not spoken with the person's GP to inform them that the person was taking this medicine regularly and a review was required. The registered manager told us that staff were signed off when assessed as fit to dispense medicines, however the issues we identified demonstrated that not all staff competently administered medicines. Staff we spoke with did not always understand the medicines they were giving to people and the possible side effects therefore staff would not have realised if there was a problem with people's medicines and reported this to the GP.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

All staff we spoke with did not understand the Deprivation of Liberty Safeguards (DoLS). In one service we saw that people were not able to access the kitchen at night as staff locked this due to other people in the service being at risk. The service did not realise this was depriving someone of their liberty and had not completed capacity assessments or referred this to the local authority or the Court of Protection. We asked that they did this as a matter of urgency and we also contacted the local authority.

Three staff we spoke with understood the Mental Capacity Act 2005 (MCA). We were told that several people at the service did not have capacity to make decisions about some areas of their life. However, neither the registered manager nor the provider had completed a mental capacity assessment or asked the local learning disability team to support them to do this. Therefore staff had not followed processes to ensure that decisions about people's care were made in their best interest by people who knew them.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

Three staff we spoke with could tell us the signs of abuse and how to report this. However, seven staff did not know the signs of abuse or what to do in the event of an incident or allegation of abuse. The registered manager told us all staff received safeguarding and mental capacity training during their induction. However the registered manager notified the CQC of any allegations of abuse when required to do so. People at the service were not always protected against the risk of abuse because the registered manager and the provider had not ensured staff understood the signs of abuse.

We saw that the service had posters in each unit that explained in pictures what people should do if they were being bullied or harassed. However, at one unit we spoke with two people who did not understand the poster and the message. We saw at some services it was recorded that staff spoke to people about being bullied and harassed and what to do. Therefore there was a risk that some people at the service would not know what to do if they were being bullied or harassed. We made the manager of the service aware of this and she planned to review the posters with the people who used the service and discuss these areas with all people who use the service.

In all of the five services we visited we saw that staff were aware of their responsibilities in ensuring the service was kept clean with the support of people who used the service. People we spoke with said that they thought the service was clean. One person said, "it's clean, no complaints" and "It's clean." Of the six toilets we saw across all the units we saw none had paper towels available for people or staff. Therefore people and staff did not have the equipment they needed to wash their hands properly and reduce the risk of cross infection. Staff we spoke with said

Inadequate

Is the service safe?

that disposable gloves were not always available when supporting people with personal care. We saw that gloves were available in each unit but staff were unaware this was where gloves were kept.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

People at the service had risk assessments. People we spoke with were not aware of these, however they were able tell us they needed help sometimes to keep safe. We reviewed eight risk assessments. We saw they were not comprehensive and were not always being reviewed. We saw one risk assessment that asked staff to monitor someone's changing behaviour to assess the impact this had on their day to day activities. However, staff had not been keeping records as requested therefore the service would not have had a clear pictures of the impact the behaviour was having on the individual and possible changes in care required for this person.

Six staff we spoke with during the inspection did not have the knowledge to care for the people at the service. They did not understand people's needs or risks and were uninterested in the people they were caring for. However, we met and saw staff that were knowledgeable, enthusiastic and engaged with people, we noted these were all permanent staff.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

Five risk assessments had been reviewed. However, it was difficult to follow changes that had been made as these were hand written and it was not clear what the level of risk was. For example, one person was recorded as high risk of going missing however this had been updated several times and it was unclear if this was still a current risk. Staff we spoke with were not sure if this was current, but commented that this person had gone missing in the past. Some staff we spoke with were aware of risks associated with people's support. However, we met several new and agency staff who had no understanding of people's risks. Therefore, people and staff were not always aware of individuals risk and ways to manage these effectively.

People who use the service told us that they would like to see more staff to support them. One person said, "We could do with a few more staff, more men would be good." Another said, "If we had staff at the weekend I could go to the cinema or visit friends." A third person said, "They keep changing staff." Another said, "I do not know some of the staff, so they do not know how to look after me and the things I like." We observed that staff were pressured and rushed when providing care to people at the service.

We observed care using SOFI. We saw one person who sat alone for an hour without any interaction from staff. We saw staff were busy supporting other people taking them to day centres and providing care. This person had communication difficulties and could not move without staff assistance. We saw they constantly watched the door to see if staff were coming. Staff later explained that this person had not been allocated enough hours therefore they were unable to provide more care although staff told us they were aware that this person needed individual time. Staff were frustrated with this situation. One said, "We want to give more time but it's impossible." The provider was not following its own equality and diversity statement. Which stated "Equality is not achieved by treating everyone the same and give a one –size-fits all service. It's about recognising that people have different needs that can be met in different ways."

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

We reviewed eight staff files. We saw the service ensured that staff had undergone appropriate checks before they started work and these were updated regularly to ensure staff were still suitable to work with people.

Before the inspection we received information about how people's money was being managed by the provider. We looked at how individual people's money was managed at the services and the provider's policy and procedures as well as talking to staff and people. We saw that people were encouraged to manage their own money. People's money was kept securely and records of payments and receipts were checked daily by staff. If any discrepancies were noted these were reported to the manager. Each month the manager reviewed receipts and payments against people's bank statements. Sometimes these monthly checks did not occur due to other pressures, but we saw managers always caught up. Records were available for people and relatives should they wish to review. Two people who we spoke with were happy with how their money was being managed and confirmed they had access to money when they needed it.

Requires Improvement

Is the service effective?

Our findings

Six people did not have a health action plans or hospital passport. Four people had these but they were not up to date. We saw one person's health action plan and hospital passport had not been updated to reflect they were now a diabetic. Therefore, if this person was being admitted to hospital in an emergency or for routine tests professionals would not have had the most up to date information at hand. These documents also help professionals to better understand people's needs and can greatly enhance people's experience of a hospital visit.

We saw that people had access to their GP, community learning disability teams and dentists however often the documents that contained details of these visits were blank. Therefore, staff might not have the most up to date information on people's physical needs. Six staff we spoke with during the inspection did not have the knowledge to care for the people at the service. They did not understand people's needs or risks and were uninterested in the people they were caring for. However, we met and saw staff that were knowledgeable, enthusiastic and engaged with people, we noted these were all permanent staff.

Staff explained and people we spoke with confirmed that they choose the food they liked and were supported to go shopping. One person showed us pictures of food they liked and what they had chosen to make on the day we inspected. In another service we were shown a cake that people had made with the support of staff. People told us, and we saw, that people were given choice and appeared to enjoy the food that they were eating. Four staff we spoke with sometimes understood people's needs in relation to their culture and religion and the type of food they liked and ate on certain days.

We saw that people had been referred to the Speech and Language Therapist (SALT) when staff had observed they had problems eating. Information that had been received from the SALT was available for staff in kitchens and people's care records. Staff who we spoke to understood the needs of these people.

We were given permission to look in people's fridges in their rooms and on the whole we saw these were clean and food was in date. However when we looked in communal fridges and freezers where people and the service kept food we saw out of date food such as mushrooms bread and open soft cheese which was green with mould. In the freezer we saw several items of food that had not been resealed such as chicken mince, sausages, and five open bags of vegetables. There were no dates to indicate when these had been opened. Staff confirmed that the food belonged to people who they were supporting to make meals. We made the staff aware that food left open in freezers placed people at risk of contamination from poorly stored food. We asked staff to remove out of date food and frozen food during the inspection to protect people living at the service. We saw that staff had not received training in food hygiene.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We reviewed staff training, supervision and appraisals. We saw that managers of the units had received appraisals however all other staff had not. Supervision occurred in some of the homes but this was not consistent. For example, in one service we saw some staff received supervision monthly however in another service supervision had not taken place since January 2014. Staff told us they were not receiving supervision, but they could talk the manager. Managers told us that agency staff did not receive formal supervision but they had regular chats with them. Therefore, staff were not being supported by the provider to ensure they were able to deliver care safely and at an appropriate standard.

Relatives we spoke with believed that staff had the skills to care for their relatives. Comments included, "Staff seem suitably trained and competent." However when we spoke with all staff we had concerns about their understanding of the MCA, DoLS, medicines, food hygiene and understanding people's physical needs such as dementia and epilepsy. We reviewed the staff training and saw that staff had not received training in MCA, DoLS, equality and diversity and basic health and safety. The registered manager told us that mandatory training for all staff was medication, emergency first aid, health and safety (moving and handling) and safeguarding. The managers we spoke with had been in post for a year however they had not received any management training to enable them to support staff and run their individual houses effectively. They told us they were supported by the registered manager and had frequent co-ordinators meetings but still believed they did not have all the skills they needed. The

Requires Improvement

Is the service effective?

registered manager confirmed that managers had not received any management training since being in post. Therefore the service left people at risk by not ensuring their staff were suitably trained to provide effective care.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Requires Improvement

Is the service caring?

Our findings

We found that not all staff understood people's needs, their likes and dislikes and personal histories.

We received some positive comments about the staff and about the care that people received, such as, "Staff here are kind and caring", and "I know the staff and they know me, when I need help they will come quickly". One relative described the care as "Simply fabulous." However not everyone was positive about the staff and the care they received. One person said, "One member of staff never smiles, another used to look stern but not anymore." Another person said, "Staff are sometimes lovely and sometimes bossy."

While speaking with one person about staff and the support they receive, they became upset. We contacted the manager who acted appropriately and supported this person to understand why they were upset. One person we met told us they had never been given a choice in the gender of their care worker and they would have preferred a male worker as they believed they would have understood their needs better and be able to join in more of the activities they enjoyed. The registered manager agreed to speak with this person to better understand their request.

Some people at the service confirmed that they attended 'service meetings.' At these meetings they discussed trips out and changes within the service. However, many people at the service were unable to communicate verbally and we did not see any evidence of how these people's voices were heard in these meetings.

People said that staff respected their privacy and dignity. One person said, "The staff give personal care very discreetly, I always feel my privacy and dignity are respected." This person was able to give us an example of what staff had done to ease their embarrassment in relation to personal care. During the inspection we saw staff treat people with dignity and respect. The eight staff we spoke with understood the importance of dignity and respect and were able to give examples how they would do this. However, in one home, we saw a staff member walked through someone's room without asking. When we discussed this with the staff member they did not understand why we had concerns.

One person told us that some staff listened and that they got looked after well. We saw this person had their own room and that staff respected their privacy. They said, "Staff always knocked at the door although I usually leave it open."

In one service we saw that when the service front door bell rang, staff answered this. We asked people why they did not answer the door, they responded "staff do that." We reviewed care records to see if there was a reason why people living at the service could not answer the door. None was recorded, therefore people may not feel as though they are in control of their service and staff did not use this as an opportunity to support people in understanding about risk and stranger danger.

An external community advocacy service was available for people and the manager in each service knew how to access this. We saw that people, family and care co-ordinators were involved in people's care and this was sometimes recorded in their care records. However, often agreed plans were not followed through. We saw one person had a white board that staff had been requested to use by the community learning disability team to aid communication however this was not always used by staff. Staff we spoke with were confused with what was the most up to date information. Therefore this person was not being helped to communicate because staff did not follow the up-to-date plans.

In one of the houses we saw that staff were kind to people, however we noted the atmosphere was strained and staff appeared under pressure. We saw people who had high needs were being supported. However, other people who were less able to communicate their needs were often left alone for long periods of time without any stimulation such as the TV, radio or staff to talk to. Staff we spoke with confirmed that they would like to be able to have more time to sit and chat with people who were isolated and were aware this was a problem. Therefore people's individual needs may not have been met.

Requires Improvement

Is the service responsive?

Our findings

People had reviews of their care and they were invited to these meetings along with family, friends and any professionals. Some relatives confirmed these occurred and were helpful. However, others were unaware of these meetings but confirmed they were invited to social events at the service. One relative said they were invited to social events and believed these were a way to communicate with staff on how everything was going with their relative.

People had access to activities they enjoyed, and some staff we spoke with knew what people liked to do and supported them. People told us that staff supported them to go out for lunch. However, people complained that at weekends and in the evening they were unable to attend activities such as the cinema, meeting friends or going for a walk as there were not enough staff to support them. Therefore people were not always supported to access the community at times they would like due to staff not being available.

Nine out of the ten relatives we spoke with had concerns about the level of staffing available at the service. The registered manager said that a high level of agency staff had been used at the service but she was currently employing permanent staff. Relatives told us that people's needs were not being met due to staffing levels. One relative told us that their relative liked to "cook, go to parties and visit friends, but there were not enough staff to support them to do this as their needs had increased and needed more help." Another said, "The problem is at weekends there are not enough staff to ensure they engage in the activities they enjoy." Relatives also commented on the high levels of agency staff. One relative said, "Agency staff do not know my relative and they do not know the agency staff." This relative told us of several incidents that had occurred when agency staff were present at the home, which included their relative arriving at an event inappropriately dressed for the weather.

We reviewed eight people's care plans. We saw that these were not person centred and often people were not referred to in a respectful way. We saw that people often had long term goals in their care plans however there were no steps to show how these people would achieve these long term goals. Care plans were not helpful in understanding people's needs, likes and dislikes and daily activities. Therefore, staff who did not know people would have found it challenging to provide person centred care to people who often found it difficult to communicate their needs.

Six staff we spoke with during the inspection did not have the knowledge to care for the people at the service. They did not understand people's needs or risks and were uninterested in the people they were caring for. For example, one person had been struggling for some time to access public transport. Staff did not understand that this was a sign of the illness the person was developing. Staff had not used alternative methods or approaches to meet this person's needs. However, we also met and saw staff that were knowledgeable, enthusiastic and engaged with people, these we noted were all permanent staff.

Staff were able to explain how they would support someone to make a complaint and some understood the complaints process. However, we did not see evidence that people knew how to complain. We asked people if they knew what to do if they needed to complain. They were unsure and thought they would go to the manager if they were available. Relatives we spoke with did not fully understand the complaints process, and did not believe they had ever been given information on how to complain. However, they said they knew who the registered manager was and the service managers and they would contact them. One relative said, "I know how to complain, but there is no point, I used to go to all the meetings, but cuts mean there is nothing they can do to improve the service." We saw that the service had received complaints in 2014 and these had been responded to following the provider's own policy. Staff and management encouraged learning to happen from complaints. We saw a recent staff meeting had reflected on a complaint and looked at ways they could have managed the situation better.

The provider completed a family survey in May 2014. Thirty five families received the survey and 10 responded. Of the 10 relatives we spoke with none of them could remember being asked to complete this. However, most said they did give feedback after they had attended a care review meeting. Questions asked from the family survey included, how satisfied or dissatisfied are you with the service, did relatives feel they were involved in care reviews and activities? We saw that relatives were satisfied with all areas of the service.

Inadequate

Is the service well-led?

Our findings

Although there were some systems in place to monitor the quality of the service they were not always effective. We saw some records of audits that had been completed, however they did not identify issues that we found during our inspection such as missed medicines and care records not being up to date.

We saw that the managers in each unit often struggled to complete tasks due to the provider's computer systems. We saw this had an impact on people using the service. They told us that the system would not allow them to access some internal and external systems such as financial spreadsheets, staff appraisals and helpful websites for people with learning disabilities. Access to these would have enabled managers to source the latest best practice ideas. Managers also told us they did not have access to a colour printer in the units; if they required this they needed to go to the head office. Four people we met were unable to read their care records and therefore did not understand what they were about. Best practice encourages providers to make notes accessible to all, by using different colours, pictures and objects.

Eight of the staff we met told us they did not feel valued by the service. They said that the provider did not understand the current pressures. They believed the current culture did not encourage an open dialogue with senior managers. We saw this had an effect on people who used the service. One relative commented, "None of the cuts have led to improved care, all work has to be done in a hurry."

Relatives told us of the effect that a changing work force had on people. One relative said, "My relative lost their key worker, it was very upsetting for them." Another said, "When a worker leaves my relative feels it like the loss of a family member." The registered manager was aware of the high turnover of staff and we saw the provider was currently advertising and interviewing for permanent staff. Relatives were all frustrated with how the service is now funded and the implications this had on the care provided. We spoke with the registered manager who explained that staffing was determined by funding from the local authority and that the service had no core hours only assessed needs hours for individuals. Therefore staff training and sickness would come from people's individual assessed hours on that day, people would then have planned activities cancelled.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Four staff we spoke with did not understand whistleblowing and their responsibilities in reporting concerns to the manager or local authority. Three staff did not know who they would inform should they witness concerns. We spoke with another member of staff who explained they had been involved in a whistle blowing incident but at the time did not understood the process and if they should have reported this incident. They confirmed an investigation had occurred and lessons had been learned which was later confirmed by the registered manager.

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
Personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The registered person and the provider had not taken appropriate steps to make sure there was sufficient staff to meet service user's needs. Regulation 22

Regulated activity	Regulation
Personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered persons and the provider did not have suitable arrangements in place to make a decision regarding service users' capacity to make decisions and consent to their care and treatment. Regulation 18

Regulated activity	Regulation
Personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person and the provider did not have appropriate arrangements in place for recording, and dispensing medicine. Regulation 13

Regulated activity	Regulation
Personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person and the provider had not taken proper steps to ensure service users were protected against the risk of receiving care or treatment that was inappropriate or unsafe, by not meeting individual service users' needs and ensuring their welfare and safety. Regulations 9(1)(b)(i)(ii).

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control The registered person and the provider had not ensured that service users, persons employed and others were protected against identifiable risk of acquiring an infection by means of not having appropriate standards of cleanliness and hygiene. Regulation 12 (1)(a)(a)(b)(c)(2)(a)(c)(i)

Regulated activity	Regulation
Personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person and the provider did not have suitable arrangements in place in order to ensure that persons employed were appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard, by receiving regular supervision and appraisals, appropriate training. Regulation 23(1)(a)(b).

Regulated activity	Regulation
Personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person and the provider were not protecting service users and others who may be at risk, against inappropriate or unsafe care and treatment, by the means of effective operation of systems designed to enable the registered person to regularly assess and monitor the quality of the service and identify, assess and manage risk. Regulation 10 (1)(a)(b).

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs The registered person and the provider did not ensure that service users are protected from the risk of inadequate nutrition and dehydration by means of the provision of a choice of suitable and nutritious food and hydration in sufficient quantities to meet service users' needs. Regulation 14(1)(a).