Mrs Jennifer Grego

Swanrise

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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Swanrise is a residential care home providing personal care to up to 6 people. The service provides support to adults with learning disabilities, autism and mental healthcare needs. At the time of our inspection there were 6 people using the service.

The layout of the building did not provide an environment where people had freedom of movement. This meant that some people were restricted to certain areas of the service, and we observed that most of the day, that is where they remained. This also impacted in some cases on people's privacy and dignity.

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

People's experience of using this service and what we found
We found the service was not able to demonstrate how they were meeting the underpinning principles of right support, right care, right culture and best practice guidance. This meant people were at risk of not receiving the care and support that promoted their wellbeing and protected them from harm.

Right Support: Model of Care and setting that maximises people's choice, control and independence.
Care was not always provided in a dignified manner and people's human rights were compromised. People were subject to restrictive practices without proper regard to legal processes and requirements. 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 and in their best interests; the policies and systems in the service did not support this practice.

The provider had failed to mitigate the risks in relation to the internal and external environment. They had not done all that was reasonably practicable to reduce the risk and provide care in a safe way. This resulted in service users being placed at risk of harm and coming to actual harm. Infection prevention and control measures were not robust and some areas of the service were visibly dirty and unhygienic.

Right care: Care is person-centred and promotes people's dignity, privacy and human rights
Care was not provided in a person-centred way which promoted people's dignity, independence or human rights. There were not always staff with suitable skills deployed to meet the needs of people; there were identified gaps in staff training and we were not assured staff had the skills and knowledge to fill the requirements of their role. We found medicines were not always safely managed and medicine records were not always completed accurately. People's dietary and health needs were not well documented which meant we could not be assured that people had access to regular health checks, or that a healthy and

balanced diet was being offered to people.

Right Culture: The ethos, values, attitudes and behaviours of leaders and care staff ensure people using services lead confident, inclusive and empowered lives.
The service lacked leadership and risk management. The provider's systems for monitoring and improving the quality of the service had not been effective, because people were not always receiving a good quality of service and some risks had not been mitigated. This placed people at continued risk of harm.

The systemic failings outlined in this report demonstrated the provider had failed to ensure people received a well-managed service which was safe and compassionate placing people at risk of potential harm.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was Requires Improvement (published 16 December 2019).

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We received concerns in relation to the poor quality of care people were receiving. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from Requires Improvement to Inadequate based on the findings of this inspection.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Swanrise on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to safeguarding people, staffing, risk management, medicines, nutrition and hydration, and governance at this inspection. Due to the significant concerns we found, after the inspection we continued to work closely with the local authority and safeguarding teams.

We issued a Notice of Proposal to vary the conditions of the providers registration so they were no longer authorised to carry on providing services at Swanrise. We received no representations from the provider, so we issued a Notice of Decision. This means the service is no longer in operation.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led

Details are in our well-led findings below

Swanrise

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by 3 inspectors (one of whom specialised in medicines) 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.

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

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We reviewed support plans and associated records for 4 people. We reviewed medicine administration and associated records for 6 people and spoke with 2 members of staff about medicines. We spoke to 2 people who lived at the service briefly and observed staff delivering care to 3 people. We spoke with the deputy manager and operations manager.

After the inspection we received further documentation electronically, such as governance audits, recruitment files, supervisions and minutes of meetings. We spoke with 5 relatives, 3 support workers and one learning disability nurse. We continued to liaise with the local authority about our concerns following the inspection.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question Requires improvement. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection we found environmental risks were not fully addressed. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made and the provider remains in breach of regulation 12.

- We identified external environmental risks in the garden area, such as planks of wood from broken fencing in the garden, with gaps large enough for someone to leave the premises without staff knowledge, or for an intruder to access the grounds. Other items were found which could be used as weapons or to cause damage to property.
- The internal environment also contained numerous items which service users could access and cause potentially cause harm to themselves or others. This included knives, sharp pieces of wood, and chemicals, such as cleaning products, which should be securely stored.
- The risk of people ingesting chemicals harmful to their health had not been properly managed which had led to several incidents where a person was able to access and ingest these.
- Some people were at risk of constipation, which can pose a serious risk to people's health if left untreated. Staff confirmed there were no bowel charts or monitoring of people's bowels which placed people at risk of harm.
- When physical intervention was used by staff to protect people and others, a prompt review was not carried out to ensure care plans or behaviour support plans were updated if required. The forms completed were not signed off by a manager to ensure adequate oversight.
- Some people experienced behaviours which put themselves and others at risk. A positive behavioural support plan (PBS) was not always in place, and some were overdue review. PBS plans provide guidance for staff on specifically how to support people at varying levels of distress. Not having these in place meant that staff's approach may not be consistent and the interventions could therefore be less effective.
- We found some areas of the service to not be compliant with fire safety, such as holes in doors which can pose a risk of fire spreading.
- Not all staff were up to date with fire safety training.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The fire service visited in February 2023 to check fire safety. Recommendations from this visit were added

to the services internal fire risk assessment which the provider advised had been met.

Staffing and recruitment

At our last inspection the provider had failed to ensure staffing levels were adequate to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had not been made and the provider remains in breach of regulation 18.

● The provider had not ensured that sufficiently skilled staff were deployed to ensure they could meet people's care and treatment needs. For example, at the time of the inspection only 35% of staff were trained in medication awareness. This meant that on some shifts there was no staff member to administer certain medicines.
● We had concerns about the competence of some individual staff members who had not always followed guidance in order to keep people safe. This resulted in people coming to harm as they had not followed the care plan.
● People living at the service required staff to be with them at all times. Rotas showed the number of staff on duty would cover the required levels, however, this did not allow staff to have scheduled breaks, and at times staff told us they worked with minimal breaks throughout a twelve hour shift which does not meet legal requirements, and has the potential to affect their concentration and practice. One staff member said, "I'm exhausted at the end of a shift, I barely get any breaks for the whole 12 hours."
● Staff told us that there was not always the full compliment of staff to ensure people went out. They told us, "There are usually 6 staff on, but if people go out in the community they need 2-1 staff and there isn't always enough, so people don't go out so often."

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

● The provider had made contact with the local authority and requested funding for an additional staff member to facilitate staff breaks and enable 2-1 access in the community.
● Staff were recruited safely.

Systems and processes to safeguard people from the risk of abuse
● People were subject to restrictive practices without the proper legal authority to do so, which included locking people in their rooms and restricting people to certain areas of the service. We made safeguarding referrals to the local authority in relation to this practice.
● We could not be assured that staff were knowledgeable about how to identify and report potential abuse, as only 52% of staff had completed training in safeguarding and protection of adults.

This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● The service was unable to provide confirming evidence that staff authorised to handle people's medicines on their behalf had been recently assessed as competent to give people their medicines. In addition, at the time of inspection there were no members of staff on duty that had been trained and assessed as competent to administer a specific medicine needed if a person has an epileptic seizure.

● Medicines for most people living at the service were stored in a locked room dedicated to this purpose. However, within the room we noted a significant number of medicines that were no longer in use and that had not been promptly disposed of.
● For one person whose medicines were located in a cabinet within their room the cabinet was not sufficiently robust either in nature or how it was fitted to the wall. For another person with a medicine cabinet also located in their room the service had not considered the risks around this. We also identified medicines risks around the use of paraffin-based topical medicines and fire and asked the service to put in place appropriate risk assessments.
● When we looked at people's medicines and their records we identified some discrepancies which indicated that incorrect doses of some medicines may have recently been given to people. Whilst staff carried out daily medicine checks we found that some of these were inaccurately recorded. Staff had not recently completed records for the application of people's topical medicines such as creams and emollients. The service was unable to provide evidence that there were processes in place to handle and oversee medicine errors and incidents in a way that would lead to improvements being made.
● We found that some information about people's medicines available to staff to assist them give people their medicines was inconsistently recorded and potentially misleading. This included identifying photographs, and information about people's medicine sensitivities. Some protocols for medicines prescribed to be given when required (PRN) had written doses that were inconsistent with prescriber instructions. In addition, these protocols had not recently been reviewed. Body maps were not in use for people's topical medicines.
● The service was unable to provide confirming evidence that people living at the service received regular reviews of their medicines by prescribers in line with national guidance.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● People lived in an unclean environment and were not protected from the risk and spread of infection.
● Adequate systems were not in place to prevent and control the spread of infection. This included in people's bedrooms and in communal and utility areas.
● We found the environment to be poorly maintained and standards of hygiene in some areas were inadequate.
● Failure to ensure the environment is clean, hygienic and safe, puts people at risk of harm and infection.
● Not all staff had received infection prevention control training. This posed a risk in relation to managing and minimising the risk of infection.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes
● Relatives we spoke with informed us that they were able to visit their loved ones at the home. Visits outside of the home, to see family or take part in activities, were facilitated also.

Learning lessons when things go wrong
● Systems were not fully embedded into care practice or robust enough to demonstrate incidents were effectively monitored, reviewed or used as a learning opportunity.
● Accidents and incidents were logged. However, these were not always sufficiently detailed and were not always signed off by a manager to ensure adequate oversight.

● The findings of our inspection identified a culture that was not based on learning. This meant that when things had gone wrong, the potential for re-occurrence was possible because systems were not sufficiently robust.

Inadequate

Is the service effective?

Our findings

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

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has changed to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

At our last inspection we found that staff did not always receive the training required to ensure they were skilled to deliver people's care and treatment needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made, and the provider remains in breach of Regulation 18.

- The training matrix showed that a high number of staff had not completed training in numerous subjects relevant to their role. This placed people at risk of harm as staff may not have the skills required to support people with highly complex needs.
- One staff member told us they were supporting people without having had the correct training for situations where people may have to be put into a safe-hold for their own protection. They told us, "I was very scared, I didn't know what to do and had to shout for help."
- The provider told us that staff worked a minimum of 5 shifts on 'shadow', carrying out observations and reading through people's support plans, and policies and procedures. However, one staff member told us their induction was very poor and they had no previous work experience with people whose behaviours may escalate and challenge them.

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

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

At our last inspection we found the provider had not properly assessed and recorded people's capacity and best interest decisions, which was not in line with the Mental Capacity Act 2005. This was a breach of regulation 11 (need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made and the provider remains in breach of regulation 11.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible,

people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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

● DoLS application had been made where required. However, these did not include reference to restrictive practices that were in place. MCA and best interests decisions were not completed in relation to locking people's in their rooms.
● Some MCA and best interest assessments were not up to date and had not been reviewed since 2021.
● Support plans did not always contain MCA assessments even though documentation stated they had been completed. We could therefore not be assured that decisions had been taken with appropriate legal requirements being met.

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

Supporting people to eat and drink enough to maintain a balanced diet
● We could not be assured that a healthy and balanced diet was always being offered to people. People's daily directives included their food intake for the day. We found this was mostly not nutritious, and there was no reference to fruit or vegetables either offered or consumed.
● Where people's support plans stated they needed to have a healthy and balanced diet, we found this was not the case.
● A staff member said, "If you look at food charts you will see people have beans on toast or bread and chips, there isn't a lot of healthy food prepared for people."
● Where people had specific hydration needs, fluid logs did not evidence these were being met effectively.

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

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support
● Due to the concerns regarding staff training and competency, we could not be assured care and support was consistently delivered in line with best practice guidance and law. We could not be assured staff were sufficiently skilled to recognise possible physical and mental healthcare needs.
● Records did not always evidence that people were regularly seen by relevant healthcare professionals.
● We were not assured that all people had been offered and received annual health checks.

Adapting service, design, decoration to meet people's needs
● The service environment was in significant need of redecorating and repair, which had been identified by

the provider as needing refurbishment.

● People's rooms were not kept in a safe, clean or hygienic state. We found broken door handles, broken bathroom tiles, and plastic television coverings which could be pulled off and used as weapons.

● The service was not kept securely to prevent people absconding or from potential intruders. The main front door was unlocked on each of the 3 days we visited.

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has changed to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.

At our last inspection we found the providers' governance systems were not effective, and were not always identifying failings in the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made and the provider remains in breach of regulation 17.

● There was not a registered manager in post. The previous registered manager left the service in August 2022. A new manager was employed in the service following this, but did not register, and resigned from their post after 3 months. The service was currently being overseen by the operations manager and deputy manager from another of the providers locations.
● Despite issues being identified at the inspection in November 2019, the provider had not resolved any of the breaches of regulation from the last inspection and new issues had also emerged. The provider had failed to ensure people received a well-managed service which was safe. This exposed people to unnecessary risk.
● Audits had been completed to monitor the quality of the service, but these had not identified and resolved the multiple shortfalls we found. Behaviours of concern and physical intervention records did not have robust management oversight.
● The systemic failings outlined in this report demonstrated the provider had failed to ensure people received a well-managed service which was safe and compassionate placing people at risk of potential harm.

This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● Reporting of notifiable incidents were made to CQC. However, there was one incident which hadn't been notified to us in relation to a safeguarding concern.
● Relatives told us the service did not always make contact with them when incidents occurred. One relative said, "There has been a lot of safeguarding issues and I didn't know about them." A second told us, "It's rare

they volunteer anything. The last few years or so have been quite challenging. The care provided is not to standard, dangerous at times. Then steps supposed to be put in place but just doesn't happen. Very unhappy about it all." A third told us, "They did call me to ask if they could release my contact details to you. That's unusual to get any communication from them. Normally an email to say I'm a new manager then don't hear again until another new manager calls. I just give up they don't communicate with us."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● People did not always achieve good outcomes or receive person-centred care. Where people had come to harm, reduction of risk was not effectively implemented. People did not live in a safe and secure environment, and items which could cause harm were accessible.

● The provider had not ensured all staff had completed relevant training to support people using the service safely and effectively.

● Leadership in the service had been weak and had failed to ensure staff understood their responsibilities and roles.

● Residents meeting minutes were not always dated and did not always state who attended. Further, people were not compatible to have a meeting together, yet the minutes stated that all residents attended. We could therefore not be assured that gaining people's views about their care was robustly completed.

● Minutes of staff meetings did not reflect that there was opportunity for a two-way conversation. Minutes did not reflect staff feedback. One staff member said, "We do have meetings but it is usually them telling us about things rather than asking us." The provider told us staff also had access to an anonymous suggestion box, outside of the forum of the staff meeting to give their views.

● Three relatives told us that they did not feel included or informed about their loved ones care, and that communication was generally poor. One relative said, "I certainly wouldn't recommend this company to anyone." Another told us, "I have fed back [concerns] to the manager. I feed back all the time and nothing changes."

● Not all staff had completed equality and diversity training. We could therefore not be assured staff were knowledgeable about people's rights and were able to recognise, respect and value differences in people.

Continuous learning and improving care; Working in partnership with others

● Effective systems were not in operation to support a culture of learning and improvement. The provider had not ensured that its workforce was adequately trained and skilled to work with vulnerable people, all of whom were living with complex needs.

● There were new and repeat breaches of regulation, which demonstrates the provider did not take action to improve care.

● The provider had worked closely with the local authority, social workers and learning disability teams.

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 11 HSCA RA Regulations 2014 Need for consent MCA and best interests decisions were not completed in relation to locking people's bedroom doors. Some MCA and best interest assessments were not up to date and had not been reviewed since 2021. Support plans did not always contain MCA assessments even though documentation stated they had been completed. 11 (1)

The enforcement action we took:

Notice of proposal

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks relating to the internal and external environment were not mitigated Infection control procedures were not robust and the environment was visibly unclean. Medicines were not managed safely in the home. 12 (1) (2) (a) (b) (f) (g) (h)

The enforcement action we took:

We imposed urgent conditions on the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment

	People were subject to restrictive practices without the proper legal authority to do so. 13 (1) (2) (3) (4) (b)

The enforcement action we took:

Notice of proposal

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs We could not be assured that a healthy and balanced diet was always being offered to people. Where people had specific hydration needs, fluid logs did not evidence these were being met effectively. 14 (1) (4) (a)

The enforcement action we took:

Notice of proposal

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems were not effective, and had not identified the many failings in the service. 17 (1) (2) (a) (b) (c) (e) (f)

The enforcement action we took:

Notice of proposal

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing numbers were not always sufficient to ensure people's holistic needs were met. Staff had not received up to date training relevant to their role. 18 (1) (2) (a)

The enforcement action we took:

Notice of Proposal