Monarch Consultants Limited

Parkside Nursing Home

Inspection report

Olive Grove
Forest Town
Mansfield
Nottinghamshire
NG19 0AR

Tel: 01623655341

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Parkside Nursing Home is a care home that provides nursing and personal care for up to 50 people in one purpose-built building. At the time of the inspection 32 people lived at the home, including people living with dementia.

People's experience of using this service and what we found
People were not protected from the risk of harm or abuse. Not all staff knew how to report or who to report safeguarding incidents too. Medicines were not managed safely, and people did not always receive their prescribed medicines on time. Risks associated with people's healthcare needs had not always been assessed and risk reduction measures were either not in place or not followed.

Infection control practices were not in line with current guidance and did not protect people from risk of harm, lessons were not learnt which resulted in incidents being repeated. Safe recruitment practices were followed.

People did not always have their needs fully assessed and care was not always delivered in line with best practice guidance and the law. This left people at risk of receiving unsafe care. People were not always offered choice in what they wanted to eat, or drink and risks associated with eating and drinking were not always managed appropriately.

People were not always supported by competent staff. Staff had received training, however, they did not always implement training into practice in areas such as moving and handling and behaviour management.

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.

People were not provided with consistently kind and caring support, they were not always given choices or consulted with about their care. Staff did not always support people in a dignified way, and they did not always acknowledge people who required support. Staff did not always communicate with people respectfully.

The leadership, management and governance measures did not provide assurances the service was well led, and that people lived and were cared for in a safe environment. Lessons were not being learnt and this resulted in a pattern of incidents which placed people at risk of harm.

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

Rating at last inspection

The last rating for this service was good (published 6 May 2021).

Why we inspected
We received concerns in relation to the management of medicines, people's nursing care needs, management of behaviours that may challenge, staff training and overall management of the service. As a result, we undertook a focused inspection to review the key questions of safe, effective, caring 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.
We reviewed the information we held about the service. No areas of concern were identified in the other key question. We therefore did not inspect it. The rating from the previous focused inspection for that key question was used in calculating the overall rating at this inspection.
The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the key questions safe, effective, caring and well led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Parkside Nursing Home www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to keeping people safe, risk management, medicines, infection control, staffing, care planning, maintaining people's dignity and governance at this inspection.

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.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Parkside Nursing Home

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 Care Act 2014.

Inspection team
The inspection was carried out by three inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Parkside Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

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. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
On 3 August 2021 we spoke with fourteen staff members including a senior clinical manager, nurse support,

registered nurse, care workers, agency care workers, kitchen staff, housekeeping staff and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with three people who used the service and two people's relatives. We observed interactions between staff and people. We reviewed a range of records. This included multiple medication records. We looked at five staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including concerns and complaints were reviewed.

Following this visit to the service we sent a letter to the provider outlining the concerns we found during the inspection, which they responded to with a detailed plan of what action they would take.

On 9 August 2021 we spoke with nine members of staff including care workers, housekeeping staff, kitchen staff, agency staff, and the registered manager. We spoke with two people who used the service. Some people were not able to fully share with us their experiences using the service. Therefore, we spent time observing interactions between people and the staff supporting them in communal areas.

We contacted three relatives to ask about their experience of the service. We contacted a further three staff to ask them about how they cared for people and their experience of working at the home. We sought further information from the provider, that we were unable to review on site, to inform our inspection judgements. This included eleven peoples care records, staff training information, staff rotas and policies.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with two professionals who regularly visit the service.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- There were not robust systems in place to protect people from the risk of abuse.
- Whilst staff received training in safeguarding most staff, we spoke with did not know how, or who, to raise safeguarding concerns too. We observed one incident which staff failed to recognise as abuse. A person who wanted and was able to get up and walk was physically restrained by staff and stopped against their will. There were no records in place to support this practice. This practice placed the person at risk of abuse.
- People told us they felt some staff were "rough" and was often left without their call bell so they could not call for help when needed. Our observations supported this during our inspection as the person was found to be nursed in bed with the call bell out of reach.
- The provider did not ensure safeguarding concerns were always recognised, recorded or reported on appropriately to the local authority safeguarding team. This placed people at risk of abuse.

The provider failed to ensure that people were protected from abuse and improper treatment. This was a breach of Regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Assessing risk, safety monitoring and management

- People were not protected from risks associated with their needs.
- Management of risk to people's safety from falls, pressure sores, and behaviours were not effectively managed. Although some risks had been assessed, care plans were not clear and not all staff were aware of how to access information relating to people's needs.
- Risks associated with pressure area care were poorly managed. For example, care plans directed staff how often to reposition people in order to prevent pressure damage. Care records we reviewed evidenced that one person who lived with significant pressure damage was not repositioned in line with their assessment; this placed them at risk of avoidable harm and further breakdown of skin integrity.
- Risks associated with people's health, which resulted in people displaying behaviours that may challenge, were not effectively managed. For example, during our inspection we observed three incidents none of which were recorded; this meant not all staff were aware of these incidents or the risks these behaviours posed to staff and other people living at the home.
- Food was not stored safely or correctly. Fridge items had not been dated when opened, this posed a risk of out of date food being given to people. Food substances such as sugar and potatoes had been emptied into dustbins which meant there was no information regarding dates of opening or when they should be used by.

Using medicines safely

● Medicines were not managed safely.
● People did not always receive their prescribed medicines on time. We reviewed three incidents where people had not received medicines for diabetes, blood pressure and pain relief as the service had ran out of these medicines. This placed people at risk of harm.
● Medicines administration records for four people did not contain any information in how they liked to take their medicines. This included people who refused their medicines regularly. This put people at risk of not receiving their medicines according to their wishes.
● Equipment used in administration of medicines posed a risk to people. For example, aids used in the crushing of medicines had not been cleaned and had both fresh and embedded dust from medicines present. This meant people could inadvertently be given medicines not prescribed for them which placed them at risk of harm.
● People did not always receive their medicines in line with best practice guidance. We observed staff administering medicines without their consent to one person without the correct authorisation or instruction. This was fed back during our inspection and the provider sent information after our visit to demonstrate they had taken action.

Preventing and controlling infection
● People were at risk of infection due to poor infection prevention and control practices.
● Best practice guidance was not consistently followed to help reduced the risk of COVID-19. For example, we observed a number of staff to not wear personal protective equipment (PPE) in line with current guidance.
● There was a large number of temporary agency staff working at the home. There was not a system in place to ensure agency staff had tested negative for COVID-19 prior to commencing work at the home which could increase the risk of possible transmission of COVID-19.
● Staff did not practice effective hand hygiene when supporting people. We observed multiple staff supporting different people, during lunch and medicine administration rounds, without sanitising or washing their hands. This placed people at risk of harm.
● Not all areas of the home were clean. For example, areas such as kitchenettes were visibly dirty, there was rust present in microwaves which meant they could not be cleaned effectively.

Staffing and recruitment
● The provider did not ensure there were suitably trained staff to meet people's needs safely.
● There was a lack of consistency of staff and they were not always provided with the information relating to people's needs. This placed people at risk of harm.
● Staff explained due to increased agency staffing in place, they felt people were at risk of harm. Staff told us, "Every day I am with someone new, they don't know people's needs and I'm on my own with all agency staff, I feel like I am letting people down, I just can't do everything".
● Unsafe deployment of staff meant people were at an increased risk of not having their needs met.

Learning lessons when things go wrong
● The provider did not effectively monitor and learn from accidents and incidents.
● Incident forms were poorly completed, and they lacked a staff de-brief or managers follow up. Lessons were not learnt as much of the information was not reviewed.
● There was a lack of analysis of incidents, which resulted in repeated incidents, and this placed people at risk of harm.

The provider failed to ensure that people received care and treatment in a safe way and protect them from risk of harm, this is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

● The provider had safe recruitment processes in place. All staff had checks to ensure they were suitable to work at the service.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People were at risk of receiving unsafe care as their needs had not always been fully assessed. Not all people received a detailed assessment prior to moving into the service which left them at risk of harm.
- People's assessments contained contradictory information about their needs. For example, one care plan we reviewed stated a person was continent of urine whereas other records reflected the person was incontinent and required assistance with their continence needs.
- Care plans were not updated when people's needs changed. One person's wound care record had not been updated to reflect a wound that had deteriorated and what action staff were required to take.
- Feedback we received from relatives detailed they had not all been involved in the care planning process. For example, one relative told us, "They never ask or contact me in relation to my [relative], I don't feel [they] are safe or are cared for in a way they would want".

Failure to provide care in line with people's assessed needs placed people at risk of harm. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

- Not all staff received an induction into the service. This placed people at risk of harm.
- Not all agency staff working at the home during, our inspection visits, received an induction. Agency staff were observed supporting people with nutrition needs. However, when speaking with staff they were unaware of the person's name or needs. Agency staff and some permanent staff told us they did not know how to access care plans for people
- Whilst staff received training in areas such as moving and handling, we observed that this was not effectively put into practice as we observed a number of unsafe moving and handling techniques which placed people at risk of harm.
- Records we reviewed, evidenced care staff completed wound dressings and assessments. Staff training files we reviewed did not demonstrate they had been trained or competency assessed in areas such as aseptic technique to provide safe care.
- Staff did not always feel supported and felt they could not approach management. Staff told us, "I can't approach [management] when I have in the past I have been ignored and told to just get on with things".

Failure to ensure staff were competent to provide safe and effective care was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We fed our concerns back to management team within the home and action was taken.

Supporting people to eat and drink enough to maintain a balanced diet
● Risks associated with eating and drinking were not always effectively managed.
● People were not always offered choice in what they would like to eat, or drink and we observed food being left in front of a sleeping person. Food was left for over an hour before the person was awoken.
● A large number of nutritional supplement drinks that had been prescribed for one person which had been dispensed in June 2021 were found in the kitchen pantry, staff we spoke with were unaware they had been placed there. This leaves people at risk of not receiving their supplement drinks.
● Where people were at risk of malnutrition, risk assessments detailed that amounts of food eaten was to be recorded. We found gaps in the records of the people we looked at. This placed people at risk of malnutrition.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People's health needs were not managed safely or effectively.
● Care plans did not contain sufficient information relating to people's health needs. For example, one person lived with a complex medical condition, care plans did not adequately direct staff how they should support that person. Another care plan, we reviewed for a person living with diabetes, lacked information relating to diabetes management. This placed people at risk of receiving unsafe care in relation to their healthcare needs.
● Records we reviewed detailed that people had been referred to specialist healthcare services, but records were not always clear as to when referrals had been made.
● The service sought advice from healthcare professionals however this advice was not always followed. For example, we reviewed a number of records whereby specialist advice from the Speech and language therapy team in regards to the consistency of food had not been followed. This placed people at risk of receiving food at incorrect consistency, placing them at an increased risk of choking.

Adapting service, design, decoration to meet people's needs
● Many bedrooms we observed were found to be bare and not decorated to individual taste or needs.
● We found there was no hot water in some areas of the home on the first day of inspection. Staff told us, "We've never got any hot water, it's ridiculous we can't support people with cold water". We fed this back to management and the issue was resolved.
● There was a sensory room which was being used to store wheelchairs, so people could not access this.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● People's rights under the MCA were not always respected and where people lacked capacity to consent, mental capacity assessments had not always been completed for specific decisions. For example, we found that not everyone had mental capacity assessments for the use of bed rails. This meant staff were unable to confirm if bed rails were needed or had been placed in their best interest to keep them safe.
● DoLS were in place when required and conditions documented.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Respecting and promoting people's privacy, dignity and independence
- People were not always treated with dignity and respect.
- We observed a person to be laid on the floor in an undignified position and although a pillow had been placed under their head, they had rolled off this. We were advised that the person had placed themselves on the floor, however we noted the person to be laid on the floor for at least 1 hour and 35 minutes with no staff enquiring about their wellbeing and walking past them. We escalated our concerns to staff who dismissed our concerns, we found a second staff member who assisted the person.
- People's privacy was not maintained. For example, we observed a member of non-care staff and an external contractor enter the room of a person of the opposite gender whose door was closed without knocking. They entered the room, did not acknowledge the person or request consent to enter their room, they walked around the room, conversed with one another and left without acknowledging the person in the room.
- We observed people to be wearing clothes that were too small for them and relatives fed back they often saw their loved ones wearing clothes that did not belong to their loved ones.

Ensuring people are well treated and supported; respecting equality and diversity
- People were not always treated well or with respect.
- We observed a lack of interaction and engagement. Staff who were supporting people on one to one basis did not speak or engage in any conversation with the person.
- We observed a person who had been incontinent to be pointed out in front of all staff and people in the lounge prior to being assisted to change. This was undignified and did not respect their right to privacy.
- Some staff became very upset when speaking with us as they felt they could not provide care in the way they would like due to the staffing issues at the home.

The provider failed to ensure people were being supported in a caring, dignified and respectful way. This is a breach of regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The issues we found were fed back to the management team at the home and action was taken.

Supporting people to express their views and be involved in making decisions about their care
- We found little evidence that people had been involved in making decisions about their care.
- We found that people were spoken at, rather than too. We observed one staff member telling a person to

sit down as it was lunch time without asking whether they were ready to eat.

● Relatives told us they did not feel included in their loved one's care. For example, one relative told us, "I haven't had a good visit with my [relative] as they make me see them in the lounge, my [relative] becomes distressed in the lounge as they don't recognise it but they won't let me visit in [their] room, it would benefit my [relative] so much more.

● Feedback we received from relatives detailed they had not all been involved in the care planning process. For example, one relative told us, "They never ask or contact me in relation to my [relative], I don't feel [they] are safe or are cared for in a way they would want".

The provider failed to ensure people received care in a person-centred way. This is a breach of regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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.

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

- There was not an open and inclusive culture within the home which placed people at risk of harm.
- Not all staff felt they could raise concerns and when they did, they did not feel listened too. Staff told us, "I don't feel comfortable raising concerns, I have been told to keep my mouth shut, I am concerned for the wellbeing of people, but they [management] just don't listen".
- Relatives told us, "I am not involved or consulted in my [relatives] care, I get the same generic response every time I call, every time I ask the home they say everything is ok but they cannot tell me anything about my [relative], basic things like what they have had to eat that day".

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care;

- There was a lack of effective managerial oversight of risk. The internal quality assurance processes had not been used to monitor the service effectively which resulted in repeated incidents. They had failed to identify and improve shortfalls in care at the service.
- Audits were not effective in driving service improvement. For example, audits relating to infection control, the environment and the kitchen had not been consistently completed and when they had been completed they had failed to identify any of the shortfalls we found at inspection.
- Lack of managerial oversight of care records meant these were not consistent. Care plans did not provide staff with accurate information in order to support people safely. This risk was heightened due to the large number of agency staff in use who had never met many of the people they were caring for before providing support.
- The registered manager was not always aware of their legal requirement to notify CQC of events and incidents which impact people. Records we reviewed evidenced that there had been a delay in reporting a number of safeguarding incidents.

The provider failed to ensure that systems and processes were in place to improve the quality and safety of care in the home. This was a breach of regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulation 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

● Relatives told us they were not always informed when things went wrong, and communication was poor. For example, one relative told us, "I just can't cope with it, everything is a fight. Why can't they phone me for a change when something goes wrong, it's the not knowing that's the hardest and my [relative] can't tell me so I have to keep fighting for them".
● The lack of investigations following incidents, poor communication, delay in reporting of notifiable incidents and safeguarding concerns indicated the provider was not fully aware of their responsibilities under the duty of candour.

We fed back the issues we found in regards to duty of candour and the management team completed an action plan in order to address these shortfalls. .

Working in partnership with others
● The service provided information to the local authority and clinical commissioning group when required and had begun working with them in order to improve the service.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive personalised care and support which left people at risk of harm.

The enforcement action we took:

We imposed urgent conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always supported in a dignified or respectful way.

The enforcement action we took:

We imposed urgent conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at significant risk of harm from poor risk management and their environment. Medicines management was poor. Infection control practices were not in line with guidance leaving people at significant risk of infection during the pandemic.

The enforcement action we took:

We imposed urgent conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not ensure there were adequate safeguarding processes and systems in place to safeguard people from the risk of abuse and harm.

The enforcement action we took:

We imposed urgent conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not ensure there was effective leadership in place. There were not effective systems and processes in place to assess, monitor and improve the quality of care.

The enforcement action we took:

We imposed urgent conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure there was adequate staff with the right skills to meet peoples needs.

The enforcement action we took:

We imposed urgent conditions.