Prospects for People with Learning Disabilities

# Prospects for People with Learning Disabilities - 3 Norwich Road

## Inspection report

3 Norwich Road
Long Stratton
Norwich
Norfolk
NR15 2PG

Tel: 01508536059
Website: www.prospects.org.uk

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

| | |
|---|---|
| Is the service safe? | **Requires Improvement** |
| Is the service effective? | **Good** |
| Is the service caring? | **Good** |
| Is the service responsive? | **Good** |
| Is the service well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

The inspection took place on 22 February 2016 and was announced.

The provider's website indicates that it operates as a Christian organisation providing support to people with learning disabilities and their families. The home we inspected provides accommodation and support to a maximum of three people who have lived together for a long time. The home is arranged over two floors in a small domestic setting, in keeping with other houses in the same row.

There was a manager in post who had applied for registration and was overseeing two of the provider's services. The last manager had left the service more than three years previously. The provider is required to have a registered manager for the service. 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.

People's safety within the home was sometimes compromised. There were shortfalls in the way that the environment was maintained to ensure people's safety, particularly in the event of a fire which placed them at risk of harm.

People's medicines were managed safely. They were supported by enough staff who had been subject to a robust recruitment process which contributed to protecting people against the employment of unsuitable staff. Staff understood the importance of reporting any concerns that people may be at risk of abuse.

Although training provision had lapsed during the period that appropriate management support had not been in place, staff understood how to meet people's needs. Improved systems of support for staff were being put in place. Staff ensured that people were supported to access health professionals so that their welfare was promoted. Staff were aware of the importance of supporting people to make their own decisions about their care and how they might communicate their agreement to, or refusal of, proposed treatment. The provider had not taken action in the absence of a manager to ensure people were not unlawfully restricted. However, the new manager was aware of their responsibilities in this area. They were in the process of addressing this, to ensure people's rights were protected.

People had enough to eat and drink and were able to enjoy their meals together with staff, in a family type setting.

People received support from a stable staff team who had developed good, caring relationships with them. Their privacy and dignity was promoted.

Staff were aware of people's interests and preferences and what was important to them. The manager was taking action to ensure that plans of care were updated to ensure they continued to reflect people's current

needs. People's relatives could be involved in the review process to support people with decision making if it was needed. People using the service would need support from their family members or staff to raise concerns. Their relatives had confidence in the manager that any concerns or complaints would be addressed properly.

The service had not been consistently well-led due to the absence of an appropriate manager for a prolonged period of time. The service had failed to notify the Care Quality Commission of an event taking place within the service which affected the premises, compromising facilities available to people which meant that they had to move out for a period of time. There was a lack of attention to routine 'housekeeping' which compromised the quality and homeliness of the environment people were living in.

There were systems in place for gathering people's views about the service and how it might improve. The incoming manager was attempting to prioritise a wide range of improvements they had identified as required, including updates to records and training. People's relatives recognised that they were having a positive impact on the service and welcomed the appointment of the new manager.

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

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

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not consistently safe.

There were concerns that the maintenance of the home did not robustly address risks to people's safety.

Medicines were managed safely and people received them in a timely way when they were needed.

People received support from sufficient numbers of staff to promote their safety. Staff understood the importance of protecting people from abuse and recruitment processes were robust in contributing to people's safety.

### Is the service effective?

**Good**

The service was effective.

People received support from staff who had received relevant training and support. Although some of this had lapsed, the manager was making improvements.

Staff understood the importance of seeking consent and supporting people to make informed decisions about their care. Although the provider had not taken prompt action in the absence of a manager, the incoming manager was in the process of ensuring people's rights and freedoms were protected.

People had enough to eat and drink and could make choices about this.

People were supported to access health professionals when they became unwell or when advice about their welfare was needed.

### Is the service caring?

**Good**

The service was caring.

People were supported by staff who were kind and compassionate.

People's privacy, dignity and self-esteem was encouraged.

## Is the service responsive?

Good

The service was responsive.

Staff were flexible in responding to people's changing needs. They had a good understanding of people's preferences and what was important to them.

A programme of updating people's care records to ensure they continued to reflect people's current needs and wishes had been implemented.

People's representatives were confident that any concerns or complaints they raised would be properly addressed.

## Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The home had been without a registered manager in post for a prolonged period and so without appropriate leadership to ensure standards were maintained.

A notification about events within the home affecting the service had not been made.

The new manager was working hard to prioritise areas for improvement, including record keeping practices. Staff and family members had confidence in the new manager and that their views would be taken into account as improvements were made.

# Prospects for People with Learning Disabilities - 3 Norwich Road

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 22 February 2016. The provider was given two days' notice of the inspection because this was a small care more for younger adults who are often out in the day. We needed to be sure someone would be in. It was completed by one inspector.

Before we visited the service we reviewed the information we held about it. The information included notifications about events taking place within the care home and which the provider is required to tell us about by law.

We spoke with three people using the service. Because some found it difficult to express their views verbally, we also spoke with their relatives. We observed how people were supported. We spoke with a member of staff and the manager. We also reviewed care records for two people and medicines records for all three people. We reviewed the recruitment checks for one member of staff, supervision schedules for two staff and training records for the staff team.

We also reviewed records associated with the quality, safety and management of the service, including health and safety checks and the provider's compliance team's audit.

Requires Improvement

# Is the service safe?

## Our findings

We found that there were shortfalls in the way the premises were maintained to promote people's safety. Checks on hot water temperatures had not been regularly completed between the completion of refurbishment works in November 2015 and February 2016. When they were implemented, these recorded that the shower used by people living in the home ran at temperatures that could present a risk to people's safety. On 2 February 2016 this was recorded as 55.9 degrees centigrade and on 10 February 2016 it had been measured at 65.3 degrees. The manager was aware of this and seeking advice. Guidance from the Health and Safety Executive indicates that, if hot water is above 44 degrees centigrade there is an increased risk of injury.

A side door from the lounge, led to a hallway and external door. It was clearly marked as a fire exit from the lounge. We found that it was obstructed with two mops and buckets presenting a risk of trips and falls in an emergency. An ironing board and clothes airer were also stored to one side of this hall, again presenting a trip hazard. The manager indicated that they had been advised by the fire service that this lounge exit was not needed as an emergency exit as there was an alternative door to the rear of the lounge that could be used. However, this rear lounge door was not marked and identified as a designated fire exit, presenting a potential risk in an emergency.

Access to the fire extinguishers in the hall was impeded by the vacuum cleaner which was stored with its hose across the extinguishers, presenting a risk of delaying access in an emergency. The manager informed us that the home's fire blanket, also needed to assist in extinguishing a fire in an emergency, had gone missing. They told us that staff had been asked whether they knew where it was but it had not yet been replaced.

There was a table lamp in the lounge with a loose and wobbly fitting and without a shade. This presented a risk that people could burn themselves on the exposed bulb. We found that a curtain pole, complete with curtain rings and a heavy curtain had been propped up against the back of the lounge door. When the door was closed, this fell down. Fortunately it did not hit anyone. These issues presented a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Fire detection systems were tested and serviced regularly. A recommendation to replace the kitchen fire extinguisher had been acted upon to ensure that those provided were a suitable type to deal with kitchen fires.

We reviewed the arrangements for storing and administering medicines. A staff member confirmed to us the training that they had received. They were able to give us a clear and concise description of the way they checked and administered medicines and how they recorded these on the medication administration record (MAR) charts. They were also able to tell us for what conditions the medicines had been prescribed.

There were omissions of signatures on the MAR in use for one person for the tablets they were due to receive on the morning of 21 February 2016. We found that these had been removed from the blister packs provided

by the pharmacy for that day and time and so were most likely to have been given. The manager followed this up with the staff member on duty the day before our inspection. They confirmed that the medicine had been given but that they had forgotten to sign due to the need to ensure people were ready to go out.

There were checks in place on medicines not in blister packs to ensure they were being used appropriately. We checked one of these medicines and found that the amount received and signed for as administered, corresponded with the balance remaining. We concluded that medicines were managed safely and people received them as the prescriber intended.

One relative told us that a person had been on holiday several times in the past. They said, "Then it transpired no risk assessment had been done over the years." They told us that the new manager had sorted this out and, "Now they're trying to do things properly." They were satisfied that staff supported the person safely.

People's plans of care included assessments of risk to which they may be exposed. These included risks associated with nutrition and diet, accessing the community and in relation to behaviour. There was guidance for staff about how risks were to be minimised. A staff member was able to tell us in detail about how the risks for one person were managed. We noted that staff had received training in assessing risk. The process of reviewing and updating assessments of risk was underway to ensure they remained appropriate.

One person we spoke with confirmed that they felt safe with staff. Two others nodded that they felt well treated. People's relatives said that they felt people were safe. One said, "I have no issues regarding [person's] safety." Another commented that whenever they had visited, the person had looked comfortable and at ease with staff.

A staff member spoken with confirmed that they had training to help them recognise and respond to abuse. They knew what might constitute abuse, were confident that they would be able to report any concerns and how they would go about it. Staff training records showed that all but two staff had received refresher training in this area, within the last year. For the remaining two staff this had been booked. Bank staff and volunteers were included in the training. People's care plans were clear that no restraint was to be used. We concluded that arrangements in place contributed to protecting people from abuse.

People told us that there were enough staff to support them. A member of staff told us that the staff team was good at covering for absences when this was needed and that there was a team of relief staff who could also step in if required. We verified from training records that that there were relief staff in place. We concluded that there were enough staff to support people safely. The manager acknowledged that volunteers needed to be used if increased flexibility was needed when people did not wish to engage in the same activity as others. However, we observed that people got on well together, and they told us they enjoyed doing things in a group. This was confirmed by relatives.

We reviewed the recruitment records for one staff member recently appointed. These showed that appropriate checks were made before the staff member was appointed. References were taken up and enhanced background checks with the Disclosure and Barring Service (DBS) were completed to ensure that they were suitable to work in care services. A probation period for new staff was in use so that their performance and suitability was monitored before they were confirmed in post. We noted that records showed dates by which DBS checks needed to be renewed and the manager confirmed that this took place every three years. This was good practice. We concluded that there were robust recruitment processes in place to contribute to protecting people against the appointment of unsuitable staff.

Good

# Is the service effective?

## Our findings

A relative told us how they felt that staff appointed in the past had not had good skills for supporting people. They said that they felt that this had improved and things had, "… settled down quite a lot." Another person's representative said that they felt, "Training had gone down the tubes. It could be better." However, they recognised that things were improving now the manager was in post, even if this was only part time. A further relative commented to us that they valued the continuity of staff and felt that one staff member was particularly skilled in how they communicated with people. They felt that the stability of the staff team meant that they had been able to build up knowledge of the support people needed.

The home had been without consistent management for a prolonged period. The manager told us that, as a result, staff training due for regular renewal had lapsed. This was supported by training records. For example, we found that first aid training for one established staff member was due for renewal in December 2014. There was no indication that this had happened. A staff member told us that a lot of training had taken place since the new manager had started overseeing the service. They felt they had access to training that enabled them to meet people's needs. Although there were gaps in training records, we could see from dates that recent training was completed, the manager had been working hard to address these. They were arranging that staff attended the training that was due.

A staff member said they felt well supported now but acknowledged that there had not been much supervision until the new manager took over. Supervision is needed so that staff have the opportunity to discuss their work and performance, and to address any training or development needs. We noted from the manager's supervision schedule and associated records that she was making efforts to ensure staff received this support regularly, including while they were completing induction.

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 Act 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. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Two relatives told us how they had been contacted by the manager because it was considered an application under the DoLS was necessary. One family member told us, "This should have been done sooner but obviously [new manager] is trying to sort it out." The letters written to people's relatives explained there had been a recent court judgement about DoLS which meant the applications were needed. We were aware that the judgement was in April 2014 and concurred with the view that the applications should have been

made sooner. The provider had not taken action in the absence of a manager to respond to the judgement and guidelines to ensure the home was operating within the law. We acknowledged that the new manager had taken action promptly after her appointment, to ensure people's rights were protected.

People were not able to tell us verbally how staff supported them to make complex decisions. However, one person told us how staff had discussed making a doctor's appointment with them, and had supported them to attend. A relative told us, "Staff don't dictate things and work with people using the service."

Training records showed that two out of three permanent staff had received training in the MCA to contribute to their understanding of how to support people when they may not be able to make decisions for themselves. A staff member was able to tell us how they would explain things to people about their care and treatment, using pictures if this was necessary. They told us how they supported one person with blood tests, offering reassurance. They recognised how the person's behaviour and reactions indicated implied consent to these tests.

We noted that one person's records showed how they had been supported with a dental appointment which they had agreed to attend. They did not agree to let the dentist make a full examination and their decision about this was respected. We concluded that staff understood the importance of encouraging people to make decisions about their care and seeking their consent for proposed treatment.

People told us that they enjoyed their food and were looking forward to their evening meal. One person said, "I make my own sandwiches..." and, "I like my food." They said they made their sandwiches in the evening ready for the following day when they were out and they could choose what they wanted to eat. A staff member had assisted in the preparation of a pasta salad for two other people for their lunch the next day. We observed that people were offered drinks of their choice when they returned to the home.

One person had received advice that they should lose some weight. We noted that their food intake was recorded, although there were gaps in this. Their weight was also monitored. We saw that they had gained some weight since July 2015 but remained considerably lower than they had been when referred to their GP. Their care plan reflected how staff were to encourage them with healthy eating.

We saw that the staff member on duty and people living in the home ate their meals together. The table was set appropriately. Before the start of the meal, people sat together around the table with the staff member, talking about their day. We concluded that people had enough to eat and drink, could choose what they wanted and had a positive mealtime experience.

One person told us, "I went to see the doctor." They told us about the treatment that had been prescribed. This was consistent with what staff told us about their health and welfare and what was in their care records. The support people needed to maintain their health was recorded within their plans of care. We could see from correspondence and daily notes that staff made arrangements for them to see health professionals when it was needed. This included their GP, practice nurse, dentist and hospital appointments when they were needed. We concluded that staff arranged for people to access health care advice and support when this was needed to promote their health.

Good

# Is the service caring?

## Our findings

One person told us how much they liked their key worker. They said, "[Staff member] helps me with everything." Two other people nodded that they liked the staff who worked with them. We received a small amount of conflicting information about how respectful all staff were to people. One of three relatives said that they felt a staff member could be more respectful and less "...bossy." We raised this with the manager. The relative said they were generally happy with the way that their family member was supported within the service. A second relative told us, "They [staff and residents] all get on well together. They have a good relationship." They went on to say, "Staff read how they are reacting. They take as much care as they can to do things in a way the residents want." Another relative told us that they felt their family member was, "… respected. I have no issues about the way staff support [person]. They are nice." They felt that their family member saw the service as very much, "… their home."

A relative was very complimentary about the way staff had supported a person after bereavement. They said that staff were gentle and caring. They had involved relatives in discussions about how best to share the information with the person in a way that they would understand, and how they would offer support. A staff member told us how one person liked to have reassurance if they needed a blood test or injection, and that they would hold the person's hand and talk to them about other things to distract them. The staff member said, "Well, it's a comfort, isn't it?" We concluded that staff had developed good, caring relationships with people using the service.

People's care plans recorded that people were aware of the content when they had been put together or updated. For example, we found that one, updated recently, showed that the person had not participated, but was aware of what the care plan contained. Pictures had been used as an aid to explanation with people. People agreed that they had key workers who would support them with what they wanted to do. Their relatives told us that they were kept up to date with what people were doing and if anything changed so that they could offer the person support if necessary.

One relative gave us an example of how staff had spoken to them about a person's religious wishes, which they knew were a comfort to the person concerned. They said they had been asked if they wished to be involved in discussions about this but were happy with the way the service was supporting the person. Two others said that they had been involved in reviews to support people with decisions about their care but not for some time. They were confident that they could be involved if they wanted to and that they could ask for this.

One person told us about the things that they could do independently. They were proud of being able to get up on their own although they acknowledged that sometimes they needed encouragement if they had stayed up too late watching television in their room. They told us, "I don't want a key [for my room]. I keep my door shut. I don't like people coming in." They said that staff always knocked before going into their room. We saw that this happened. We concluded that people's privacy was promoted.

People were happy with the support they received from staff to maintain their standards of dress. They

agreed that they enjoyed looking nice. Staff told us how one person preferred having assistance with a shower from a staff member of the same sex and that this was arranged around whoever was on duty. We concluded that people's dignity and self-esteem was taken into account in the way the service was delivered.

Good

# Is the service responsive?

## Our findings

Our discussions with the new manager showed that she was aware of a delay in updating information about people's needs as a result of the absence of management input for a prolonged period. The new manager was taking steps to ensure that staff were updating and reviewing people's plans of care, to ensure these reflected people's current needs, preferences and wishes.

People told us how staff supported them with what they wanted to do and their preferences. One person described how they were planning a holiday. They had ideas about where they wanted to go and who they wanted to go with them, which they discussed with staff. They were also planning their birthday celebration and said that they needed to save up for that. A relative commented that the person enjoyed accessing the local community and church and did this regularly.

Two relatives commented to us that people were not doing as many things as they used to do many years ago, such as being involved in baking or other "… duties …" around the house, to increase or maintain their skills. However, they went on to say that this was what their family members wanted as they did not like to try new things and were getting older. One went on to say that the person knew their "… own mind if staff are suggesting something [person] does not like. There's a pattern of what [person] enjoys and they're older and not wanting to learn new things."

A staff member spoken with was able to describe the needs and preferences of each person in detail. The information they gave us was consistent with what we had seen within people's assessments and plans of care. We concluded that staff understood people's individual care needs and preferences and delivered appropriate care to respond to these.

We spoke with people about whom they would talk to if they had a concern about their care and needed to complain. One person said that they did not know and another nodded their agreement. We discussed further and a person agreed they might go to, "…the boss…" or someone at their day services. They were clear who the manager was if they needed to speak to them. We concluded that, in practice, most people would need assistance from staff or their relatives if there was cause to complain about the service.

Relatives spoken with were confident in the new manager and that any concerns or complaints would be addressed. They told us that they had contact details for the manager so that they could raise issues promptly. One relative went on to say, in the first instance they would always approach the manager and if they did not get a satisfactory response, they knew how to raise issues within the provider's organisation. We concluded that people's representatives were confident that action would be taken to address complaints.

Requires Improvement

# Is the service well-led?

## Our findings

We found from records that the home had been without a hot water supply to the first floor wash basin for a long period. It was reported as out of order between the middle of June 2015 and early October 2015. During that time, the two people whose bedrooms were on the first floor, needed to use downstairs facilities. The manager reported that the leak had not been repaired promptly. Eventually, the ceiling below was damaged. Records showed that people had needed to move out of the home between 10 October and 14 November 2015 so that repairs and refurbishment could take place. The manager confirmed that there had been a period of time when people had not lived in the home. We discussed with the manager that a notification should have been made to the Care Quality Commission (CQC). This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

CQC records showed that the last manager left the home and cancelled their registration in October 2012. Since that time there has not been a registered manager in post. The provider's advertising in July 2015 was not successful in securing an appropriate appointment. The new manager reported that the provider had asked them to oversee the service, which they started doing regularly late in 2015. In November 2015 they applied to CQC for registration in respect of this service. They were also registered as manager in respect of another of the provider's services in Southend and needed to divide their time between the two locations.

The manager had identified issues that had developed during the prolonged period while the home had not been appropriately managed and led. Staff had worked together to ensure people received the care and support that they needed. However, their training had expired and standards of record keeping had declined. Supervision had not taken place and staff had needed to 'manage' themselves and their duty rosters.

Records, including some care records, were out of date. For example, we found one person's records contained reference to a key worker who was no longer employed at the service. Staff were expected to sign that they had read and understood certain records relating to people using the service. Few of them had been signed to show that staff understood and agreed to deliver the identified care and support. One person, for whom their diet was an issue, had food monitoring charts in place. These were being used sporadically with no entries at all on some days and numerous omissions about their breakfast intake. The same person's records also referred to them by the wrong name. The manager acknowledged that there were concerns about record keeping which she was in the process of addressing.

Records had not been updated to show how risks within the building had been addressed. For example, the premises risk assessment was dated as completed in March 2014. This recorded 20 required actions that presented either medium or significant risks with suggested completion dates. There was nothing on the record to indicate that the actions required had been taken or who was responsible to resolve the issues. The incoming manager was unable to follow this through and had arranged a further assessment since taking up post. They told us they were awaiting the report so that they could have a professional's view about what action now needed to be taken.

We found that the folder for health and safety had an index showing what information should be present in relation to safety checks. This contained gaps. For example, some checks on safety were to be completed weekly. However, there were blank records in the file and the manager was unable to locate others that should have been completed. Records did not show that the staff member who had been delegated tasks in respect of health and safety monitoring was completing these as expected. The manager showed us the report of a recent audit by the provider's compliance team. This had identified similar concerns in relation to checks on health and safety that we found. The manager said this was being addressed.

People did not consistently benefit from a homely and pleasant environment and we concluded staff were not accepting overall responsibility or acting on initiative in this area. One of the lounge lights had no shade and the shade itself was on the lounge floor. We asked the manager about budgets for replacement furniture and fittings and found from the information they showed us that this had not been allocated. We concluded that the provider could not demonstrate effective systems for driving improvements in the service and that this had been compromised by a prolonged period with a lack of appropriate management.

The manager was working hard to make improvements but we concluded they had not consistently received support in their role and the additional responsibilities for taking on a second service. We asked about their supervision and appraisal and the manager was unable to confirm they had received this. This was needed to enable the manager to receive support while dealing with the range of issues with which they had been faced. However, they told us that they had a new line manager in post and were hoping this would improve. We were concerned that the provider had not fully appreciated the challenges being faced within the service, associated with the lengthy absence of a manager.

People living in the home knew who the new manager was. They went to speak to her in the staff office when they arrived back from day time activities. Relatives recognised that the service had been without consistent leadership. One felt that the service had, "… ticked along…" but two others commented how things needed to improve and were confident that the incoming manager was trying hard to do this. For example, one of these two relatives said, "There have been difficult times but [manager] is brilliant. They do need their own manager." They felt that the manager was approachable and would listen to their views.

A staff member and the manager told us that the provider had a 'Forum Group' comprising of a manager and representatives of people using their services. These people visited the provider's services on a regular basis to assess service quality and seek the views of people using the services so that improvements could be made in response to suggestions. A staff member told us that the manager was approachable and that they could contact them by telephone on days they were not present in the home. They felt able to express their views to her in this way, and through staff meetings or supervision. We concluded that the manager was fostering and trying to develop an open culture where people and staff were empowered to express their views about their experiences.

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 | Regulation 18 Registration Regulations 2009 Notifications of other incidents<br><br>The provider had failed to notify the Care Quality Commission of a failure of hot water supply to part of the home and that people needed to move out during refurbishment and repair. This meant that people were not able to receive the service in their own home.<br><br>Regulation 18(1), (2)(g)(ii) and (iii) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Risks to people's safety in the way the premises was being operated, were not consistently and promptly managed and mitigated.<br><br>Regulation 12(1), (2)(d) and (e) |