Anchor Carehomes Limited

# Hatfield House

## Inspection report

Crookesbroom Avenue
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Doncaster
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Website: www.anchor.org.uk

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06 March 2018

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## 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** |

# Summary of findings

## Overall summary

The inspection took place on 6 March 2018 and was unannounced. The last comprehensive inspection took place in April 2017, when the provider was rated Good. You can read the report from our last inspections, by selecting the 'all reports' link for 'Hatfield House' on our website at www.cqc.org.uk.

This inspection was brought forward due to concerns we received. We therefore needed to inspect the service to ensure people were receiving safe care.

Hatfield House is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Hatfield House provides residential care for older people and people living with dementia, who require personal care. It can accommodate up to 48 people over three floors. There is access to the floors by a passenger lift. All the bedrooms have an en-suite with toilet, wash basins and shower. The service is situated in Hatfield near Doncaster.

At the time of our inspection the service did not have registered manager. 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.

The registered provider had appointed a manager who had left prior to our inspection. This manager had been replaced and a new manager commenced in post on 5 March 2018. The regional support manager had been based at the home for three weeks supporting the previous manager and the new manager. The regional support manager told us they would remain at the home for some time supporting the new manager.

We observed there was a lack of staff which put people at risk. The dependency tool used by the manager was not effective and did not include all people currently living at the service. It was not always reflective of people's current needs. Risks associated with people's care were identified, but they were not always reviewed and there was a lack of action taken to minimise risks to people.

Accident and incident analysis was not taking place and there was no evidence that trends or patterns were being identified and actions taken to reduce hazards in relation to people's care.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice. This was because the new management were not aware of who had an authorised Deprivation of Liberty Safeguards or if any conditions were attached.

People were supported to maintain a balanced diet which met their needs. However, food and fluid charts

were poorly completed and some people had lost weight and this had not been addressed.
Staff told us they received training and support to carry out their roles and responsibilities. However, we found records did not support this.

We spoke with people who used the service and they told us that staff were kind and caring. We observed staff interacting with people and found they had a gentle and caring manner. However, staff could not always respond to people's needs in a timely way and therefore care was not always person centred.

We found people did not always receive care that was responsive to their needs. Care plans we looked at contradicted each other and were not always followed in line with people's current needs. We observed a lack of social stimulation for people who used the service. This did not meet the social needs of people.

All the people we spoke with knew how to raise a complaint and said they felt comfortable speaking with any of the staff.

We found that there had been a lack of consistent managers and a lack of registered provider oversight and governance which had contributed to the decline of the service. Audits in place to monitor the quality of service provision did not always take place in line with the registered provider's policy. Where audits had taken place they were not effective and did not always identify the concerns we had raised as part of this inspection. Some concerns were highlighted as part of the audit process but there was no evidence that sufficient action had taken place to correct them.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were breaches in; Regulation 9; Person-centred care, Regulation 11; Need for consent, Regulation 17; Good governance. Regulation 18; Staffing. You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to the more serious concerns found during inspections are added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

## 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.

We observed there was a lack of staff which put people at risk.

Risks associated with people's care were identified, but they were not always reviewed and there was a lack of action taken to minimise risks to people.

Staff were aware of safeguarding people from abuse and what actions to take if they suspected abuse.

We looked at how the registered provider managed people's medicines and found some minor issues in this area.

Accidents and incidents were not monitored and did not identify trends and patterns. No action had been taken to reduce risks to people.

### Is the service effective?

**Requires Improvement**

The service was not always effective

We found the registered provider did not always work within the guidelines of the MCA.

We looked at care records and some found people had access to healthcare professionals when required. However, other people had not been referred to appropriate professionals.

Staff did not always receive training and support to carry out their role effectively.

People were supported to eat a well-balanced diet and food looked appetising. However, food and fluid charts were poorly completed and some people had lost weight and this had not been addressed.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

We observed staff interacting with people and found they were kind and pleasant. However, people had to wait for periods of time to receive personal care. Therefore care was not always delivered in a person centred way.

People we spoke with told us the staff were kind and caring.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

We looked are care records and found that care plans did not always reflect people's current needs. Some information was old and some new which contradicted each other making it unclear what the person's needs were.

There was a lack of social stimulation provided to people.

The provider had a complaints procedure and managed the complaints process effectively.

## Is the service well-led?

**Inadequate**

The service was not well led.

We found that there had been a lack of oversight and governance which had contributed to the decline of the service.

Audits in place to monitor the quality of service provision did not always take place in line with the registered provider's policy.

# Hatfield House

**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 6 March 2018 and was unannounced. The inspection was carried out by two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Prior to the inspection visit we gathered information from a number of sources. We also looked at the information received about the service from notifications sent to the Care Quality Commission by the registered manager. We did not ask the registered provider to submit 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. This was because our inspection had been brought forward due to concerns we had received about the service. We also spoke with other professionals supporting people at the service, to gain further information about the service.

We spoke with people who used the service and relatives of people living at the home. We spent time observing staff interacting with people.

We spoke with staff including care workers, senior care workers, the cook, the manager, and other members of the management team. We looked at documentation relating to people who used the service, staff and the management of the service. We looked at people's care and support records, including the plans of their care. We saw the systems used to manage people's medication, including the storage and records kept. We also looked at the quality assurance systems to check if they were robust and identified areas for improvement.

Inadequate

# Is the service safe?

## Our findings

We spoke with people who used the service and they told us they felt safe living at the home. One person said, "I feel safe because there are people around." Another person said, "Yes, I just am, always someone on call." We also spoke with people's relatives and one said, "Yes, my relative is safe. She is fed; she is in a good, warm and secure place. Her room and facilities are spot on." However one relative we spoke with felt their family member was not safe living at the home. This was because another person had hit out at the relatives family member on several occasions.

We asked people living at the service if they felt there were enough staff to meet their needs. One person said, "Always, no waiting. I know faces not names." Another person said, "At times no, but I don't have to wait and all staff are lovely." Another person said, "Staff would say they could do with more but they are always there. They [staff] answer call bell in minutes." One relative we spoke with told us, "Never a problem but don't really know." Another relative said "No," adding that last Thursday there was one care worker and a team leader and one agency worker who did not know people. Another relative said, "Would like the carers to have more time for residents. More staff." One relative told us that a care worker had left recently who told them they were leaving due to too much paperwork and not enough time for people.
One care worker we spoke with said, "We don't have the time to give people a bath." One relative said that when they had been visiting they heard another relative ask an agency staff member to assist a person who had a tendency of shuffling forward in their chair and then falling on the floor and needed prompting to sit back in chair. They explained they had to ask as no permanent staff were available and the agency was not aware of the person needs.

The registered provider did not always ensure there were enough staff available to meet people's need in a timely way. We observed staff in communal areas were very busy and rushing. We observed people having to wait for support. For example during an observation in the morning we saw one person ask for the toilet on four occasions and had to wait at least 40 minutes before a member of staff was available to take them. We also observed people had to wait for breakfast. We saw the last person to have breakfast was at 11.50am and by this time people were sitting down to prepare for lunch. We observed lunch and many people told the staff they were not hungry as they had only just had breakfast. This impacted on what people ate and affected their nutritional intake as they were missing a meal.

Staff we spoke with told us there were not enough staff on duty. They told us they struggled to meet people's needs with the staff that were on duty. Staff explained that people's needs had increased over the last few weeks and this had not been taken into consideration. For example staff told us, on the top floor there were nine people who required two staff for all care and support and six who required one care staff. There were only two people who were independent and they said one person at times required three care staff due to challenging behaviour that they could present with. There was one team leader, two care staff and an agency worker on duty. The team leader we observed was administering medication during the morning and did not complete this until nearly 12 midday. This was as they kept getting interrupted by phone calls and trying to contact the GP surgery. The two care staff were providing personal care to people getting them up and as they got people up and they came into the dining room the agency worker was

serving breakfasts. The agency worker did not fully know people's needs or risks. When people requested to go to the toilet they were unable to take until one of the other care staff were available.

On the day of inspection one new care worker who had only commenced in post the previous day was supposed to be shadowing an experienced member of staff. We did not see any evidence of this. Instead the new care worker (who wasn't new to care but to the service) was used to observe the lounge area and prepare breakfast and drinks for people. This could have been a risk as the new care worker had not had chance to get to know people so was unsure about their needs. The other care worker on duty had to support 13 people living with dementia with personal care needs whilst the team leader on duty was administering medicines. When the care worker sat down to complete daily charts she was called away to assist on a different floor. This left a new care worker and team leader on the floor.

The registered provider had a dependency tool which was out of date and did not include all people currently living at the home. Dependency scores did not always reflect the current needs of people. Staff told us that they should have nine staff on duty throughout the home between 8am and 8pm over three floors. However, staff informed us that this had dropped as low as five per shift. Some people required the use of the hoist or stand aid and two staff for every transfer. This meant that people had to wait until there were sufficient numbers of staff available to meet their needs.

We looked at accident forms and found that a lot of accidents had occurred during the hours of 8pm to 8am when three care workers and two team leaders were on duty to support 44 people over three floors. There was no accident analysis to monitor trends and patterns and no evidence that any action had been taken to look at reducing the number of falls during this period. We saw records of many falls out of bed with the accident report stating 'found on floor.'

One care worker said they did not have time to bathe people as there was usually just two staff working on the ground floor during the day. At night this reduced to one care worker on this floor. One care worker said, "I don't think this is enough as there are two people on the ground floor who are hoisted." They advised us that this had been mentioned to management.

This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems were in place to ensure people received their medication as prescribed. Medicines were recorded on receipt, administration and when disposed. However, we found some minor issues that could be improved. People we spoke with told us they received their medicines as prescribed. One person said, "The carer who gives out the medicines is really excellent."

We found risks had been identified and assessments were in place to be able to meet people's needs. However we found many were duplicated which could cause confusion. For example, one person had four risk assessments for use of the hoist. One for hoisting 'In bed', one for 'Out of bed', one was for hoisting into 'The bath', and one for hoisting from the 'The chair'. All were exactly the same but recorded separately.

We completed a tour of the service and found that it was clean and tidy. However, we identified areas of the home which were worn and in need of repair. Each unit had a kitchenette which had kitchen cupboards. These units were tired and worn and becoming difficult to clean and maintain and food debris was gathering in worn cracks. Sluice areas had shelving which had worn and bare wood showing. This made them difficult to clean as wood is porous. We also saw a carpet on the top floor which was worn and creating a trip hazard. We spoke with the regional support manager about this who took action and addressed this

straight away.

Staff we spoke with were knowledgeable about safeguarding people from abuse. They told us they would be able to recognise abuse and would report matters of this nature to the management team without delay. The staff were confident that the management team would take appropriate actions.

We looked at recruitment files and found the provider had a safe and effective system in place for employing new staff. The files we looked at contained pre-employment checks were obtained prior to new staff commencing employment. These included two references, and a satisfactory Disclosure and Barring Service (DBS) check. The DBS checks help employers make safer recruitment decisions in preventing unsuitable people from working with vulnerable people. This helped to reduce the risk of the registered provider employing a person who may be a risk to vulnerable people.

Staff we spoke with confirmed that these checks had taken place and that they had completed an induction when they commenced employment. Staff told us that their induction had included training and the opportunity to shadow experienced staff. However, on the day of our inspection we saw a new care worker who had been allocated a shadow shift, but was working on their own in the lounge and dining area for quite a lot of the morning. This did not help the person get to know the needs of people living at the home.

Requires Improvement

# Is the service effective?

## Our findings

Staff told us they received training and support to carry out their roles and responsibilities. However, we found records did not support this. Staff files contained some supervision records but these had not been completed regularly. We spoke with the regional support manager who informed us that staff should receive supervision six times a year in line with the registered provider's policy and procedure. Staff supervision was individual one to one sessions with their line manager.

Following our inspection we asked the regional support manager to send us confirmation of staff training which had taken place. We saw that training was not always up to date. Some staff had not completed mandatory training in line with the registered provider's policy. For example, the record showed that one team leader had not completed updates for subjects such as medication, infection control, dementia awareness, falls awareness and moving and handling training in line with the registered provider's policy. Eight staff had not completed or received updates in line with the provider's policy in relation to health and safety and six staff for safeguarding training.

This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with felt able to make their own decisions and felt in control of aspects of their life such as when to get up, go to bed, and choice over meals. One person said, "I am told you can go to bed when you like." We spoke with a relative who said, "She [relative] definitely makes her own decisions."

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are 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. We found there were no records of DoLS in the service. Management were not able to tell us who had an authorised DoLS or if they did, if any conditions were attached to the authorisation. There was no overview available for staff to refer to. We discussed this with the quality lead, who explained they had been bought in to support the service and had identified that there was no records of DoLS. They said they were in the process of collating this to ensure staff were aware of what was in place and record any conditions in people's care plans so these could be met. .

Staff we spoke with lacked knowledge on MCA and DoLS, they also did not know if anyone they were supporting had an authorised DoLS. This did not ensure people received support in line with the MCA. We saw that best interest decisions had not always been documented to ensure people were receiving care and support that was in their best interests if they lacked capacity to make a specific decision. For example, we saw some people had bed rails in place who were not able to fully understand why these were required. We found no best interest decision had been completed to ensure the decision to use bed rails was in the person's best interest, to maintain their safety and was not used as a restriction on their liberty.

This was a breach of Regulation 11 (Need for consent), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with people about meal provision and one person said, "You can pick what you want, it is really good, choices, too much at times." Another person said, "I am very fussy but they [staff] give me what I like and more than enough." Another person said, "What I have is good, I don't like foreign food and they [staff] know, they always ask what we want." One relative said, "[Relative] has put weight on, they enjoy the food." Another relative said, "The menu is often incorrect. I look at the board and tell [relative] what they will have to eat and she gets something else. It's very confusing."

All said they could see a doctor if they needed. One person said, "The chiropodist visits regularly." Another person said, "I try and manage without (seeing a doctor) but no problems." Another person said, "It's very good in this respect. I have seen the optician, the dentist has been and the chiropodist came three weeks ago." One relative said, "Our family take [relative] to all appointments and the doctor will see her if needed."

We looked at records and found that in some cases people had been referred to healthcare professionals when required. We spoke with a visiting healthcare professional on the day of our inspection and they gave good feedback about how the staff responded to advice and how staff identified concerns and actioned them. However, we looked at one person's care record and found they had lost weight, but this had not been addressed and staff had not referred them to appropriate healthcare professionals. Another person had five unwitnessed falls between December 2107 and February 2018 but there had been no referral to the falls team to look at preventative measures to ensure the person was safe.

The environment was not always dementia friendly. We saw that some dementia friendly signage was available; however there were no tactile objects. There were no picture menus available to assist people in choosing meals available.

Requires Improvement

# Is the service caring?

## Our findings

People we spoke with felt staff were kind and caring. One person said, "They [staff] are all okay, I think they look after me. Sometimes a bit busy and sometimes they will sit with us." Another person said, "They [staff] have been there when I want them, support me (emotionally), but busy, but good to me." Another person said staff were, "Excellent, can't fault them, on the whole never kept waiting." One relative said, "In one word the staff are 'Lovely,' they smile, they know my name, they are very busy but when [relative] has needed anything they are there very quickly." Another relative said, "The majority of them are lovely."

We observed that care staff were kind and caring and interactions we observed were positive, appropriate and inclusive. Staff took their time with people supporting them how they liked to be supported and respecting their choices and decisions.

However, staff were very busy and as such did not always respond to people in a timely way. For example we observed people waiting a considerable time to be given support to be able to go to the toilet. People also had to wait to get out of bed as staff were busy with other people. We observed staff did their best to support people as quickly as possible but had to explain to people they would have to wait. This had a negative impact on people as one person had to wait for over 40 minutes to be taken to the toilet and told us, "I couldn't wait, I think I have had an accident." This did not maintain their dignity.

Relatives we spoke with told us they were able to visit the home when they wanted to. This helped them to maintain relationships with their family members.

Requires Improvement

# Is the service responsive?

## Our findings

People we spoke with were not aware that they had care plans to direct staff in meeting their needs. Relatives we spoke with were also unsure. One relative said, "I have no involvement with care plans but I think another relative does." Another relative said, "Care needs are discussed now and again."

Care plans did not always meet people's current needs and they were not evaluated to ensure people's needs were met in the most effective way. Care plans were confusing as they contained old and new paperwork. Care plans did not always include relevant and up to date information in relation to people's needs. For example, one person needed the assistance of a care worker most of the time as they were at high risk of falling. We looked at this persons care records and found no information relating to this aspect of care and support.

Activities within the home were minimal and people therefore lacked social stimulation as there was not enough staff available to meet social needs as well as personal care needs. We spoke with people who used the service about the activities they received. One person said, "I do movement to music but could do with a few more activities." Another person said, "I join in, play bingo, card games, quizzes and exercise to music."

We spoke with care workers regarding the provision of social activities and stimulation available for people. Care workers told us they were too busy to do many activities. One care worker said, "We do what we can, when we can." Some activities are provided by outside agencies who do chair exercise on a monthly basis and an entertainer, such as a singer is invited monthly. A bingo afternoon takes place once a fortnight. One care worker said, "I think they should employ an activity co-ordinator as we don't have the time to provide them." One care worker told us that some people enjoyed completing jigsaws and drawing and loved to watch old movies.

There were no activities specifically designed for people living with dementia. Staff told us there were no trips organised outside the home as there were not enough staff to support these. Staff also told us there were no links with churches and other community groups.

This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider had a complaints policy and procedure in place. This was displayed in the main area of the home. We looked at records in relation to complaints and found they were recorded and appropriate actions had been taken to address concerns raised.

People we spoke with told us they were able to raise concerns. One person said, "I would talk to one of the carers. I would approach them before you go any higher." Another person said, "I would go to the office."

Inadequate

# Is the service well-led?

## Our findings

At the time of our inspection the service did not have registered manager. 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.

The previous manager left the organisation a couple of days prior to our inspection and a new manager had commenced in post on 5 March 2018. The regional support manager had been based at the home for about three weeks prior to our inspection. This was to support the previous manager and the new manager and to oversee the handover period. The manager was also supported by two deputy managers and a group of team leaders. The changes within the management team had contributed to the current situation. The district manager had left this position and the home was currently being supported by the regional support manager and the head of care.

There was lack of governance and oversight as the service had not been effectively managed. However, the registered provider had acknowledged this and had put a management structure in place to ensure improvements were made.

The registered provider had systems in place to monitor the service and to identify areas to develop. However, we found that these systems had not always been used effectively. There was a lack of audits completed at manager level. Therefore issues we identified as part of the inspection had not always been identified or where they had been identified, not enough action had been taken to ensure they were addressed effectively. For example, an infection control audit had been completed on 15 January 2018, but this had not identified the areas we found on inspection. The current management team were not able to find an up to date falls tracker or an analysis of accidents and incidents. Therefore trends and patterns had not been identified. We also looked at the dependency tool which was a system used by the registered provider to identify the numbers of staff required each shift. This was not up to date as it did not identify all the current people living at the home and in some cases it did not identify people's current needs. This had impacted on the numbers of staff provided.

The district manager had compiled an action plan dated 13 October 2017. We saw some of the actions identified were similar to those found on our inspection. These areas related to staffing levels not being maintained, care plan documentation not being detailed and not adequately reflecting people's needs and meeting the requirements of the Mental Capacity Act 2005. We found that a lack of action had taken place to address these areas.

Lack of management oversight had led to staff not receiving effective training and support in line with the registered provider's policies and procedures. Staff competencies were not always completed to ensure staff were carrying out their role and responsibilities in an appropriate manner.

This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

Following our inspection the regional support manager and head of care informed us of actions that would be taken to address the concerns raised. This included ensuring systems and audits were carried out in line with the provider's policies and procedures. These required embedding in to practice.

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 9 HSCA RA Regulations 2014 Person-centred care<br><br>People did not always receive person centred care. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The registered provider was not always compliant with the Mental Capacity Act 2005. |

This section is primarily information for the provider

# Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>There was lack of governance and oversight as the service had not been effectively managed. |

**The enforcement action we took:**

Warning notice

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The registered provider did not always ensure there were enough staff available to support people to meet their needs in a timely way. |

**The enforcement action we took:**

Warning notice