Mr Canabady Mauree

Boundary House

Inspection report

Haveringland Road
Felthorpe
Norwich
Norfolk
NR10 4BZ

Tel: 01603754715
Website: www.newboundariesgroup.com

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Boundary House provides accommodation, personal care and support for up to 16 people with a learning disability or autistic spectrum disorder. At the time of the inspection there were 15 people living in the home. There were 10 single bedrooms and shared facilities in one area which is known as Horizon House and six self-contained flats in the area of the home known as Boundary House. The home is in a rural location with a day centre and offices on the same site.

People's experience of using this service and what we found
People were not always receiving safe care and treatment. Allegations of abuse or harm had not always been reported to the local safeguarding team or the Commission. We could not be sure that these allegations had been dealt with appropriately or that action had been taken to prevent a reoccurrence. During the inspection we made safeguarding referrals to the local authority safeguarding team. People had not always received medical attention in a timely manner.

There was no effective oversight or management of incidents which had occurred. As a result, staff were placing themselves and others at risk. Incidents happened regularly and people were harmed. People's care needs, risks and behaviours were not always properly assessed or planned for. Care plans and risk assessments were not being followed by staff consistently. This placed people at risk of not receiving they support they required.

There were not always enough staff on shift to meet people's assessed needs. People told us that staffing shortages meant they couldn't always choose what they wanted to do or if they got to go out. Not all staff had training or competency assessments that had been renewed as required by the providers training policy. Staff had not received regular supervisions or annual appraisals and often relied on their colleagues for support and guidance rather than the management team.

Infection, prevention and control measures were not being followed to prevent the spread of infections. Hazardous chemicals were not always securely stored. Testing of the fire equipment such as alarms, emergency lighting and fire doors had not been carried out regularly. This put people's health and safety at risk.

Some areas of the home had furnishings that were worn and dirty and not fit for purpose. The shared areas of the home were not homely.

People were not supported to have maximum choice and control of their lives and staff did not always 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. We saw records that one person had been physically restrained by up to five members of staff. Deprivation of Liberty Safeguards had expired and had not been renewed when needed for some people.

There was a lack of oversight and governance over a prolonged period. The provider had recognised that there were areas that needed improving and were keen to take action.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

This service was not able to demonstrate how they were meeting some of the underpinning principles of Right Support, Right Care, Right Culture.

Right care:
• The care and support provided did not always meet the needs of people with learning disabilities. Staff did not receive the training needed on how to meet the needs of people with learning disabilities and autism, so they did not have the skills they needed to provide appropriate support.

Right Support
• People's care wasn't person centred or planned with people having choice and control over how their health and care needs were met. Care plans were not consistently followed. People were not always cared for in a safe and consistent way.

Right culture:
• The ethos, values, attitudes and behaviours of leaders and care staff did not always ensure people with learning disabilities led confident, inclusive and empowered lives. This was because there was a lack of leadership and oversight. The service was not person centred, open and inclusive nor did it always achieve good outcomes for people. People's human rights were not always respected; people had been harmed and others put 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 (report published 17 July 2019).

Why we inspected
The inspection was prompted in part due to concerns received about staffing levels, the environment, storage of chemicals, training and support of staff. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only. We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this full report.

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 questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were 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.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Boundary House on our website at 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 people's health, safety and welfare, staffing levels, training and support, infection prevention and control and the environment.

We have placed conditions on the provider's registration for Boundary House. We have stopped them from allowing any new people to move into Boundary House. The provider must also improve their quality assurance systems and send a summary to the Commission every month to be reviewed.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below

Boundary House

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.

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

Inspection team
This inspection was carried out by two inspectors. The inspectors visited the home on 8 and 14 September 2021.

Service and service type
Boundary House 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 did not have a manager registered with the Care Quality Commission. A new manager had been in post for a week.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
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 reviewed all information we had received about the service since the last inspection and took this into account when we inspected the service and made

judgements in this report. We also used this information to plan our inspection.

During the inspection
We spoke with two people who used the service about their experience of the care provided. We spoke with 10 members of staff including the provider, the manager, the manager from another service who was supporting the home and seven support workers. We also observed the care and support that was being provided.

We reviewed a range of records. This included care records and medication records. We looked at two staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. 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

- The systems to protect people from the risk of abuse were not always being followed by staff.
- Not all allegations of abuse by a member of staff or other person living at the home were reported to the local authority safeguarding team. We saw seven records of person on person harm that had not been reported. One person's care plan stated that they had made allegations against staff and another person living in the home. These had not been reported to the local authority safeguarding team as required.
- Not all staff had completed their annual refresher training in safeguarding people from abuse. Staff said that they reported any concerns of harm to the senior staff who they thought would then report it to the local authority safeguarding team. Evidence demonstrated to us that these incidents had not always been reported.

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

Preventing and controlling infection

- The provider had not ensured that COVID-19 government guidance for protecting people from infection was implemented and followed consistently by staff.
- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were not assured that the provider was meeting shielding and social distancing rules. We did not see any attempts by staff to support people to social distance.
- We were assured that the provider was admitting people safely to the service.
- We were not assured that the provider was using personal protective equipment (PPE) effectively and safely. Some staff were wearing fabric masks instead of the required masks as defined by current guidance. Staff told us that they had not been told that the fabric masks were not appropriate to wear at work. The manager confirmed that although they had advised staff to only wear the appropriate masks, they were still witnessing staff wearing fabric ones. We also saw staff with their masks being worn inappropriately. For example, pulled down under their chin. Used PPE was not always being disposed of by staff appropriately.
- We were not assured that the provider was accessing testing for people using the service and staff. There were very few records of people and staff completing testing for COVID-19. One member of staff told us they had not done a COVID-19 test since the previous manager was in post (several weeks).This was still not in place on the second day of the inspection, even after the issue was raised as a concern with the provider by the CQC.
- We were not assured that the provider was promoting safety through the layout and hygiene practices of

the premises. Not all areas were well maintained and easy to clean.
● We were not assured that the provider was making sure infection outbreaks could be effectively prevented or managed. Although the providers policy stated that people and staff should have their temperature taken twice a day to identify anyone with a raised temperature; this was not being consistently carried out.
● We were assured that the provider's infection prevention and control policy was up to date. Although it was not always being followed by staff.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

We have also signposted the provider to resources to develop their approach.

Learning lessons when things go wrong
● Systems to monitor incidents which occurred in the home were not effective.
●Staff had completed accident and incident forms, however these were not analysed to see if action could be taken to prevent the accident or incident recurring.
●The provider stated that there had not been an analysis of accidents or incidents in the previous year. They stated that the previous managers had not raised any concerns with them or told them about accident or incidents in the home.
●The new manager who had been in post for just over a week had already identified that one person had fallen 18 times and action had not been taken to prevent further falls. The new manager had made the necessary referrals and taken action since being in post.

Assessing risk, safety monitoring and management
●Staff were not always following procedures and guidelines to ensure that risks in the home were reduced.
●The manager and provider stated that they had advised staff on numerous occasions that the cupboards/rooms containing cleaning chemicals must be locked to ensure no unauthorised access. After the first day of the inspection we raised this with the provider as it needed immediate action to keep people safe. However, we found the keys to laundry rooms to be accessible to anyone in the home and cleaning chemicals left unsecured on the second day of the inspection posing a risk of potential ingestion by people at the service.
●A fire risk assessment completed in October 2020 identified actions needed to improve fire safety. However, not all of these had been completed. For example, a high priority action with a set timescale of 'within one month' was to box in the paper floor plans next to the fire panels, so that in the case of a fire the fire service could still see the layout of the building. This had not been done.
●The fire records showed that regular testing of the fire doors, alarms or emergency lighting testing had not been carried out as required. Not all fire doors closed as they should when the door guard was released. The lack of action and lack of testing of the fire systems put people's health and safety at risk in the event of a fire.

The provider had failed to ensure that risks to people's health safety and well - being were reduced where possible. The provider had failed to ensure that infection prevention and control guidelines were followed by all staff. The provider had failed to ensure that there was safe management of medicines. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
●Staffing levels were regularly not meeting the minimum number of staff that would ensure people

received their one to one funded hours with staff. The provider stated that they could not always provide people with their one to one support they required due to staffing shortages. This put people at risk of not receiving the individual support that they needed. One person told us that they could not go out as often as they would like.

The provider had failed to ensure that there were sufficient numbers of staff deployed to meet people's assessed needs. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Safe recruitment practices were being followed to ensure the right people were employed. Checks were completed to ensure that new staff were suitable to work with vulnerable people.

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

- Although people's needs were assessed, action was not always taken to meet those needs in an effective or holistic way.
- For example, one person was deaf and used sign language and lip reading to communicate. However, staff told us that they had not been trained to use sign language to help their communication with the person. The provider also told us that it would cost too much money to provide face masks with a clear panel so that the person could lip read what the staff were saying. The impact of the person not being able to lip-read what was being said to them by staff caused increased frustration, a feeling of isolation and resulted in the person displaying distressed behaviour.
- Staff did not always update people's risk assessments and incidents and events were not reviewed to ensure people's needs could be met effectively by staff at Boundary House. The local authority assessments and the manager had identified that six people living in the home were not appropriately placed. This meant that staff were unable to meet their needs.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- Staff had not always supported people to attend healthcare appointments. Action had been taken by local healthcare professionals to ensure that people could receive their COVID-19 vaccines. However, people had not always been supported by staff to attend these appointments. Healthcare professionals had not been notified by staff of any issues prior to the appointment such as the person being fearful of the injection.
- Staff had not made referrals to the local authority safeguarding team when needed and had not raised their concerns about people's needs not being met appropriately with external services such as the local authority.
- Documents for people to take with them if they were admitted into hospital were in place. This helped identify what people's needs were. However, these had not all been reviewed and updated, and vital information to help guide external health professionals was missing.
- Staff made referrals to other services and were familiar with health professionals and their scope of support. This included the dietician, speech and language therapy, chiropodist and GPs.

Staff support: induction, training, skills and experience

- Staff were not always adequately trained and had not received regular support from their managers. We reviewed staff training records and identified gaps in training for three out of four staff. People were at an increased risk of unsafe or ineffective care and support as they were being supported by staff whose training

was either not up to date or had not been undertaken.
● Staff told us that they didn't have time to carry out training whilst at work as they were normally responsible for providing one to one care for people whilst on shift. They also stated that they had been requested to do the training in their own time at home.
●The provider confirmed that staff had not received regular supervisions and no staff had competed an appraisal within the last year. These meetings would help staff identify areas of support needed and raise any suggestions of concerns they may have in a formal setting with their manager. Staff told us that they relied on colleagues for support as there had been a high turnover of managers.

The provider had failed to give staff appropriate support, training, supervision and appraisal as is necessary to enable them to carry out their duties. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulation.

Adapting service, design, decoration to meet people's needs
●The communal areas in Boundary House were not homely. Some furniture needed replacing as it had missing doors and drawers and the paint was flaking off. The carpets in the hallways were dirty and stained. The tiles in the bathroom had what looked like black mould around them. There was plastic storage unit with unnamed toiletries in the bathroom which posed a risk of cross - infection.
●The gardens looked uncared for and garden furniture was worn and stained. The flower beds contained dead plants and the grass areas were overgrown.
●On arrival in the car park the bins had cleaning cloths on the floor around them and used face masks were seen littered on the driveway. This increased the risk of the spread of infections.
●Equipment was not always replaced when it was not working. For example, we saw some walkie talkies in a box. A support worker told us that they were used in an emergency for staff to contact each other when working in the separate flats however they did not work properly. The staff member explained that staff had resulted in trying to shout for other staff when needed.

The provider had failed to provide people with premises and equipment that was clean and well maintained. This was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●People's bedrooms had been personalised to reflect their taste.

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.
● The provider and manager confirmed that not all people had their DoLS reviewed and extended as

needed. OF the three records we looked at only one had been updated as required. This meant that people were at risk of having restrictions placed on them that had not been legally authorised.

The provider had failed to ensure that any restrictions were legally authorised. This was a breach of Regulation 11 (Need for consent)v of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had an understanding of the MCA and the principles of making decisions in people's best interests.

Supporting people to eat and drink enough to maintain a balanced diet
● People received the support they required with eating and drinking.
● When needed people received support with specialist diets for example, one person was on a soft diet with food cut up into bitesize portions. Staff were aware of the supported needed.

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.

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

●After our first inspection day our concerns for people's health and safety were so serious that we wrote to the provider and requested a response about how they would take immediate action to ensure people were safe. The provider gave us assurances of the action they would take. However, during the second day of the inspection we found that not all of the measures the provider had put in place were being monitored to ensure they were effective.

● There had been a significant lack of effective management over a considerable period of time. This had adversely impacted on the care people received, their safety and the safety of staff. The governance system that was used to monitor the quality of the care and support being given was not robust enough. There was no organisational oversight by the provider. This resulted in a failure to identify that not all management duties were being fulfilled as required in a timely manner.

●There was no effective system for analysing, investigating and learning from incidents. This failure meant opportunities had been missed to identify ways of preventing future incidents, and exposed people to the risk of continued distress or harm. We discussed the lack of reporting safeguarding incidents to the local safeguarding team and the CQC with the provider. The provider stated "I raised my hand, I hadn't checked [that this was being done]."

● We identified concerns with the way the provider had dealt with statutory notifications to the commission. We will investigate this further.

●Information about people was not always kept secure and confidential. We saw records throughout the home that were accessible to anyone in and visiting the building.

Continuous learning and improving care; 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

● There had been a complete lack of oversight and governance from the provider. During the inspection, we found multiple breaches of regulations. These failings demonstrated there were widespread and significant shortfalls in the way the service was led.

● The provider had failed to identify risks or act upon risks reported to them by staff. This included known risks relating to people's behaviour, health and wellbeing.

● The provider had failed to monitor and improve the quality and safety of the service. The provider had failed to identify and act on the issues within the service.

The provider had failed to consistently assess, monitor and mitigate risks to people's health, safety and welfare. The provider had failed to improve the quality of the service. This was a breach of Regulation 17 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

● The provider acknowledged the serious shortfalls identified at this inspection and were eager to put processes in place to ensure people receiving care and support were safe and protected from harm.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Care was not always person centred and people were not always cared for in a safe and consistent way.

●Staff members told us that there was a lack of structure. One staff member told us, "There used to be a shift leader. If you do something wrong like not filling in records, there needs to be consequences."

●There were not always clear, accurate and contemporaneous notes in respect of each person. For example, we asked to see the incident form for one person who had significant bruising to their foot and what action had been taken to request healthcare for the person. The incident form supplied did not include the bruising to the persons foot. The manager stated that although they had tried to call the GP for an appointment it had not been recorded. The manager told us that they had been trying to organise records but that, "Half are missing."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● There was a process for monthly keyworker meetings and reviews. This included asking the person's views about the support they were receiving. However, these reviews had not always taken place.

●Since the new manager had been in place staff meetings had been arranged so that information could be shared, and staff could be updated. The provider stated that he had updated the supervision template and planned to have a supervision with all staff in the two weeks following the inspection.

●The local authority had recently carried out reviews of the service. However, they had found it difficult when requesting information to be sent to them as this had not always been completed in a timely manner.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured that any restrictions placed on a person where legally authorised.

The enforcement action we took:

We have imposed positive conditions on the providers registration. They must not admit any new people to Boundary House without the permission of the CQC. The provider must submit governance documents and assurances on the first Monday of each month to the CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that risks to people's health safety and well - being were reduced where possible. The provider had failed to ensure that infection prevention and control guidelines were followed by all staff. The provider had failed to ensure that there was safe management of medicines.

The enforcement action we took:

We have imposed positive conditions on the providers registration. They must not admit any new people to Boundary House without the permission of the CQC. The provider must submit governance documents and assurances on the first Monday of each month to the CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to safeguard people from abuse.

The enforcement action we took:

We have imposed positive conditions on the providers registration. They must not admit any new people to Boundary House without the permission of the CQC. The provider must submit governance documents and assurances on the first Monday of each month to the CQC.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to provide people with premises and equipment that was clean and well maintained.

The enforcement action we took:

We have imposed positive conditions on the providers registration. They must not admit any new people to Boundary House without the permission of the CQC. The provider must submit governance documents and assurances on the first Monday of each month to the CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to consistently assess, monitor and mitigate risks to people's health, safety and welfare. The provider had failed to improve the quality of the service.

The enforcement action we took:

We have imposed positive conditions on the providers registration. They must not admit any new people to Boundary House without the permission of the CQC. The provider must submit governance documents and assurances on the first Monday of each month to the CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that there were sufficient numbers of staff deployed to meet people's assessed needs. The provider had failed to give staff appropriate support, training, supervision and appraisal as is necessary to enable them to carry out their duties.

The enforcement action we took:

We have imposed positive conditions on the providers registration. They must not admit any new people to Boundary House without the permission of the CQC. The provider must submit governance documents and assurances on the first Monday of each month to the CQC.