Medina Connect Ltd

Connect House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We conducted an unannounced inspection at Connect House on 5 and 6 February 2018. Connect 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.

Connect House is situated in Basford, Nottingham and is operated by Medina Connect Limited. Connect House work closely with staff employed in CityCare partnership and Nottingham University Hospitals, to provide a service where people are enabled to access expert support from a range of specialist health professionals. It is a fast-paced service with multiple admissions and discharges each week. The service accommodates 56 people across two distinct units, Heritage Suite and Garden Suite.

Heritage Suite is comprised of 24 short-term beds providing a reablement service, to people who have recently been discharged from hospital, to help them regain their independence. A range of health professionals including physiotherapists, occupational therapists and nurses support this. There are also four long-term bedrooms in Heritage. During our inspection there were 25 people staying in Heritage Suite.

Garden Suite provides nursing care. 17 beds in Garden Suite are 'Discharge to assess' beds, which are for people who no longer require a hospital bed, but still require an enhanced level of healthcare. A further six beds in Garden Suite are dedicated to the care and rehabilitation of people who have experienced a stroke and the remaining five beds, are for people who require long term nursing care. Garden Suite is staffed by nurses and health care assistants who are supported by a range of visiting clinicians including GP's, consultants and specialist nurse practitioners. During our inspection there were 20 people staying in Garden Suite.

This was the first time we had inspected the service since its registration in September 2017.

There was no registered manager in place at the time of our inspection. The previous registered manager had left Connect House in September 2017. 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. There was a manager in post at the time of our inspection who had been in post for a period of approximately four months. They informed us they would be submitting an application to register with CQC. We will monitor this.

During this inspection, we found the service was not safe. People were not always protected from risks associated their care and support. Risks were not always identified and addressed in a timely manner and this placed people at risk of harm. Measures in place to reduce risks were not consistently used as intended. People did not always receive safe support to move and transfer with the use of mobility equipment and there was not enough equipment available to meet people's needs.

There were not always enough staff employed to ensure people's wellbeing and safety, and staff were not deployed effectively. Adequate steps had not been taken to ensure people were protected from staff that may not be fit and safe to support them. There were systems and processes in place to minimise the risk of abuse and incidents were investigated. The service was clean and hygienic. □

People were not protected from the risk of poor food and fluid intake, as monitoring systems were not consistently effective. People's dietary preferences were not always taken into account and mealtimes were not organised effectively. 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. Staff had not received adequate training in key areas such as moving and handling, safeguarding and medicines management. Staff felt supported but were not all provided with regular supervision. People had access to a range of expert health professionals. However, there was a risk people may not receive appropriate support with specific health conditions. Care plans did not consistently contain sufficient information and staff did not always have adequate knowledge of people's health needs. There were systems in place to ensure information was shared across services when people moved between them, however these were not fully effective.

People told us staff were kind and caring but we observed interactions were task focused. People's right to privacy was not always respected and people were not treated with dignity at all times. Although people received focused support to maintain their independence from external health professionals, we observed variable practice in the Connect House staff team. People were not always involved in decisions about their care and support. People had access to advocacy services if they required this.

People were at risk of receiving inconsistent support as care plans did not all contain accurate, up to date information and staff did not always follow the guidance in care plans. People's social and recreational needs were not met, as there were very limited opportunities for meaningful activity in Garden Suite. This meant some people who used the service spent their time unoccupied. People's friends and family were welcomed into the service. There were systems in place to investigate and respond to concerns and complaints; however, a number of people commented they did not know how to make a complaint.

Governance systems at Connect House were not consistently effective; this resulted in a failure to identify and address areas of concern and placed people at risk. Records of people's care and support were not always accurate and were not stored securely. Systems and records were not well organised. Staff did not always have a good understanding of their role and this had a negative impact on the quality of care plans and risk assessments. Opportunities for people and their families to provide feedback were limited and where feedback systems were in place they were not effective. Staff felt supported and people were positive about the impact of the management team. The provider had plans in place to address some of the concerns identified at our inspection.

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 is 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.

Risks associated with people's care and support were not always managed safely. There was not always enough equipment available to meet people's needs.

There were not enough staff to ensure people's safety and wellbeing at all times. Staff were not always deployed effectively to ensure the delivery of safe care and support. Safe recruitment practices were not followed.

People received their medicines as prescribed but medicines were not always stored safely.

There were systems and processes in place to minimise the risk of abuse. The service was clean and hygienic.

Is the service effective?

Inadequate

The service was not always effective.

People's rights under the Mental Capacity Act (2005) were not respected.

People were not protected from the risk of poor nutrition and hydration.

People were supported by staff who had not received adequate training. Staff felt supported but were not always provided with regular supervision. There were plans in place to make improvements in this area.

There was a risk that people may not receive appropriate support with specific health conditions. People had access to a range of specialist health care professionals.

Systems to share information across services when people moved between them were not always effective.

Is the service caring?

Requires Improvement

The service was not always caring.

People's rights to privacy and dignity were not always respected.

People were not always involved in decisions about their care and support, and were not supported to be as independent as possible.

Staff were kind and caring, but interactions were task focused.

People had access to advocacy services if they required this.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People could not be assured they would receive the support they required as care plans did not all contain accurate, up to date information and staff did not use these to inform support. There was a risk people's end of life wishes may not be respected.

People were not consistently provided with the opportunity for meaningful activity.

There were systems in place to respond to complaints. However, people did not know how to make complaints.

People were supported to maintain relationships with family and friends.

Is the service well-led?

Inadequate

The service was not well led.

Systems to monitor and improve the quality and safety of the service were not effective.

Records of people's care and support were not accurate and up to date. Sensitive personal information was not stored securely.

Staff did not always have a good understanding of their role and some systems were confusing.

Opportunities for people and their families to provide feedback were limited and where feedback systems were in place they were not effective.

Staff felt supported and people were positive about the impact of the management team.

Connect 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, to look at concerns we received about the quality and safety of the service and to provide a rating for the service under the Care Act 2014.

The inspection took place on 5 and 6 February 2018 and was unannounced. The inspection team consisted of three 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 care service.

Prior to our inspection, we reviewed information we held about the service. This included information received from local health and social care organisations and statutory notifications. A notification is information about important events, which the provider is required to send us by law, such as allegations of abuse and serious injuries. We also contacted commissioners of the service and asked them for their views. We used this information to help us to plan the inspection.

During our inspection visit, we spoke with 15 people who lived at the home and the relatives of 10 people. We also spoke with 12 members of the care staff, three nurses, a member of the catering team, a member of the domestic team, the deputy manager, the manager, the operations manager and the nominated individual. The nominated individual is a person who is nominated by the provider to represent the organisation. We also spoke with four visiting health and social care professionals.

To help us assess how people's care needs were being met we reviewed all or part of twelve people's care records and other information, for example their risk assessments. We also looked at people's medicines records, four staff recruitment files, training records and a range of records relating to the running of the service, for example, audits and complaints.

We carried out general observations of care and support and looked at the interactions between staff and people who used the service. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

As this was a responsive inspection, we did not request a Provider Information Return prior to our inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make.

Inadequate

Is the service safe?

Our findings

We received mixed feedback about safety at Connect House. Some people and their relatives told us they felt safe. One person said, "It feels safe," another person said, "It's as safe at night as in the day." In contrast, other people told us they did not feel assured about the safety of the service. One person told us they sometimes felt frightened of others living at the home and expressed concern that staff were not always available to respond. A relative told us they had concerns their relation's call bell was not always left within their reach, consequently they were concerned they may not be able to request support if needed.

People were not protected from risks arising from the behaviour of others. One person told us "[Name] walks into my room at night and day time. If you say anything, they come at with you with a stick. I do not feel safe when I go to bed. I am petrified, they have never hit me but it is frightening. Staff do not always come when you press the buzzer. They do come, but it feels like a good time to wait, over half an hour and they (the other person using the service) are in the room." We informed the manager of the allegations on the first day of our inspection and they said they would deal with it. The next day we reviewed the person's care plan and found there was no reference to the allegations of threatening behaviour or guidance for staff on how to mitigate the risk.

Behaviour charts for this person documented six incidents of verbal aggression and threatening behaviour between 25 January 2018 and 4 February 2018. Some of these incidents had resulted in distress to others. For example, a behaviour chart documented the person was 'scaring other residents and making them upset (crying).' Despite this, there was no risk assessment in place in relation to the risk posed to other people or staff at the time of our inspection. Their care plan contained a 'mental health' plan put in place by external health professionals. This did not contain personalised information about potential triggers, patterns of behaviour or actions staff should take to de-escalate periods of agitation or approaches that could be used to safeguard other people or staff. This did not assure us staff had all the required information to provide safe support and left people at risk of emotional or physical harm.

Where guidance was in place about people's behaviour, it was not always followed. For example, another person's care plan documented frequent verbal aggression and occasional physical aggression. The care plan stated the person should not be seated next to others at meal times to protect them from harm. Despite this on both days of our inspection, we observed the person was seated with others at mealtimes, without direct supervision from staff. Although there were no documented incidents of physical aggression towards others, this has been identified as a risk and the failure to follow guidance placed people at risk of harm. A third person resisted some elements of their care. Their care plan stated staff should explain, reassure and if necessary leave the person a while and return later. However, a behaviour chart documented the person's hands were held by staff in order to be able to provide essential care. This approach was not documented in their care plan and staff had not received training in physical intervention. This exposed the person to the risk of harm and did not respect their rights.

In addition to the above, there were no effective systems in place to analyse patterns of behaviour, identify the triggers and support staff to come up with ways to reduce these behaviours. Although behaviour charts

were in place these were only to record incidents of risky behaviour, no analysis of behaviour charts was completed. This meant opportunities to reduce the recurrence of these incidents may have been missed.

Risks associated with people's care and support were not always managed safely. Staff did not have insight into why certain control measures were place and consequently they were not employing them effectively. For example, one person's care plan stated their legs should be elevated to improve blood flow and circulation. They also had foot protectors to reduce the risk of deterioration of wounds. Staff did not demonstrate an understanding of the different purpose of these measures and consequently we observed these were used interchangeably and inappropriately.

People were at risk of harm because of poor moving and handling practices. Staff did not have sufficient training in moving and handling, this placed people at risk of harm. During our inspection, although we witnessed some safe examples of moving and handling practice, we also observed some instances of poor practice. For example, we observed two staff members assisting a person to reposition in a chair. After unsuccessfully providing verbal prompts, the staff manually lifted the person back in the chair. This was not a safe way of assisting the person to move and posed a risk of the person being injured. Later the same day we observed different staff assisting the same person, again, the person looked uncomfortable in their chair and instead of lifting them the staff correctly used a hoist to reposition the person safely. This inconsistency did not assure us that all staff had the required skill and competency to assist people to move safely.

People were at risk of not receiving the treatment they required in the event of an emergency. Only four of the 88 staff employed at Connect House had training in how to respond in an emergency, such as the recovery position, cardiopulmonary resuscitation (CPR) and choking. This meant there were not routinely staff on shift with the skills and competency to respond to life threatening situations. Furthermore, we received feedback from an external health professional that staff sometimes took inappropriate action in emergency situations, such leaving the person to look for an external health professional rather than pressing the emergency call bell. This meant we were not assured people would receive the support they required in the event of an emergency.

There was not always enough equipment available to meet people's needs. During our inspection, we observed a person using a wheelchair that was not appropriate for their needs. We spoke with an external health professional about this who confirmed this to be the case but said an alternative was not available. Records for another person showed they required bedrails to ensure their safety after they were discharged from hospital. However, their care plan documented bed rails had not been available for the person when they were admitted to Connect House so they had used alternative measures. This did not assure us that equipment was available to meet people's needs and placed them at risk of harm.

Systems in place to review and learn from adverse incidents were not consistently effective. There were not always clear records of incidents, such as falls. For example, one person's care plan documented they sustained a fall, and stated 'incident record not completed at time because no forms.' We were not able to locate any further detail of this incident of ascertain what learning had taken place as a result. An incident form for another person provided a good description of the incident and the action taken by staff. The manager had reviewed the incident and considered actions that could be taken to reduce the risk of further falls. However, the person's care plan was not updated following the fall. This meant there was a risk staff may not be aware of changes made to ensure the person's safety.

The above information was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing levels were not always sufficient to ensure people were provided with safe and responsive support. People told us staff did not always respond to their requests for support in a timely manner. One person told us, "When you press what is supposed to be the urgent buzzer nobody comes for a very long time. I feel that if someone had a fall or stroke or heart attack what would they do. It's all of the time, day and night." Another person said, "I have to wait sometimes for help. There aren't enough staff." A third person told us, "The call bell, ha ha, you can wait, they come, busy and rushed, very busy because they are very understaffed. It's a nuisance, they are going off all night." A relative told us, "Sometimes they (relation) want to go to the toilet they have had to wait a long time, over 10 minutes. [Name] has been annoyed that they could not go to the toilet. It has happened a few times, I think it's because they are too busy." Our observations supported the above feedback. For example, we observed one person waited 15 minutes to go to the toilet as there was not a second member of staff available to assist them. Staff told us they had raised concerns about staffing levels which had resulted in an agreement about how many people with complex needs were supported by the service. However, they also told us admission documents were not always completed accurately and this resulted in some people requiring more support than stated which impacted negatively on staffing. The manager told us they were using a dependency tool to determine staffing levels but told us this required development.

We had particular concerns about the staffing levels at night. Staff rotas showed three staff were deployed at night on Heritage Suite. Before our inspection, we were notified of a safeguarding concern where a person became unwell at night but was unable to summon staff assistance as they called and shouted for assistance and no one came. During our inspection, we found a number of people required the assistance of two members of staff or close supervision to ensure safety. We did not feel assured three staff was sufficient to ensure people's safety and wellbeing. This was supported by feedback we received from people living at the home. One person told us, "A few times I have wet myself because they didn't come quick enough at night." They went on to explain they now used continence products so they did not worry about staff not getting to them quick enough. This was also supported by feedback from external health professionals who told us there were not routinely enough staff on duty when people wished to go to bed. An example was given of one person who had waited two hours to be assisted to bed. This meant we were not assured there were sufficient numbers of staff to ensure people's safety and needs.

Staff were not always deployed effectively to ensure people's needs were met. We observed temporary agency staff were not provided with the required information or resources to enable them to provide safe and effective support. On one occasion, we observed a member of agency staff responding to a call bell. Agency staff were not provided with a key fob, which was needed to silence the call bell, consequently they spent five minutes search for a fob before to attending to the person. On another occasion, we observed one person's bell ringing for a period of six minutes and observed three staff available in a communal area who did not respond, as they were not allocated to that area. This did not assure us that staff were deployed effectively and posed a risk that people may not receive safe, effective or timely support.

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

Adequate steps had not always been taken to ensure people were protected from staff that may not be fit and safe to support them, as safe recruitment processes were not always followed. We identified shortfalls in two of the four staff files we reviewed. For example, one staff member had previously worked in other care settings, but they had not given details of their previous employers and had not stated their reasons for leaving these posts. Another member of staff only had one reference on file, there were no references from previous employers. We also found the provider did not conduct robust checks of nurses Nursing and Midwifery Council (NMC) PIN numbers as part of the recruitment processes. The NMC is the regulator for all

nurses and midwives in the UK. This had resulted in a failure to identify important information as part of the recruitment processes. These failings in recruitment processes meant the provider did not have all the relevant information to make a decision about the suitability of staff members.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they got their medicines as required. One person told us, "I get my medication on time and no mistakes." Another person said, "They always tell me what they (medicines) are for and what they're testing for." Despite this positive feedback, we found some areas of concern in relation to medicines management. Medicines were not always stored safely. We observed the medicines trolley was left unlocked and unsupervised in a communal area. This meant there was a risk someone who used the service or a visitor could access people's medicines unobserved by staff, and a further risk they could take these. Records relating to controlled medicines were not always completed as required. In one case, there were more tablets in stock than were recorded and in another case, the same medicine for one person was recorded in two different places. This increased the risk of error or abuse of controlled drugs. Other than the above medicines were well organised and the majority of medicines records were completed accurately to demonstrate that people had been given their medicines as prescribed.

Further work was required to ensure people were protected from risks associated with the environment. Both the fire and legionella risk assessments were out of date. The operations manager had identified this and told us they had planned for external contractors to conduct full risk assessments in these areas. Records showed regular safety checks were conducted on the environment such as water temperatures, call bells and moving and handling equipment.

There were systems and processes in place to minimise the risk of abuse. The majority of staff we spoke with understood how to recognise and report allegations of abuse and knew how to escalate concerns to external agencies if needed. However, we found temporary agency staff did not always have sufficient understanding of their safeguarding duties. Staff were confident that any concerns about people's safety were dealt with appropriately by the management team. Records showed that the manager had taken action to escalate some safeguarding concerns to the local authority. We observed staff handovers were used to identify and discuss safeguarding concerns. Prior to our inspection, we were advised of a number of concerns raised about the quality and safety of the service. These remained under investigation by the local authority safeguarding adults' team at the time of our inspection.

The home was clean and hygienic and effective infection control and prevention measures were in place. During our inspection, we observed both bedrooms and communal areas were cleaned to a sufficient standard. Staff had access to plentiful supplies of personal protective equipment, such as gloves and aprons, to ensure good infection control practices. Records showed the majority of staff had up to date training in the prevention and control of infection. A team of domestic staff took responsibility of the cleanliness of the home and they completed regular audits of the environment to identify issues and ensure good practice.

Inadequate

Is the service effective?

Our findings

The Mental Capacity Act (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. We checked whether the service was working within the principles of the MCA.

People's rights under the Mental Capacity Act 2005 were not protected. During our inspection, we identified that people's capacity in relation to restrictive practices had not been assessed. Records showed one person was a "heavy smoker" prior to admission. Upon admission to Connect House, a decision had been made to put the person on nicotine patches as an alternative to smoking. A member of staff told us the person experienced 'sun downing' (increased levels of agitation in people with dementia in the late afternoon / early evening) and at this time they became agitated looking and asking for cigarettes. The member of staff told us the person was never given any cigarettes and added they probably did not understand due to their dementia. Despite this significant restriction upon their choice, there was no mental capacity assessment in place and no consideration had been given as to whether this was in their best interests. Another person was subject to continuous monitoring either through direct observation or movement sensors. This was a significant intrusion of their right to freedom. We observed the beeping of the chair sensor caused them significant distress. Despite this, no capacity assessment had been conducted to assess whether or not they had capacity to consent to this arrangement or ascertain if this was in their best interests.

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 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.

Some people were being deprived of their liberty without the necessary application to the local authority having been made. For example, one person, who lacked the capacity to consent to their care, had significant restrictions on their freedom of movement including physical restraint imposed by staff for the purposes of personal care. They also had their freedom restricted as they were not free to leave the home unescorted and were under the continuous supervision of staff. Despite this, there were no mental capacity assessments in place and no application had been made to authorise these restrictions on the person. This failure to apply the principles of the MCA did not respect people's rights.

Training records showed only 18 of the 88 staff employed at Connect House had MCA training and although most staff we spoke with had an adequate theoretical understanding of the MCA, they had not applied their knowledge in practice and this resulted in people's rights not being respected.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected from the risk of poor hydration or nutrition as food and fluid intake was not always appropriately monitored. For example, one person had been identified as being at risk of poor hydration and as a result, the staff team were monitoring their fluid intake. However, the amount of fluid recorded was not added up, which meant staff were not calculating their total daily intake to assess if the person had taken on board enough fluids. One fluid chart showed they received a total of 360mls throughout the day on one occasion; this not been totalled by staff and there was no evidence that action was taken to promote increased fluids. Furthermore, we found fluid charts were not always completed. Fluid charts for the same person were not completed at all for a period of four days. This further increased the risk of poor hydration.

Food and fluid intake were not always monitored when there was a high risk of poor intake. For example, one person's care plan documented a very recent history of poor food and fluid intake and they had also been prescribed medicine to increase their appetite. Despite this known risk, their food and fluid intake was not monitored. This failure to monitor food and fluid intake placed them at risk of poor nutrition or hydration.

People were not protected from unplanned weight loss. One person's care plan identified they were at risk of weight loss and stated they should be weighed weekly. Their care records indicated they were not weighed between 9 December and 30 December 2017 or between 6 January and 28th January 2018. They lost a total of 9.4 kg in this period. There was no evidence of a referral to GP or dietician to get advice or support for the person. Another person's care plan directed staff to weigh them daily; however, records showed they were only weighted 11 times in the three months prior to our inspection.

There was a risk people may not receive adequate amounts of food. During our inspection, we observed four people who had not been served their lunch. These people were reliant upon staff to access food. We intervened and staff told us these people had eaten. The staff member checked with another member of staff and then realised the people had not been offered any lunch. The staff member said, "It is a good job you asked." This did not assure us that effective systems were in place to provide people with adequate amounts of food.

There was a risk people may be discouraged from eating because their portion size preferences were not taken into account. People were served large portions and we observed this put some people off eating. One person told us they had a small appetite and their care plan documented they should be offered 'little and often'. Despite this, we observed they were served a large portion for lunch. They ate very little of their food. A further two people were observed telling staff there was too much on their plate. After lunch, a member of staff asked another person if they enjoyed their lunch and they responded, "Not really, I think there was too much." This failure to ensure food was served in line with people's preferences did not promote good nutritional intake and put the people at risk of poor nutrition. We discussed this with the manager who advised us they would address this with the staff team.

This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the above people were, overall, positive about the food served at Connect House. One person told us "We get enough to eat, we get a choice." Another person commented, "It's very good, the meals are excellent." A relative told us, "[Relation] is struggling to eat and drink, they are really trying. If [relation] hasn't eaten at breakfast, they'll offer food later…we've seen them feeding [relation], I think they do a better job than me." People who required assistance were supported in a discrete and compassionate manner.

People's diverse dietary needs were identified and catered for. For example, one person had a number of allergies and specific food items had been purchased to meet their needs.

People received care and support from staff who did not have the necessary skills and competence to support them safely. Training records showed that 23 of the 88 staff employed at Connect House had not had any training at all since starting work at the service. Nurses employed at Connect House had also not received sufficient training. Two of the six nurses had attended moving and handling training, but other than that, the nurses had not had any training whilst at the service. This meant they did not have training in key areas such as medicines management, health and safety and infection control. A high number of staff lacked training in key areas. Only 11 staff had health and safety training and only 14 staff had training in safeguarding adults.

This lack of training had a negative impact on the safety and quality of the service and placed people at risk of harm. For example, records showed that just over 50 per cent of staff had moving and handling training. This meant there were not always enough staff on shift with the skills and competency to safely support people to move. Consequently, we observed poor moving and handling practices. Staff did not have any training in managing challenging behaviour. This was of particular concern given the significant level of behaviours that posed a risk to others being managed on a day-to-day basis. This meant there was a risk staff did not have the required competency to safely manage people's behaviours. Training was planned for staff, however at the time of our inspection; the above insufficiencies placed people at risk of not having their needs met appropriately or safely.

Staff did not always receive regular supervision of their work. Although staff told us, they felt supported on an informal basis they had not been provided with formal supervision. Records showed many staff had not had individual supervision for approximately five months. This meant that staff were not given opportunities to access support and opportunities to reflect on their practice and share any concerns may be missed. This was of particular concern given the above gaps in staff training and knowledge. The manager had put a plan in place to ensure staff received supervision, we will report on the impact of this at our next inspection.

The above information was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People could not always be assured they would receive the support they required with health conditions. Some people expressed concern that staff may not respond in a timely manner should their health deteriorate. One person told us, "If I felt poorly, I would ring the bell, which is the thing they don't answer." When people had specific health conditions, care plans did not consistently contain adequate detail in order for staff to provide effective support. For example, one person had a specific health condition but their care plan did not contain any information about it. This lack of information placed people at risk of not receiving the required support. Staff knowledge of people's health conditions was variable. Some staff were aware of people's health conditions and had an understanding of indicators of deterioration. However, other staff had insufficient knowledge and we saw this had a negative impact on people who used the service. For example, one person had a health condition that caused them to become pale and shaky if they were unwell. Records showed staff had not recognised these symptoms as an emergency and had not taken the immediate action required to try to improve the person's health. This issue had been highlighted to the manager and they were in the process of providing additional training to the staff team.

The above information was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had access to a range of specialist health professionals. In Heritage Suite, people were provided with access to health and therapy services from professionals such as physiotherapists, occupational therapists and nurses, to aid their rehabilitation and recovery to enable them to return home. In Garden Suite, people were supported by a team of specialist health professionals from CityCare and Nottingham University Hospitals, this included consultants and advanced nurse practitioners. In addition to this support for people who had experienced a stroke was provided by the CityCare specialist stroke team. In garden daily 'ward rounds' were completed to review the health needs of each person.

Systems to share information across services when people moved between them were not always effective. The provider received information about people's care needs when they were transferred from hospital; they then used this information to develop a care plan. However, staff told us this information was not always accurate or adequately detailed. Furthermore, admission documentation was not always used to ensure care plans were put in place in a timely manner. This resulted in staff not having access to detailed and personalised information about the people they supported. Following our inspection, the provider informed us they had planned improvements to their systems and processes to ensure people's care needs were known when they moved into the service. External professionals told us the teams worked well together but felt communication could be improved. They told us there were times when information about changes to people's care had not been passed on. Staff spoke positively about the support they received from external health professionals.

People's needs associated with dementia had not always been taken into account in the design and decoration of the environment. Although there was dementia friendly signage throughout the building there were other aspects of the service which did not cater to people's needs and may have led to confusion. Signage and information was inconsistent and misleading. Some bedroom doors had photos to help people orientate themselves, some had basic written information and other bedrooms had no information at all. A board in Heritage displayed the incorrect day and date for three days prior to our inspection. This may have led to people becoming disorientated and confused. In contrast, consideration had been given to people's physical needs in the design and decoration of the building. For example, aids and equipment had been installed in some areas to enable people with mobility needs to navigate around the building and there was a call bell system to ensure people could request staff as required. There were communal lounges areas, with separate dining areas, on each floor which meant people had ample space to spend time socialising with friends and family. The provider had also recently developed a quiet lounge that people could use if they wanted more privacy.

Requires Improvement

Is the service caring?

Our findings

People's dignity was not always promoted. People told us there were not always enough staff to respond to their continence needs in a timely manner. One person told us, "(If you are in the lounge), you have to keep shouting if you need the toilet, then staff tell us off for shouting. It's not only me who gets into trouble." Some people told us evenings were a particular problem and said they sometimes had to call out on behalf of others for staff to provide support to access the toilet. During our inspection, we observed this to be the case, people who used the service had to shout across a busy communal area to alert staff to one person who required urgent assistance with their continence. This did not respect or promote people's dignity. Feedback about respect for privacy was mixed. This was summed up by one person who told us, "Sometimes staff knock on my door and sometimes they don't." This was also supported by our observations, whilst we observed some staff knocked before entering people's rooms others did not. In addition, we observed people were being weighed in a communal area. One person became very distressed, shouting and crying when being moved, this was a known behaviour. However, no consideration had been given to weighing the person in a more private area to maintain their dignity.

Signs displayed in people's rooms did not promote their dignity or respect their privacy. We saw signs relating to people's continence and care needs displayed in bedrooms. This information would be visible to family, friends and other visitors. The manager told us they had implemented this to try to ensure staff had access to key parts of information about people's care and support. However, this did not promote people's dignity or respect their right to privacy.

The language used by staff to describe people who used the service was not always dignified. We heard staff referring to 'toileting' people and staff routinely used words such as 'doubled' to describe people who required the assistance of two staff. This language did not promote respectful, dignified support.

People were not always supported to maintain their independence. Although there was a strong emphasis on building and maintaining people's independence to enable them to return to the community, this was led by external health professionals. During our inspection, we observed variable practice in the Connect House staff team. People were not provided with adapted cutlery and crockery. In Garden, we observed some people struggled to use a knife and fork and consequently scraped their food onto the tables, this was not identified by staff. Another person was unable to use one of their hands, staff did not consider this when serving their meal and consequently placed their cutlery and condiments on this side. This resulted in the person not being able to eat, this was not identified by a member of staff for 12 minutes, at which point they moved the cutlery, however the food would no longer have been hot and we observed they ate very little. In contrast on Heritage we observed a person struggling to use their cutlery, a member of staff intervened and offered an alternative which had a positive impact. Furthermore, more information was required in some people's care plans to ensure people received consistent support to maintain their independence. This meant people were not always supported to be as independent as possible.

Most people and their relatives were positive about the caring approach of staff but commented staff were very busy. People used words such as caring, kind and patient to describe staff. One person said, "They take

care of you. They can't do enough for you, the staff work hard." Another person said, "They explain what they are doing when they help me." In contrast, a person said, "Staff are nice, except mornings, because they are so overloaded. Both regular and agency staff." A fourth person commented, "This morning care staff knocked on the door and said 'hello how are you', but I didn't have time to say, before they'd shut the door and gone again." During our inspection, we found staff were kind and caring, but, interactions were limited and task focused due to how busy staff were. Although staff treated people with warmth and kindness, many of the interactions were focused on daily routines of personal care and meal times.

Most people told us they felt staff knew them well. One person told us, "I believe staff know me. I think they are helpful. They don't ask me, I tell them, for example, in the shower, I say which bits I want them to clean and they listen to me." A relative told us, "The staff know [relation] well, they know their needs and character. They know when to leave them and when to pick their moments." Despite this, we found people's care plans were focused mainly on care needs and contained insufficient information about their background and preferences. This posed a risk people may receive inconsistent support. This risk was exacerbated due to the use of temporary agency staff.

People were not always involved in decisions about their care and support and did not have a good understanding of the purpose of the service. Although some people told us they were involved in their care plans, others had not been involved and said communication was not effective. One person told us, "They haven't talked to me about a plan, about what will happen to me, because I don't think they know. I used to do exercises every day, but the man who did it has gone to college, so no one did them with me today. I don't know if someone else will come, no one has told me, I shall just have to wait and see." Another person said, "I don't know what needs to happen for me to be able to leave, they don't tell me anything other than they'll arrange transport for me when I go home." A relative commented, "[Relation] doesn't know when they are going home. I'd like people to better inform them. I think [relation] needs to know what's happening." Furthermore, there was limited evidence to demonstrate people had been involved in the development of their care plans.

The manager told us people had access to an advocate if they wished to use one and there was information about advocacy displayed in the service. Advocates are trained professionals who support, enable and empower people to speak up. No one was using an advocate at the time of our inspection.

People were supported to maintain relationships with friends and family and people's friends and relations were welcome to visit the home. One person told us, "My relative visits every day after work and they make them welcome." There were no restrictions upon visitors to the home.

Requires Improvement

Is the service responsive?

Our findings

People were at risk of inconsistent, unsafe support that did not meet their needs. There were insufficient processes in place to ensure that staff had access to adequately detailed care plans when people were admitted to Connect House. This resulted in a failure to both identify and address risks and to provide staff with adequate guidance to inform support. Consequently, people were placed at risk of unsafe and inconsistent support. One person moved into the home 19 days before our inspection. During our inspection, we found their care plan was blank, except a sleep and rest care plan. Records, such as the transfer of care document from the hospital and daily records, kept by staff showed they had complex support needs in relation to dementia, continence, health, behaviour and personal care. Despite this, they did not have a care plan in place to inform their care and support in these areas. The manager took immediate action to address this but it remains of concern this was not identified before our inspection.

The quality of other care plans was variable. Some care plans did not accurately reflect people's needs and some lacked individualised information. One person's care plan stated they mobilised with a walking frame. However, we observed that staff used a wheelchair to move them and staff confirmed the person did not walk with a frame. This placed people at risk of inconsistent and potentially unsafe support. Given the fast turnaround at Connect house and service users' complex needs, it is particularly important adequate care plans were in place. We were not assured that sufficient systems were in place to ensure all staff had access to clear guidance to inform safe and effective support and this placed people at risk of harm.

In addition to the above, staff were not always using care plans to inform the care and support provided. One member of staff told us they had not looked at any care plans yet. A nurse also told us they had not read any care plans and said they used a handover sheet rather than care plans. An agency member of staff also told us they used the handover sheet to inform their support. This detailed room number, the person's initials and basic key details about support required. This meant these staff had a very limited knowledge of people's needs. External health professionals told us staff did not always have time to read the care plans implemented by allied health professionals and described staff as being "overwhelmed" by the high turnover of people. This failure to ensure staff used care plans to inform support exposed people to the risk of inconsistent and potentially unsafe support.

The above information was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records relating to people's care and support were not always personalised and were not consistently completed to demonstrate they had received care. A relative told us, "When [relation] first came in, [they] had a booklet with someone else's name on it, so they changed the name to [relation's] name. I think they are supposed to fill it in every day, but I'm not sure they do. I've not seen any plan about [relation's] care." One person's care plan stated staff must record their bowel movements; however, records kept by staff stated the person was independent, so the purpose and value of the recording was unclear. Another person's care record showed a period of seven consecutive days when they declined assistance and on a further day, the record stated they were independent. Their care plan stated they required the assistance of

staff and this was confirmed by an external health professional who told us person would not be able to be independent with their personal care. We therefore could not be sure the person was supported to keep themselves clean.

There was a risk people's end of life wishes may not be respected. Some people who used the service had Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) orders in place stating they did not wish to be resuscitated in the event of an emergency. Some of DNARs had been put in place whilst the person was in hospital. We found four DNARs that had not been completed to allow the transfer of the DNAR from the hospital to Connect House. Staff had not identified this. This failure to ensure DNARs remained valid when transferred across care setting meant people may not have their end of life wishes respected.

Furthermore, people had not been offered support to discuss their end of life wishes. One person was coming towards the end of their life. They had an end of life plan in place but this only covered their medical needs. It stated 'End of life wishes will be discussed with [name] and family.' However, there was no evidence the person had been offered the opportunity to discuss their end of life wishes. This placed them at risk of not having their wishes met.

The approach to social and recreational activity was inconsistent. The service employed a dedicated activity coordinator. The activity coordinator told us that they met with people to discuss their social and recreational preferences and this information was then used to inform the activities programme. In Heritage Suite, we observed people were provided with opportunities for meaningful activity and occupation. This included activities such as a quizzes, knitting, exercise classes and films. The activity coordinator also spent time one to one with people. In contrast, there was a significant lack of meaningful activity for people in Garden Suite. People told us there were very few activities. One person told us, "Activities? I haven't seen any, I don't take much notice." Another person had two activities recorded over a two month period. Staff had recorded in notes that the person was 'bored'. A member of staff told us, "[The activity coordinator] has not been here (Garden) for a long time." We observed people's routines were focused on tasks such as meals and personal care and many people in Garden Suite lacked meaningful occupation. This did not meet people's social needs and may have had an impact on their wellbeing. The manager acknowledged the lack of activities for people in Garden Suite and stated they were aware they needed to take a different approach due to people's complex needs.

The above information was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was not fulfilling their duties under the Accessible Information Standard. The Accessible Information Standard ensures that all people, regardless of impairment or disability, have equal access to information about their care and support. Some of the systems within the home did not take account of people's communication needs and therefore did not maximise their decision making ability or promote choice. For example, the approach taken to supporting people to make choices about their meals was inconstant. Some people were offered a visual choice from two dishes, others were only offered choice verbally, this appeared to depend upon staff member rather than the person's needs. In the morning, written information about meals was supported by photos to help people choose, however, at lunchtime only written information was displayed. This could have been confusing for people with memory impairments and confusion and did not maximise choice. Other systems in the home did not promote good communication. It was difficult to identify staff because a number of different uniforms were used, some staff were not wearing uniforms and the uniforms did not correspond with the uniform poster on display. We asked on person who they would talk to if they had a concern about their health and they told us, "I would not know who to ask." We spoke with the manager who told us this was an area for development. They were

in the process of developing information leaflets about the service and told us they would ensure these were available in alternative formats as needed. We recommend the provider reviews their approach to communication to ensure people have equal access to information.

The manager told us people's diverse needs were recognised and accommodated. For example, an interpreter had been used for a person's whose first language was not English. A member of the kitchen team also explained how they catered for people's cultural dietary requirements.
However, we were not assured people's religious needs were sufficiently catered for. One person told us, "I've never seen anyone come to do religious activities." The activity coordinator told us a pastor used to visit the service but this stopped a few months ago. They said, instead, staff played CD's of religious hymns or put songs of praise on the TV. The activities coordinator told us there was no one staying on Heritage Suite who had any expressed religious needs. However, was unclear how the religious needs of people in Garden Suite were identified and catered for.

People did not know how to make a complaint. Although there was a complaints procedure on display in the service, a number of people told us they were not aware of the complaints procedure. One person told us, "I don't really know how to complain. There doesn't appear to be a focal point for you to go to if you have a problem." We asked another person what they would do if something went wrong or they had a problem, they said, "I don't know. I guess you wouldn't say anything." A third person said, "I wouldn't know who to report it to if something went wrong or if I wanted to complain." In contrast, people's relatives told us they knew how to complain and had confidence complaints would be handled. One relative told us, "We'd go to the office if we had any concerns, we always nip to the office if we have any questions." Another relative said, "We've had a few mishaps ... I went and told the staff I am not happy about it and they said they'd look into it. It hasn't happened again, that was two weeks ago."

There were systems in place to ensure that complaints were responded to in a timely manner. Records showed that complaints had been documented, investigated and responded to appropriately. For example, a family member had raised concerns about some aspects of the service. The manager had taken action to arrange a meeting with the family and address the issues raised. Staff we spoke with were aware of their role in recording any concerns received and communicating these to the management team.

Inadequate

Is the service well-led?

Our findings

The service was not well led. We identified a number of shortfalls in the way the service was managed, this included concerns related to the safety of the service, the implementation of the Mental Capacity Act and the privacy and dignity of people who used the service. This led to breaches of a number of the legal regulations.

The provider did not have sufficient systems to check people's care and support was carried out safely or in a way that met their needs. The service had been registered for five months at the time of our inspection. However, very few audits had been completed in the period since registration. The manager showed us new audits they planned to implement, but this system was not operational at the time of our inspection. We saw very recently implemented medicines and nutrition audits. As these had only just been completed at the time of our inspection we were not able to assess the impact. Furthermore, although the provider visited the service regularly they did not complete any formal quality audits of the service. This failure to implement an effective audit and quality assurance system resulted in a number of serious concerns about the safety and quality of the service not being identified.

Records relating to the care and treatment of people who used the service were not consistently accurate or up to date. Care plan audits were not completed and consequently areas for improvement were not identified. The provider informed us they were aware improvements were required to care plans; they had developed a new care plan format and had prioritised the redevelopment of care plans based upon risk. Despite this, we found one person who did not have a care plan in place at all, they had a number of risks associated with their care and support. The manager told us this care plan must have been 'missed'. Furthermore, we saw the care plan review and evaluation chart was disorganised which meant it was unclear what was left to do. This meant we were not assured the provider's systems were sufficiently robust. This failure to identify areas for improvement put people at risk of receiving inconsistent and potentially unsafe support.

There was no formal system for analysing, investigating and learning from accidents and incidents across the service. Trends of accidents and incidents, such as the location or timing, were not analysed. This failure to analyse accidents and incidents meant that opportunities may have been missed to identify ways of preventing future incidents and exposed people to the unnecessary risk of potential harm and injury. The manager had identified this as an area for improvement and had developed a system for the analysis of incidents. However, this was not operational at the time of our inspection. This meant we could not be assured all reasonable steps had been taken to improve the quality and safety of the service.

People who used the service and their families had very limited opportunities to provide feedback or make suggestions about the services provided at Connect House. Other than a suggestion box, there were no formal ways for people to provide feedback. The manager told us there were no meetings or surveys at present, they said they had identified this as an area for improvement and we saw dates for future meetings had been planned. Where feedback systems were in place, they were not effective. We observed a book for people to provide comments about the food served at Connect House but this had not been completed

since the provider had taken over ownership of the service. There were 'you said, we did' boards displayed around the building. However, many of the improvements displayed had not been made or sustained. For example, it stated reception cover had been extended to weekends, however during our inspection we saw a sign displayed on reception which said reception was not 'manned' at weekends. The board documented a welcome brochure had been created as people had said they were not sure of the services delivered at Connect House. Despite this, we were informed by staff and the manager there was no welcome brochure. This meant we were not assured effective action was taken in response to feedback from people who used the service.

Staff did not always have a clear understanding of their role. The boundaries between external health professionals and staff employed at Connect House were unclear. This had resulted in staff not fully understanding their responsibilities and had impacted negatively on the quality of care plans and risk assessments. For example, we found some risk assessments, for pressure ulcer risk, moving and handling risks and nutritional risk, had been completed by external health professionals as part of the admission process but had not been updated by Connect House staff when people's needs had changed.

In addition to the above, we also found concerns about other areas of governance during our inspection. Sensitive personal information was not stored securely. We found that cupboards containing care plans were left unlocked throughout the duration of our inspection. This meant information relating to people's health and support needs could be accessed by people who used the service and visitors. This was a breach of confidentiality and did not respect people's right to privacy. The storage and organisation of systems and records was confusing. For instance, in Garden we found records relating to people who no longer used the service in the care plan cupboard. Information relating to people's care was recorded in multiple folders and some recently recruited staff told this was confusing.

The above information was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not ensured we were notified of incidents at the service, which they are required to by law. There had been a failure to notify us of an event that stopped service running safely and effectively. The service had experienced a recent 'staffing crisis' which had a negative impact on the quality and safety of the service. A failure to notify us of incidents has an impact on our ability to monitor the safety and quality of the service.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Despite the above most people and their families we spoke with were positive about their experience of the service. A relative told us, "It's good, clean and friendly ... The staff are really helpful. It feels pleasant." Another relative commented, "We are very happy, our relative has been here on and off … we have no qualms, we are always informed. They have been on both units and we couldn't speak more highly of them."

People, their relatives and staff were positive about the management team. A relative told us, "They are really accommodating and make time to answer any questions." Although there were no formal meetings for care staff they told us they felt supported. A member of staff told us "[deputy manager] is a great support and works with us to put changes in." Staff felt the changes made by the manager and provider were positive. Visiting health professionals also gave positive feedback about the impact of the management team. They told us recent improvements had been made and said they felt that when concerns were raised they were taken seriously and acted upon. The provider had developed an action plan in response to concerns raised about the service and were working towards improving the quality of the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to inform the commission when insufficient staffing levels stopped the safe and effective running of the service. Regulation 18 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not provided with appropriate support that met their needs. Regulation 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's rights under the Mental Capacity Act were not respected. DoLS were not always applied for as required. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Safe recruitment practices were not followed. Regulation 19 (2)

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 12 HSCA RA Regulations 2014 Safe care and treatment People were not always protected from risks associated with their care and support. Risk associated with people's care and support were not always identified and addressed. Staff providing support did not all have required the qualifications, competence, skills and experience to do so safely There were not always sufficient quantities of equipment to ensure people's safety and to meet their needs. Regulation 12 (1)

The enforcement action we took:

We took urgent action impose conditions on the registration of the service. These conditions required the provider to regularly provide the CQC with reports about the quality and the safety of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People were not always provided with adequate amounts nutritious food and hydration. Regulation 14 (1)

The enforcement action we took:

We took urgent action impose conditions on the registration of the service. These conditions required the provider to regularly provide the CQC with reports about the quality and the safety of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to monitor and improve the quality and

	safety of the service were not effective. Records of people's care and support were not accurate and up to date. Sensitive personal information was not stored securely. Opportunities for people and their families to provide feedback were limited and where feedback systems were in place they were not effective. Regulation 17 (1)

The enforcement action we took:

We took urgent action impose conditions on the registration of the service. These conditions required the provider to regularly provide the CQC with reports about the quality and the safety of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not deployed. Regulation 18 (1) (2)

The enforcement action we took:

We took urgent action impose conditions on the registration of the service. These conditions required the provider to regularly provide the CQC with reports about the quality and the safety of the service.