Barchester Healthcare Homes Limited

# Challoner House

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

The 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.

We carried out a responsive unannounced inspection of this home on the 02 and 03 August 2018 following concerns which had been raised by the local authority about the safety and welfare of people. At our last inspection of this home we had rated it Good. At this inspection we found concerns for the safety and welfare of people. The registered provider had failed to be compliant with all of the required Regulations.

Challoner House is a 'care home' and is registered to accommodate up to 49 people. 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. At the time of the inspection 42 people were accommodated at the home.

The registered manager had just left the service the week before our inspection but was currently still registered with the Care Quality Commission. 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.

We found peoples safety was compromised in some areas. There were inadequate numbers of permanent staff and the home was reliant on agency staff especially at night. The provider had been running the

services with inadequate staffing levels which staff felt was unsafe and that they could not meet people's needs safely.

Relevant recruitment checks were conducted before staff started working at the service to make sure staff were of good character and had the necessary skills. However, there were unexplained gaps in staff employment histories.

Staff understood safeguarding procedures to keep people safe. However, systems were not in place to monitor these

Environmental risks were not managed effectively; fire alarm tests were not up to date as recommend by fire safety regulations. People did not have individual personal evacuation plans to support staff in the event of an emergency. A legionnaires water risk assessment had needed to be reassessed since 2015. Infection control procedures needed to be more robust.

Risks associated with people's care had not always been identified and assessments made to reduce these risks for people. Emergency call bells were not always available to people in the case of an emergency to call for help. Improvements were required for the safe management of medicines.

Staff did not receive regular support and one to one sessions or supervision to discuss areas of development and to enable them to carry out their roles effectively. Staff completed a range of training but felt it didn't always support them. Dementia training was not always available to all staff.

People's rights were not always protected because staff did not always understand and work within the principles of the Mental Capacity Act 2005 or Deprivation of liberty safeguards. These were in the process of being reviewed.

People care plans provided information to guide staff in how to support them. However, we found some contained inaccuracies and missing information. There were concerns with missing entries and gaps in charts to monitor people's food and fluid and skin integrity.

People and their relatives told us staff treated them with kindness but people were not always treated with dignity and respect. People did not always receive care that was person centred and individual to their needs. People received varied meals including a choice of fresh food and drinks.

There were not meaningful activities and interactions in the home for people cared for in bed to reduce the risk of social isolation for people. People and staff told us people were lonely.

During our inspection we found there was a lack of effective management and leadership in the home. Staff felt unsupported and let down by management and morale was low amongst staff. Areas of concern we had identified during our inspection had not always been identified by the governance processes in the home. We could not be assured complaints were always responded to appropriately.

Records were not always accurate. The provider did not send in all notifications to CQC as required by law of all significant events.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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 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.

There were insufficient staff deployed to meet people's needs and keep them safe.

Risks associated with people's care had not always been identified and assessments made to reduce these risks for people. Improvement was required for the safe management of medicines

Emergency evacuation planning were not robust. People did not have individual personal evacuation plans in place to keep them safe during an emergency. Infection control procedures needed to more robust.

Recruitment practices were not always managed safely and pre-employment history was not explored. Staff understood safeguarding procedures to keep people safe. However, systems were not in place to monitor these.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Staff did not always receive sufficient support and supervision to complete their roles effectively.
Training was not always effective.

Legislation designed to protect people's rights was not correctly applied. Staff were not aware of the people who had Deprivation of Liberties Safeguards (DoLS) placed on them to keep them safe.

People did not always receive appropriate support to ensure their nutritional and hydration needs were met.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

People and their relatives said staff were caring, helpful and

willing.

Care practices did not always ensure peoples dignity and independence.

People's privacy was usually protected by ensuring doors were closed while carrying out personal care.

## Is the service responsive?

**Requires Improvement**

The service was not responsive.

There were not meaningful activities and interactions in the home for people cared for in bed to reduce the risk of social isolation for people.

People did not always receive care that was person centred and individual to their needs.

The provider could not be assured complaints were always responded to appropriately.

## Is the service well-led?

**Inadequate**

The service was not always well led.

Staff felt unsupported by all of management and morale was low. Staff were concerned and felt upset that they were not always meeting people's needs due to the lack of staff.

Records were not always accurate and lacked up to date information.

The quality and monitoring system was not effective in order to ensure necessary changes were implemented. Audits did not notice the concerns we found at the inspection. The provider did not send in all notifications to CQC.

# Challoner House

**Detailed findings**

## Background to this inspection

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

This inspection took place on 02 and 03 August 2018 and was unannounced. It was completed by one inspector, a specialist advisor in nursing care and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before this inspection, the provider completed a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give us some key information about the service, what the service does well and improvements they plan to make. We also checked other information we held about the service including previous inspection reports and two whistleblowing concerns which had been sent to CQC in June and July 2018 and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with eight people who used the service and three relatives'. We spoke with the regional director, temporary manager, two registered nurses, eight care staff, one activities coordinator, second chef, an administrative assistant and two housekeepers. We received feedback from two health and social care professionals who had contact with the service.

We looked at a range of records which included the care records for 12 people, medicines records and recruitment records for seven care staff. We looked at a range of records in relation to the management of the service, such as health and safety, minutes of staff meetings and quality assurance records.

Following our inspection, we liaised with the local authority and local commissioning groups to provide feedback on our findings and gain their views on the service.

We last inspected the home in November 2015 where no concerns were found. The home was rated as good in all domains.

Inadequate

# Is the service safe?

## Our findings

People and their relatives told us they felt safe. However, some people raised concerns regarding staffing levels and told us there were not always enough staff present to support their needs. One person told us, "I think staff numbers could be improved. On the whole well looked after but have to wait for calls. Not always quick, so when you press your buzzer you not sure who's coming and when". Another person said, "There are more now than when I first came. I was told there were the right number for what there should be. They get fewer when it's holiday time". A third person told us, "Sometimes I think they are short of staff during the day but if you employed more you'd have to pay more". Other comments included, "I think they're getting short staffed here". A relative told us, "I want [person's name] to be safe and secure. I want the best care for [person's name], but often when I phone in the morning [person's name] had a bad night". Another relative said, "I believe they are improving staff ratios. I have raised several things with social services who have sent a social worker in". A health professional told us they were aware of, "Multiple concerns of neglect presently, not enough staff to meet client's basic needs and apparent push on the part of company directors to maximise occupancy without increasing staffing. Concerns that the increased staffing presently is a response to current large safeguarding enquiry and not a long-term commitment to ensuring the safety of their residents".

On 24 July 2018, we received information from the local authority about concerns which had been raised with them about the staffing levels in the home. The provider had acted following the concerns and had increased staffing levels, by an extra staff member in the day and an extra staff member at night which had been in place for just over a week. Staff told us this made a big difference. However, the provider did not have enough permanent staff especially at nights and were in the process of recruiting new staff to cover permanent posts. During this time a high level of agency staff were deployed throughout the home, about which we received mixed responses from people and staff. For example, on the 02 and 03 August there were three agency staff working nights and only one permanent night staff member. Staff felt very unsupported as a result of this lack of permanent staff.

Even though staffing had been increased following the concerns by the local authority, staff told us there were not enough staff deployed to care for people safely. One staff member told us, "We were short staffed before, which is why everyone is so stressed. Atmosphere was horrendous, everyone so unhappy. Too busy to record on charts. Could still do with more staff, so feeling that you haven't got to rush, so could sit and talk to residents". Another staff member said, "Staffing has been hard. Increased staff has made a big difference. Was really challenging constantly trying to do our best and not achieving it. Difficult. Just kept being told working to Dice [the provider's staff dependency assessment tool]". Other comments included, the safety of the resident and their wellbeing is my main priority, but sometimes we don't have time. We were short staffed until recently so all we did were tasks. Obviously, you do the best you can".

Staff were constantly busy and spent little time with people who needed more support or monitoring to keep them safe. Staff carried out checks on people in their bedrooms as required by the care plan but these were quick with little interaction between the member of staff and the person. When we asked staff the purpose of these checks, one staff member said, "Just to make sure they are ok, I am not really sure". Staff

did not have the time to give people the social interaction they needed, as they were required to immediately return to assist others in the communal areas. One person who was unable to leave his room told us, "I feel lonely here sometimes".

Insufficient staffing levels meant that staff did not have time to respond to all of people's needs. For example, for one person, a physiotherapist had left exercises for them to complete with the support of staff to improve their quality of life. Staff told us they didn't have time to complete the exercise and one staff member said, "We are too busy, the exercise is helping him sit in the chair". We spoke to the person who confirmed they have not completed the exercises.

For another person they had a catheter bag which should be changed weekly. Records showed it was only changed once in March and once in April and nothing recorded for May or June. This meant the provider could not be assured if the catheter bag was being changed to prevent the person from being at risk of infection. We saw other records with large gaps in all aspects of care including turning charts. One staff member told us, "We would turn people but quickly. Sometimes six hours instead of four". Staff told us they completed care for people but did not always have time to record the actions taken. We have written more about records in the well led section of this report.

We received information from the local authority that staff were not able available to meet the personal care needs of people such as having a regular bath or shower. We asked people if they were able to have a bath regularly. One person said, "Usually every, Thursday morning". We saw there were three communal bathrooms and shower rooms in the home. However, two of these were used for storing hoists and other manual handling equipment and shower chairs. This meant that only one bathroom/shower room was available for the 42 people living at the home. we only saw a couple of showers take place and most people had a wash in their bedroom. At the time of our inspection the weather was extremely hot as we were experiencing a heat wave. Staff told us a rota was in place for baths and it worked out that people could have a bath or shower once a week or could request one if they wished. However, staff told us they didn't have the staff in place to offer more frequent baths or showers. Staff told us before the increase in staffing levels people would continue to receive personal care up to the middle of the afternoon. With the new staffing levels, we saw and staff confirmed, people were still being supported to get dressed and receiving personal care up to lunch time.

We also received information from the local authority that staff were moving people on their own where people had been assessed as requiring two members of staff to support them with moving. One person told us, "There is one particular lady [staff member] who does it [moves me] on their own, we somehow manage. They have been doing it for a very long time". This put both the staff member and the person at extremely high risk of harm, and is not in line with manual handling regulations and best practice, or their moving and handling risk assessment. One staff member told us, "I thought staffing was unsafe. Residents were misled of expectations, we couldn't meet resident's needs". Another staff member said, "Fear for myself as well as under pressure and cutting corners, to get it done".

We were contacted by ex-members of staff before the inspection through the whistleblowing process. Whistleblowing is where staff can report poor practice without the risk of recriminations. They were concerned about the safety of people living at the home and the shortness of staff especially at night. We spoke with someone who contacted us with concerns who used to work nights and said they left as they felt nights were so understaffed it made it very unsafe and that night staff were leaving as they were worried about people's safety. We also spoke with current staff. One staff member said, "I used to do work nights it would be just be three of us [staff members], just couldn't do it all. I've come off nights, as no support at nights. Only two permanent staff at night now". Another staff member told us, "On Sunday night agency staff

didn't turn up as double booked and [temporary managers name] said they couldn't get anyone else. So, I had to work on my own, working on two floors top floor and ground floor. One floor ten people the other floor eleven people on my own".

People also told us about their concerns at night due to the levels of staffing. One person told us, "If it's change over time in the evening they are very slow but they come as quickly as they can". Another person said, "It's agency staff at night. This floor is like the forgotten floor. We always get agency". A relative told us, "Three or four night carers have left this year".

Night staff told us their concerns with call bells not always being effective at night. One staff member told us they felt there seemed to be a delay in the nurse call system being switched to night mode. They said, "I don't think it's set right as if [I'm] on the bottom floor can't hear the top floor buzzer till about 8.30, not sure of actual time, but a delay in coming through as residents had said they called and it hasn't come through or heard". They also told us they have to prepare breakfast trays and wash up cups and deliver trays to the floor which means that when in the kitchen they cannot hear if people are calling for assistance. They said they used to have pagers but these are now broken or have disappeared.

On the second day of our inspection there were only one housekeeper available to clean the whole three floors of the home due to staff sickness and annual leave. We spoke with them and asked how they could clean the three floors of the home on their own. They told us they just emptied the bins and cleaned bathrooms and only hoovered rooms that needed hoovering. The rota showed that there was only one cleaner at the home for the following three days after our inspection. The Tuesday before the inspection there was no cleaner available all day. We spoke with regional director and temporary manager about our concerns who told us it was short notice and there were no agency staff available to cover.

The home had a business continuity plan in case of emergencies. This covered a range of eventualities for laundry, cleaning, IT, loss of documents, personal care and medicines etc. However, for cleaning of resident's rooms and communal areas. The plan states the minimum staffing levels with what they could still maintain some form of activity with was one staff member. This meant the home were providing unsafe levels of staff to keep the home clean and protect people from the risk of infection. We recommend the home puts in plan a continuity for replacement for domestic staff.

The provider had failed to deploy sufficient numbers of staff in order to meet people's needs and keep them safe. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Staffing.

Risks to people were not always identified and managed effectively. A health professional told us care plans did not always have information on how to manage risk, such as choking. For one person they had fallen out of bed so bed rails had been put in place without the full assessment completed. Bed rails can result in further risk and should only be fitted with a comprehensive risk assessment completed detailing what other measures have been considered and that bed rails is the safer alternative. When fitted they should be regularly reviewed to ensure they are still safe for use and it is still the safer option. Records showed for one person this had not been completed and no other options had been considered. No reviews had taken place since they were assessed in March 2018 and these records were usually reviewed monthly. A health professional told us care plans did not always have information on how to manage risk, such as choking

People were not always able to call for assistance in an emergency. A relative told us, "Due to [person's name] medical condition [person's name] isn't able to use a usual buzzer. We brought their buzzer from the previous home. [Person's name] was two weeks without a buzzer and then it took them one week to hitch it

up."

Staff did not always support people to be safe at night. One person told us they felt unsafe. Due to their medical condition they must be regularly turned from side to side to help prevent pressure areas on the skin break down. They informed us the previous evening they had been asleep after they were turned and then woke up due to a noise in the middle of the night, they went to check the time and noticed the table wasn't moved next to them so did not have access to the emergency call bell. This meant if they had an emergency in the night they were unable to call for help. However, records showed that staff had ticked on the hourly checks records that the call bell was in reach and it wasn't, which meant records were not kept accurately.

The provider did not have an appropriate system to assess and analyse accidents and incidents across the home and lessons were therefore had not learnt from them. Staff were not recording or reporting to senior staff all accidents and incidents that occurred meaning they could not be reviewed and any trends or patterns identified. This also prevented any action being taken to reduce the risk of repeat incidents. We could also not see any records to show that people had been referred to the falls clinic to help people manage their falls and keep them safe.

We could only see records of accidents and incidents for May, June and July 2018. The temporary manager told us this was all the records they could find. Records showed there had been a high number of people falling in the home resulting in bruising, head injuries and skin tears. Some of these falls had been while people were trying to get to the toilet and knocks from hoists and wheelchairs. One staff member told us, "A few weeks ago I came in early and saw [person's name] on the floor as they had been left on the commode for a long time, and after 30 minutes of waiting tried to get and slipped off. I pressed the bell and help came. It's so frustrating as we all knew you were coming in [CQC] so extra staffing put in place and it should have been done before." This showed the impact staffing had had on people living at the home with delays for the toilet and rushing personal care.

The risks associated with people's care had not always been identified and actions taken to mitigate these. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Safe care and treatment.

People's medicines were not always managed safely. A number of medicine administration records (MAR) had missing signatures. The MAR chart provides a record of which medicines are prescribed to a person and when they are given. Staff administering medicines are required to initial the MAR chart to confirm the person had received their medicines. For example, one person's medicines were not given and this was not recorded as the person was too sleepy but when we spoke to staff they could not explain why it was not offered when they were not asleep. One relative found a tablet by her mother's bed on the first day of our inspection. This was handed over to staff to investigate and we informed the regional director and temporary manager.

An external audit for medicines had been completed by a pharmacist. Records showed for one person that handwritten records should be signed by two staff members. This is in line with good practice guidance issued by the National Institute for Health and Clinical Excellence (NICE).

For people who required their drinks to be thickened with a prescribed thickener to reduce the risk of aspiration, they were prescribed individually and kept securely. However, prescribed thickeners were not used for individuals. For example, one staff member told us, "We get this from the nurses and we use this". They showed us one tin that was prescribed for a person. We asked them if they use this for all people and they replied, "yes". Another staff member said, "Share thickener, names don't match up, gets used for each

one". The registered nurses told us and showed us individual prescribed tins, so this should not be happening.

Failure to ensure the safe and proper management of medicines is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Safe care and treatment.

There were up to date policies and procedures in place to support staff. Where people had been prescribed medicines to be given 'when required' (PRN) protocols were in place. There were instructions for staff about giving medicines people could take as and when they were needed; which ensured people had prescribed access to pain relief or laxatives, with suitable spaced does. One person had a self-assessment for self-medication and was supported to do this. Only authorised staff had access to medicine. Staff was aware of good practice guidelines and were able to explain these to us.

Suitable checks were not always made to ensure the building was safe. Safety checks were conducted regularly of gas and electrical equipment. However, weekly and monthly fire checks were not always carried out to ensure people were kept safe. Records showed the last weekly fire tests were completed on the 26 June 2018 and monthly checks of fire doors, escape routes and emergency lighting had not been completed for July 2018. With the last check on escape routes recorded at the beginning of May 2018. Guidance issued on fire safety for care homes states, 'test fire detection and warning systems weekly following the manufacturer's or installer's instructions.'

Individual personal emergency evacuation plans (peeps) were not in place to keep people safe. These should be detailed and reviewed to show assisted means of escape and evacuation strategies with escape time and travel distances. They should detail the level and type of assistance each individual needed which may include, if accommodated on the first or second floor, an evacuation chair. Not all staff seemed aware of this, and some staff seemed unsure of where the designated fire points were.

The provider's fire policy stated that all staff should attend four fire evacuation drills annually. This was also highlighted on the fire risk assessment as an action; that more fire evacuation drills needed to be take place. One staff member told us, "I've done a fire drill in another home but not here. Wouldn't know what to do. I always said what would the residents do". Another staff member said, "I think I know where to meet, not really sure. In fire training not gone through peeps. Not seen any peeps". Records showed that two fire evacuation drills taken place but only a few staff had attended one and not all the staff had attended the second evacuation. The training matrix also showed that some staff were out of date with annual for safety training, including 'evacuation drills'. The provider had not ensured that staff would be competent in the event of an emergency evacuation.

The failure of the provider to ensure that the risk to people was minimised in the event of an emergency or evacuation meant that people had been put at risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Safe care and treatment.

Infection control practices were not always safe. An infection control audit was completed in March 2018 which showed improvements were needed in infection control. All care homes are required to have an infection control lead in line with the Department of Health code of practice on the prevention and control of infections and related guidance. Records of the audit showed the service had appointed a named bank nurse when available to take the lead. An infection control lead is someone with appropriate knowledge and skills to take responsibility for infection prevention and cleanliness. However, they were unable to provide formal training and not all staff at the time of the audit had received infection control training. An action plan was produced following the audit which stated staff required in-depth knowledge on infection control

and to identify further infection control leads and champions. We spoke with the temporary manager who told us infection control actions had not been completed yet and an infection control lead or champion has not been appointed. They were aware of the concerns and planned to appoint an infection control lead soon.

The provider put preventative measures in place where necessary, for example, ensuring the adequate provision of personal protective equipment (PPE) for staff, such as aprons and gloves. However, we noticed there were not bins provided in all communal bathrooms to dispose of PPE. We saw examples of rooms where people were sitting on stained and unclean equipment. Access to the hand washing sink in the laundry was blocked on the first day of our inspection by a spare cleaning trolley, but later removed when we brought it to the attention of the temporary manager. A store room on the middle floor next to the care office containing a cleaning trolley with chemical stored on the trolley was unlocked. This had a keypad in place for staff to secure the cleaning chemicals. However, on both days of the inspection we found this to be unlocked. This presented a risk for people living with dementia.

Recruitment processes were followed that meant staff were checked for suitability before being employed in the home. Staff files included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records checks) to make sure staff were suitable to work with vulnerable people. However, there were a couple of unexplained gaps in staff employment history, which had not been explored by the provider.

Staff we spoke with had the knowledge and confidence to identify safeguarding concerns and told us they would act on these to keep people safe. A safeguarding policy was in place and support staff were required to read this and complete safeguarding training as part of their induction. Staff were knowledgeable in recognising signs of potential abuse and the relevant reporting procedures. One staff member said, "I have done my safeguarding training and I have no problems reporting anything wrong. I know what to do". However, when we went to review safeguarding concerns we found the safeguarding folder to be empty. This meant we could not be assured people were being protected from abuse and monitoring checks were not in place to safeguard people.

People benefited from staff that understood and were confident about using the whistleblowing procedure. Whistleblowing is where a member of staff can report concerns to a senior manager in the organisation, or directly to external organisations. One staff member told us, "Raise to manager or whistle blow, poster in staff room". Another staff member said, "I know my residents, and I would have no problem whistleblowing if I saw something wrong. I care, I wish I had more time to spend with them".

Requires Improvement

# Is the service effective?

## Our findings

People told us they felt happy living at the home. One person told us, "I am well looked after physically. I find things couldn't be better". They also told us, "I'm not a great meat eater but I can have fish every day". Staff felt they offered people support to choose how they lived in the home although they did not always feel they were supported in their own roles.

However, all the staff we spoke with told us they felt unsupported and had not received supervisions or appraisals for several months. One staff member who had been at the home for six months told us, "No supervisions. I haven't even had my twelve-week probation yet". Another staff member said, "Supervisions we have had them in the past. I've been here a long time and not had many checks since I've been here. It depends on how busy we have been, morale is so low". Other comments included, "One supervision once, it was quick let's sit down in the office". As well as, "Supervision, haven't had one in a long time". Supervisions (one to one meetings) are meant to provide an opportunity to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and learning opportunities to help them develop.

The providers policy stated staff should have access to a supervision meeting for a minimum of six times a year. We saw some records in staff members' files but these dated back to October 2017. We spoke with the regional director and temporary manager who informed us they were in the process of completing staff supervisions and had carried out a few group and individual supervisions in July 2018. Following the inspection, we were sent an action plan for staff with monthly supervisions booked in to support staff for the next few months.

Training was not always effective to meet the needs of people living at the home. Even though the home is not a specialised dementia home there were people living with dementia at the time of our inspection. One staff member told us there was, "No dementia training for staff and a few residents are now living with dementia". Training records showed no dementia training was in place for staff. The regional director and temporary manager told us dementia training was included during training induction. However, this meant staff who were not new to the service had not completed training for people living with dementia.

Training was refreshed annually but some staff thought the training needed to be improved. One staff member told us, "Training refresher every year that lasts three hours meant to be from 10 – 4 moving and handling refresher awful, wasn't a room available, so we couldn't do any practical just watched a power point presentation. Never completed first aid. Lots of training fitted into refresher day". Another staff member said, "All the catch-up refresher training is done in a few hours, sometimes we need more time". The provider also provided staff with e-learning training. One staff member told us, "I need to catch up on some training I've got some e-learning which I don't like".

The lack of effective supervision and training for staff meant the provider could not be assured people received care from staff who had the right skills and competencies to meet their needs effectively. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014;

Staffing.

Registered nurses were supported to develop skills and ensure they were up to date with practice to meet the requirements of their registration with the Nursing and Midwifery Council (NMC). Registered nurses told us their training was comprehensive and up to date. However, we found their knowledge of Deprivation of Liberty Safeguards and the Mental Capacity Act 2005 (MCA) to be limited.

Most of the people supported by staff had capacity to make their own day to day decisions. People told us that they made their own decisions and that staff respected these and carried out their instructions. Records showed staff had received training in relation to the MCA. The MCA provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. However, when we spoke to staff not all staff had the understanding and knowledge to support people. One staff member told us, "Never heard of the MCA or know what it is".

Care records demonstrated that staff did not understand the MCA. For one person, we found a capacity assessment and best interest decision had been made for one person who had capacity but lacked communication skills. This is contrary to the MCA. The person could have made the decision for themselves if the assessment had been completed in a way that they could understand and contribute to. Staff failed to seek consent from this person to provide care because the person was unable to communicate with them verbally.

Failure to seek consent is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Consent.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application for this in care homes is called the Deprivation of Liberty safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of our inspection the regional director and temporary manager were unsure which people had been considered for DoLS and if any applications had been sent and these were in the process of being looked at. A health professional told us, "We have identified clients who should be considered for DOLs but whom the provider have not requested an assessment".

Failure to act at all times in accordance with the MCA Deprivation of Liberty Safeguards; code of practice is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Safeguarding service users from abuse and improper treatment.

We received mixed views about food. One person told us, "Everything I eat is wonderful". Another person said the food was, "Not too bad". A third person said, "Food very good, you get two choices, you can get an alternative, one day I had an omelette". A relative told us, the food was, "Repetitive, it's a four-week cycle".

There was a choice of two meal options at lunch time. If people did not want the choice on the menu they could chose an alternative. The chef was aware that some people could change their mind or forget what they ordered and this was taken into account when preparing the food. People on specialist diets were identified. People were offered a variety of diets for their specific needs, for example, chopped, pureed, diabetic, low fat, low salt.

Care plans detailed the support people required from staff at mealtimes. This included any risks associated with eating and drinking. Several people had been identified as being at risk of choking and we saw that there was guidance for staff to follow about how to keep them safe. We saw that people with complex needs of eating and drinking were protected from risks. For example, one person who had difficulties swallowing food was being appropriately supported in line with their care plan. The service had arranged for the SALT team to assess the person. Records showed all actions had been applied instantly following this visit including the kitchen being updated of the person's requirements for a soft diet and a referral to a dietician.

During the inspection we looked in people's rooms to see whether drinks were available to them and within reach. We saw a drinks trolley going around the home in the morning and afternoon, with tea, coffee and fresh fruit and jugs of juice or water were in people's rooms. Most people had a drink by their bedside and most were in reach. However, we could not be sure people were always provided with the adequate provision of fluids. One person told us, "When the [staff members name who delivers drinks] has their days off on a Friday and Saturday, two weeks ago we didn't get any coffee. They don't seem to cater for people having holidays". We spoke to staff and one staff member told us they felt people got the food and drink they needed most of the time, but said they could not always be sure of this because sometimes staff did not always record when they had given people what they needed. A health professional also raised concerns and told us, "multiple concerns that clients were not being encouraged to drink fluids regularly throughout the recent heatwave".

We looked at one person's food and fluids chart and saw that their fluid intake was not always being recorded by staff. We spoke to senior staff who told us that they had little time to oversee monitoring records to ensure they were completed, and trusted staff to complete these. There were clear gaps in the chart and some sections were not completed. Staff did not always add up the fluid intake each day. Therefore, it was not easy for staff to identify whether people had received enough to drink each day to keep them hydrated. We have written more about records in the well led section of this report.

Daily morning meetings take place. These daily meetings were attended by heads of departments including housekeeping, administration, kitchen and nursing staff and were chaired by the manager. The purpose was to ensure that information was shared and acted upon where necessary. In addition to the meeting there were handovers between staff throughout the day and night to make sure that important information about people's well-being and care needs were handed over to all the staff coming on duty. However, staff felt these could be improved and were not always effective. One staff member told us, "I only work part time, there could be changes. Now handover happening, but think things still can be improved. I didn't know someone was on thickener. I only found out when the resident mentioned it to me today. It's only because I heard her coughing, so I asked and she said only when I drink". The staff member then checked it out and they were on thickener. This put them at risk of harm as they could have been given a drink without thickener.

People had not always received appropriate care to help them maintain their health and wellbeing. The local authority shared concerns with us about one person's care and wound management, and we looked at their records. Their assessment indicated the person was at high risk and had a large open wound on their leg as a result of a specific health condition and other associated conditions. Their care plan did not give specific details on the health condition and how staff should recognise and deal with any potential complications. We spoke with care staff and they were not aware of what the person's health condition was. We looked at records in detail and spoke with staff but there was no explanation for the delay of nearly three weeks until the tissue viability nurses were contacted to support the healing of the wound.

The lack of consistent and effective leadership and poor record keeping associated with peoples drinking

needs and wound management had not always been identified and actions taken to mitigate these was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance.

The environment had been decorated and accessorised to provide a positive and suitable environment for people who lived there. The home was also suitable to meet the physical care needs of people with wide corridors and doorways and bedrooms large enough for the use of any specialist equipment required.

Requires Improvement

# Is the service caring?

## Our findings

People and their relatives told us staff were generally caring and they were treated with kindness by staff. One person told us, "The staff are most helpful". Another person said, "The staff are very good indeed". Other comments included, "You can't beat them". As well as, "They are quite willing to look after you". A relative told us, "The staff here seem very nice". A health professional told us, "Impression I have from visiting the home is that there is a lot of caring staff, but they are disillusioned and concerned that because of staffing levels they are unable to ensure a safe and effective service".

However, people did not always experience care from staff who understood the importance of respecting people's privacy and dignity, due to lack of staff. One person told us, "Very good with [providing personal care to] men and privacy. They make me feel comfortable which is important". Staff would knock on people's doors and identified themselves before entering. They ensured doors were closed and people were covered when they were delivering personal care. However, staff did not always have time to promote dignity and independence, and people were left waiting a long time for personal care and needing to use the toilet.

People told us they were sometimes encouraged to use their pad instead of the bathroom if they needed to use the toilet. One person told us, "I wear a pad and then I don't have to bother them [staff]". Another person said, "I wouldn't say 'encourage' but I would have to ring more if I didn't use it". A relative told us, "At times there hasn't been enough staff to take [person's name] to the toilet when [person's name] has asked and [person's name] was told to wee into their pad. It certainly hasn't done [person's name] any good and such a lack of dignity".

We spoke to staff about our concerns who felt very upset that they didn't have the time to spend with people and support them with their needs. One staff member told us, "I wouldn't put my nan in here ever. I would not want her to wait for an hour to go to the toilet". Another staff member said, "Just been constant battle and not achieving everything you want. I like coming to work and want to talk to people and get to know them but haven't got time to do it". A third staff member told us, "A couple of months ago a couple of ladies died, sad as could have died on their own, as didn't have time to be with them. That's when it was bad". Other comments included, "I've seen a picture of care with a carer sat next to a resident with a cup of tea. Nice. I thought that was care, wish we could do that. I would love to sit and talk to residents. Would be nice to go for a walk in the garden with them".

People were not always introduced to new agency staff by staff and management to make them feel valued. Due to the lack of staff a high level of agency staff were being used in the home especially at night. One person told us, "Some of the agency staff don't wear uniform or a name badge. They don't introduce themselves. Recently a gent, in jeans and T shirt wearing a gold watch came in. Didn't introduce himself, no idea who he was. He really didn't say a lot". They also said, "Other agency carers have introduced themselves but sometimes there is a communication issue".

The provider had failed to ensure people were treated with dignity and respect at all times due to

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

When we spoke with staff it was evident that they genuinely cared for the people they looked after. For example, one staff member told us, "I always treat residents as my own relatives, trying to make life a bit easier for them". Another staff member said, "All the staff are lovely. Lots of staff have left". One staff member told us they brought biscuits on their way to work to offer variety and choice. They said, "I can't keep giving digestive biscuits and rich tea biscuits. So, feel I have to buy some as when I ask I get told budget this and budget that".

We observed some interactions between people and staff which were positive and friendly. Relationships were good between staff team members. Staff members were courteous, and friendly. Residents enjoyed talking to staff. All staff appeared to be enjoying their work, including the domestic staff who was cheerful and busy. Staff made us aware they did not feel valued or cared for by the management or the provider. One staff member told us, "I am expected to care for people and I do, I care the best I can, but who cares for me?". We saw staff being helpful and cheery to people in their approach.

Confidential information, such as care records, were kept securely and only accessed by staff authorised to view it. When staff discussed people's care and treatment they were discreet and ensured people's care and treatment could not be overheard.

Requires Improvement

# Is the service responsive?

## Our findings

People who were cared for in bed were at risk of social isolation due to the lack of activities and meaningful interactions. One person told us, "My day is waking up, wonder which staff I will have, being turned, sitting in the chair, back to bed, being turned, wondering whether I will have a good night depending on who is on duty". A relative said, "I wish they would just come and talk to him when I'm not here".

Organised group activities were held in communal areas in the morning and afternoon. These included, flower arranging, quizzes, bingo, games, PAT dog, music therapy and reminiscence. When we visited, the main lounge was being set up by outside visitors for a morning church service. However, this had caused some upset and confusion as the weekly newsletter of planned activities had advertised the church service for the afternoon and floor games for the morning. We heard one person say to a staff member, "Can you take me back to my room. I don't come to the church service. I didn't ask to come". We also spoke to one person who told us they would like to go to the church service in the afternoon and we explained that it was being set up now, so they were able to attend.

The provider employed two-part time activities coordinators, and on both days of our inspection one activity coordinator was providing planned activities. We heard the activity coordinator going into people's rooms asking people of they would like to join in the planned events. However, they had to bring people to the lounge on their own and leaving people whilst they went to collect other people. We observed one person nearly roll over one person's foot with their wheelchair and we had to intervene to stop them receiving an injury. We spoke with the activity coordinator who told us, "Tried to ask for more staff and hours but keep being told no, as no budget. I do 24 hours and [staff member name] does 30, as no money to do full time. When two of us, [person's name] does some pampering. On a Friday and a Saturday, I also help in the kitchen as no host [staff member to deliver drinks] so two things to do. I would love to do more. I would love to do meaningful activities".

For people who could not attend activities and were cared for in bed, no planned activities were provided for them. Some people we spoke with told us they were lonely and staff confirmed this. One staff member said, "We had one man so lonely just wanted to talk to someone, so lonely. Felt so bad, still not time to sit and talk to people". Another staff member told us, "[Persons name] only time they have company is when his wife is there". We spoke with the activities coordinator about the lack of meaningful activities for people in their rooms. They told us, "We do offer 1.1 activity, but hard when only one of us. Try to say hello, when give out newsletters".

People were at risk of social isolation due to the lack of activities and meaningful interactions available to them. The provider had failed to deploy sufficient numbers of staff in order to meet people's needs and keep them safe. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Staffing.

Whilst people's needs had been assessed prior to their admission to the home, these did not always contain enough detail and people's preferences, likes and dislikes, personal history, interests and aspirations were

not always explored. When we spoke with staff about people's opinions, strengths and levels of independence, it was clear they knew them. However, information was not recorded in care plans. We could not see if relationships were thought-out or if plans included cultural and sexual needs to ensure the person had the opportunity to reflect important relationships and needs if they chose to.

Care plans did not always provide information about how people wished to receive care and support and were not always followed by staff. A moving and handling care plan for one person, stated that they needed two members of staff and at times three members of staff due to their weight, with staff to assess the third person if needed. There was no clear guidance as to when the third person would be needed and why they would sometimes only need two staff members. We spoke to the temporary general manager who told us they were reviewing all care plans with support from the providers clinical lead.

Records and guidance needed to be clearer. For example, one person had a catheter but guidance did not provided sufficient information to allow staff to support the person safely. Their care plan stated to staff needed to change the catheter every twelve weeks, however the it did not contain guidance as to the action staff should take if the catheter was blocked, which if not treated could cause pain and infection and there no guidance for staff in how to monitor the person's catheter care. Records showed a gap between date due 18/02 and the change on the 28/05. Records were not always clear where staff should record this information. The registered nurse agreed this was confusing and said, "I am sure it's done as we change it regularly, but it would be useful if it was documented in one place".

We saw end of life care plans, although these could be more person centred to reflect psychological needs of dying. We were told that when people were at the end stages of their life, procedures were in place to ensure that people were cared for in a culturally sensitive and dignified way. If needed, we were told that people at end of life were encouraged to remain in the care home via the provision of any specialist equipment needed. People were supported by palliative care specialists such as hospice and Macmillan nurses and the GP surgery in the home if required.

The complaints policy was displayed in the entrance to the home. However, we were unable to review complaints as records were missing and no formal process of auditing complaints were in place. We saw a complaint from September 2017 on line which had been responded to. The temporary manager told us they were working on putting process in place to manage complaints effectively.

Inadequate

# Is the service well-led?

## Our findings

At the time of our inspection the registered manager had left the service the week before our inspection and the provider had appointed a temporary general manager for four months to manage the home. Feedback from people and relatives showed the service was not always well led. One person told us, "I don't see much of [outgoing registered manager name] but [outgoing registered manager name] is approachable". A relative told us, "[person's name] moved here from another home. We were assured by the outgoing registered manager that all needs could be met. It's been awful due to the management". They also told us, "Recently we had to buy a toileting sling because they couldn't provide one". As well as, "I have raised several things with social services who have sent a social worker in". A health professional told us, "The registered manager is currently not working, situation unclear but it was the case she was very stressed when I met her, evidence to show she highlighted concerns about staffing to regional managers who denied her request for additional staffing hours. Also, the case that pressure was applied to maintain high levels of admissions with no commitment to increasing staffing. Multiple recent whistle blower alerts from disgruntled ex-employees about morale and exhaustion". When we asked another health professional if they thought the service was well-led they said, "In my opinion at the present time no. It gave excellent care in the past which was shown in the care plans and evidenced in walk arounds I used to undertake, however at my last visit there was evidence of neglect and poor care plans".

All the staff we spoke with did not feel the home was well run and were clearly upset about the impact the lack of staff and support had on them and the people they cared for. They all told us they had been voicing concerns about the lack of staff and putting people at risk for many months. One staff member told us, "When we raised concerns about staffing, we were told, well we have enough". Residents asked about staffing and the [registered manager name] said to them, got enough". Another staff member said, "I voiced concerns to registered manager, said she would see what she could sort out. Hearsay was from higher management we had to come in on days off, as we weren't getting agency in. Morale with staff very low". A couple of times I went home and cried as not meeting people's needs". A third staff member said, "Management kept saying Dice numbers got enough staff for the whole of the home. I told them you need to be looking at needs of the people. As a lot of double ups and you need two people to sit people up. I heard of staff doing this on their own, which puts staff at risk".

Staff did not feel supported by the outgoing registered manager and provider and told us staff morale was low. One staff member told us, "No support from management at all, none". Another staff member said, "I don't feel supported. Bit disappointed with management at the moment". Other comments included, "Management not helpful at all. Staff are supportive but not management". As well as, "Don't feel cared for as a staff member".

Staff made us very aware they did not feel valued or cared for by the management or the provider. One staff said, "The last manager did, I know she tried to get more staff. She was very good. She listened. Then she disappeared and they got staff, but the horse has bolted. We are already tired". Although things seemed better now, staff were exhausted by the changes in management. However, during our inspection visit most staff told us they were beginning to feel more supported and cared for by the new temporary manager and

the provider. With one staff member telling us, "I've been to [temporary manger name] a couple of times, been helpful with agency staff".

Staff told us they did not feel listened to or valued as a team member. This was reflected in records we saw that a staff meeting was held for care staff in April 2018. This was not attended by any care staff and only the registered manager and deputy manager attended, yet it still went ahead. Staff meetings are an open forum amongst staff and are usually held to discuss concerns about people who used the service and to share best practice. Staff should feel part of a team and feel listened to and supported and able to contribute to ideas around the home. Meetings can also be used to reinforce the values, vision and purpose of the service. We were not shown any other records of recent staff meetings. Staff told us some staff meetings were cancelled and one staff member said, "Never had any staff meetings to know what's going on".

We saw some minutes from a registered nurses meeting in April 2018 which showed that actions were required on completing supervisions, appraisals and accidents and incidents were not being fully completed. At the time of our inspection a staff meeting was planned for the evening so the provider could listen to staff and update them on recent events in the home.

Residents' and relative meetings were held regularly where activities, maintenance, food and care and management were discussed. Minutes from a meeting in April showed a family member was happy with their mum's care but felt there was never a carer around when you needed one. A meeting from June showed one person was unhappy with the registered manager and said they don't see them and they never talk to us. The provider also sought feedback through the use of an annual quality assurance questionnaire which was sent to people living at the home and their relatives. The feedback from the latest quality assurance in September 2017 showed improvements were needed on staff having time to talk with people. An action plan had not been implemented on how to improve these improvements.

The provider and registered manager used a series of audits to monitor the service. These included, medicines, records and documents, dining experience, and daily walk around the home. However, these had failed to ensure compliance with the regulations, and where actions were recorded as needed these weren't acted on to keep people safe and improve the quality of the care. For example, records and documentation audits were completed monthly and showed gaps in records were not always completed for medicines, fluid charts, food charts, and repositioning charts. Also, that no life histories are in place in people's care plans. An action was recorded to remind staff via team meetings, however staff we spoke with had not attended team meetings and we could not see records that staff had attended meetings.

As part of the provider's audit process, managers are meant to complete a general manager daily walk round. We saw only two were completed for July 2018 which showed there were no activities for people in their rooms but no action plan as to why and what would be put in place for people cared for in bed to prevent isolation. We also found no night's checks had been completed, which is where staff reported most of the problems from due to lack of staffing levels and permanent staff at night. The temporary manager informed us they plan to complete these.

An assessment of Legionella risk had been completed and this was last reviewed in June 2015. Where it made a recommendation that a new risk assessment is commissioned due to outstanding recommendations from a previous assessment and changes to legislation and guidance. This meant the service cannot confirm compliance with HSG274, HTM04;01 and approved code of practice and guidance L8 fourth edition. These set out duties including those in control of premises to help them comply with their legal duties in relation to legionella.

Audits had also not picked up concerns we had found, for example, the legionella water risk assessment, concerns with fire safety, staff supervisions and personal care. We looked at how long before maintenance issues were rectified when these had been reported. However, no dates were recorded just ticked when completed which meant the provider couldn't be assured these were rectified in a timely way to keep people safe and provide an accurate audit process.

Records were not always accurate, consistent or up to date. For example, one person's notes said they had their call bell in reach all night, when they told us clearly, they were turned in the opposite direction from the call bell and it was out of reach. We were shown a supervision matrix that showed all staff had received recent supervisions and no one was overdue. However, staff we spoke with clearly had not received these and we could see no records of recent supervision records to support the matrix. A bed rails recorded all assessments were fully completed and this was not the case as we identified a bed rail risk assessment had not been completed.

The provider did not have effective systems and processes in place to identify those incidents and occurrences that needed to be notified to CQC. All services registered with CQC must notify us about certain changes, events and incident's affecting their service or the people who use it. We use this information to monitor the service and to check how events have been handled. The service had not notified CQC about all incident's and events as required.

A health professional told us, "Lack of reporting of incidents is also a primary concern". The local authority has identified a serious wound that had not been reported in a timely manner and this was eventually sent in to us by the provider after being raised with the local authority. We received this serious notification three weeks after the event. During the inspection we also saw incidents of choking and falls resulting in head injuries that we were not notified about.

Accidents and incidents not always investigated or monitored to prevent reoccurrence or reported to us. For example, we saw incident's where people had fallen and hit their head but this had not been reported to us and we could see no records of monitoring following the injury. Staff we spoke with were not always sure what signs or symptoms they should be looking for and no guidance in place to support staff. This meant the service could not look for any themes or trends which could be identified and investigated further. It also meant that any potential learning from such incidents could not be identified and cascaded to the staff team, resulting in continual improvements in safety.

The lack of consistent and effective leadership, poor record keeping and poor governance in the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance.

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<br><br>Treatment of disease, disorder or injury | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider had failed to ensure that consent to care was always sought from relevant persons. |

**The enforcement action we took:**

We have imposed a condition on the provider that they must send us an action plan each month

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The Provider had failed to ensure people were kept safe from harm. Systems to identify, assess and mitigate risks were ineffective. |

**The enforcement action we took:**

We have imposed a condition on the provider that they must send us an action plan each month

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The provider had failed to ensure their systems and processes were effectively operated at all times in accordance with the MCA Deprivation of Liberty Safeguards. |

**The enforcement action we took:**

We have imposed a condition on the provider that they must send us an action plan each month

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had failed to operate effective systems and processes to assess and monitor the quality of the service and to identify and mitigate risks. Records were not always accurate and completed. |

**The enforcement action we took:**

We have imposed a condition on the provider that they must send us an action plan each month

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider had failed to ensure sufficient staff were deployed to meet peoples needs. The provider had failed to ensure staff had been supported through supervisions and meetings |

**The enforcement action we took:**

We have imposed a condition on the provider that they must send us an action plan each month