

Balance (Support) CIC Woodbury

Inspection report

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Ratings

Overall rating for this service

Requires improvement



Is the service safe?

Requires improvement



Is the service effective?

Requires improvement



Is the service caring?

Requires improvement



Is the service responsive?

Good



Is the service well-led?

Requires improvement



Overall summary

This inspection took place on 8 and 20 April 2015 and was unannounced. This was the first inspection since the service was taken over by Balance (Support) CIC and was registered with CQC in December 2014.

Woodbury provides accommodation and personal care for up to 15 people with a range of learning disabilities, autistic spectrum disorders as well as physical disabilities. On the day of our visit there were 15 people living in the home.

The registered manager had recently left the service and recruitment of a new manager was taking place while an

acting manager was in charge. 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.

The service did not manage risks to people well. Risk assessments in relation to pressure ulcers, choking and to

Summary of findings

the provision of first aid were not always in place. In addition, staff did not always monitor people's weight regularly when people developed nutritional needs to ensure they were eating and drinking adequately.

Medicines management was not safe. We could not always confirm people had received their medicines as prescribed through stock balance checks because the service did not keep accurate records of medicines in stock. Arrangements to ensure over the counter 'homely remedies' were administered safely were also not in place.

People were not safeguarded appropriately from abuse. This was because bruises and accidents and injuries were not always well recorded and investigated to check whether they occurred because of abuse. Accidents and injuries were also not analysed to check risks were being identified and managed appropriately.

Recruitment was not always safe because the provider did not ensure staff were capable of working with people due to any physical or mental health conditions. However, the service followed legal requirements in checking all other aspects of staff recruitment, such as references and criminal records checks, before they started work at the service.

The auditing systems in place were ineffective in identifying the breaches of regulations we found during this inspection. In addition, records in relation to the management of the service were not always well maintained.

Staff had not received regular supervision, although the provider was aware of this and was addressing this. Staff also did not receive regular training in topics to enable them to meet people's needs. There was no policy in place which identified how often staff should receive training on the various topics, and staff received refresher training inconsistently.

Not all staff understood their responsibilities under the Mental Capacity Act 2005 in their day to day roles and there was no clear programme for training staff to ensure they had the necessary understanding of this act.

However, the service worked with other organisations so that when people lacked capacity to make certain decisions, decisions were made for them in their best interests. The service was meeting their requirements under the Deprivation of Liberty Safeguards (DoLS). These safeguards are there to help make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom. The provider had assessed whether people required DoLS and made the necessary applications. In this way people's rights in relation to this were recognised, respected and promoted.

A range of checks were in place to ensure the premises and equipment were safe and the home was well maintained.

People were provided with a choice of food and received appropriate support to eat and drink. Staff supported people to access health services in order to remain healthy.

Staff treated people with kindness, dignity and respect. Staff knew the people they were supporting well, including their preferences, communication styles and background and supported them to be as independent as they wanted to be. This information was all well documented in people's support plans to guide staff in supporting people in the best ways for them.

The complaints system in place was followed in investigating and responding to complaints raised. People had access to advocates who supported them to make complaints about support they found unsatisfactory.

Staff supported people to access activities they were interested in and each person had an individual activity plan which they followed.

At this inspection we identified a number of breaches. These were in relation to safe care and treatment, safeguarding people, recruitment, staffing and good governance. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe. Risks to people were not always appropriately assessed with appropriate management plans in place for staff to follow in reducing risks.

Accidents and injuries and bruises were not always investigated and recorded appropriately to check whether they occurred due to abuse so people were protected against the risk of abuse.

Medicines management was not always safe. Inaccurate records of medicines stocks meant we could not evidence people received their medicines as prescribed.

Recruitment processes were not robust enough as mental and physical health conditions were not explored to check staff were suitable of working in the home.

The premises and equipment were safe and there were enough staff deployed to meet people's needs.

Requires improvement



Is the service effective?

The service was not always effective. Staff did not always receive appropriate supervision or training in relation to their roles. Staff did not monitor people's weight regularly when they developed needs in relation to their nutrition.

Staff supported people to access health services when this was required. People were provided with a choice of food and drink and received sufficient support to eat and drink appropriate amounts.

Requires improvement



Is the service caring?

The service was not always caring. Staff did not always show enough concern for people's wellbeing in a caring way. However, in day to day interactions staff treated people with kindness, dignity and respect. Staff knew the people they were supporting well, including their preferences, backgrounds and the best ways to communicate with them. Staff supported people to be as independent as they wanted to be.

People were supported to remain in contact with their relatives to enable them to maintain relationships that were important to them.

Requires improvement



Is the service responsive?

The service was responsive. Staff supported people to have care plans which reflected how they preferred to receive their care. Staff supported people to access activities and outings they enjoyed, including holidays. The provider investigated and responded to complaints appropriately and people had access to advocates to help them complain when necessary.

Good



Summary of findings

Is the service well-led?

The service was not always well-led. Although some audits were in place these were ineffective in identifying the breaches of regulations and issues we found during the inspection.

The provider investigated whistleblowing concerns thoroughly and identified actions necessary to improve the service as a result of these. The service was meeting their legal requirements in submitting statutory notifications, including those of abuse to the CQC.

Requires improvement



Woodbury

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 8 and 20 April 2015 and was unannounced. It was undertaken by a single inspector.

Before our inspection we reviewed information we held about the service and the provider. We also contacted three local authority reviewing officers to ask them about their views of the service provided to people.

During the inspection we observed how staff interacted with the people who used the service. We spoke with four people who used the service. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with the head of operations, the acting manager and four members of staff. We looked at five people's care records, five staff recruitment files and records relating to the management of the service including quality audits. We also spoke with a visiting physiotherapist and a psychiatrist.

After the inspection we communicated via e-mail with the chief Executive Officer and spoke with the relatives of three people who used the service.

Is the service safe?

Our findings

The provider did not ensure that risks were appropriately managed to ensure the safety of people. Staff had not ensured the risks to people of developing pressure ulcers had been fully assessed and recorded in risk assessments with suitable management plans in place. This meant staff might not have enough information to support people in relation to this risk. However, people at risk of pressure ulcers had equipment in place such as pressure-relieving cushions and mattresses. Staff were able to recognise pressure ulcers and had referred people to the district nurse for further support promptly when concerns arose. When we informed the head of operations of our concerns they told us they would ensure risk assessment and suitable management plans were put in place for people where relevant.

For one person staff told us they were at risk of choking if they were left alone with certain objects such as socks. We checked their risk assessments and found no reference to this risk with no suitable management plans in place. This meant this person could be at risk due to inadequate risk assessment and planning. The acting manager told us they would put the necessary risk assessments in place promptly.

There was no evidence the service had carried out a risk assessment to identify whether staff on shift required first aid training to deal with first aid issues which may occur. For example, several people were at risk of choking and yet there was no system to ensure staff trained in first aid were on shift.

These issues were in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us, “I get my medicines on time.” However, we found some aspects of medicines management were not safe. We were unable to evidence people always received their medicines as prescribed as records of medicines in stock were sometimes inaccurate. Medicines brought forward from one cycle to the next were not routinely recorded and so the total quantities in stock were unknown. However, effective systems were in place for the management of medicines to be administered as and when required as staff recorded the amount remaining after each administration.

When we checked medicine administration records (MAR) we identified staff had not recorded administering one medicine two days earlier. We were unable to check whether this was a recording omission or whether staff had neglected to administer the medicine because the quantity of medicine expected to be in stock was unknown. Effective auditing systems were not in place to identify and respond to errors and/or omissions such as this to keep people safe. The acting manager told us staff should check medicines management at handover to look for any omissions. However, guidance on this for staff was not included in the medicines policy and the handover we observed did not include checking of medicines.

Staff administered several homely remedies to people and administration was clearly recorded. Homely remedies are non-prescription, over the counter medicines. However, there was no information in the medicines policy to guide staff to administer homely remedies safely. There was no evidence it had been considered whether some people should not receive homely remedies and how long they should be administered before medical advice is sought.

These issues were in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe at Woodbury. One relative told us, “It’s very safe, my [family member] has lived there many years and I have no concerns”. Staff received training in safeguarding adults and knew signs of abuse and how to report concerns. However, we identified that the provider did not have appropriate arrangements for the recording and investigation of bruises. This meant managers may not have enough information to rule out whether bruises were due to abuse to ensure the necessary action was taken to protect people. We found six body maps where staff had recorded bruises they found on people. However, there was no evidence these were then reviewed by management for further investigation to identify whether abuse was taking place. Recording on the body maps was sometimes poor as several did not identify the name of the person in question so could not be used reliably to investigate concerns. We observed bruises on a person’s arm which had not been recorded or investigated. Staff told us they were not concerned about these as they were due to self-injurious behaviour, but they had not carried out any investigations to rule out other possible causes such as abuse.

Is the service safe?

These issues were in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also found that records of accidents and incidents were not always made appropriately. A recent body map for one person showed a large area of bruising. Staff recalled this was due to an incident when the person fell and received hospital treatment. However, an accident and incident report in relation to this was not available for us to see. In addition, evidence showed managers did not always review accident and incident reports to ensure staff supported the person appropriately and the right measures had been taken to prevent a reoccurrence. There was also no evidence accident and incident reports were analysed to look for patterns which may indicate concerns such as abuse or changes in people's needs.

These issues were in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

With regards to other risks, up-to-date risk assessments and management plans were in place which were specific to people's identified risks. This meant there was sufficient guidance for staff to understand the risks to people and how to support them safely in relation to these.

Recruitment practices were not always safe because the provider did not ensure checks were carried out in relation to staff's capability to perform their roles due to any physical or mental health conditions. We informed the acting manager of our concerns and they told us they would feed this back to the operations manager and CEO.

However, the service carried out other checks such as obtaining satisfactory references, completing enhanced criminal records checks and obtaining full employment histories.

The premises and equipment were safe as checking and maintenance systems were in place. These included testing of the electrical wiring, central heating and hot water systems and, hoists and fire-fighting equipment. The fire authority inspected the home in 2014 and found it to be satisfactory in relation to fire safety. A Legionella risk assessment was in place and actions identified from this had been taken. Legionella is a bacterium which can accumulate rapidly in hot water systems if control mechanisms are not in place. Staff told us systems in place to ensure day to day repairs were carried out were efficient and repairs were promptly dealt with. The service had installed finger-protectors on doors around the home and had covered electrical sockets to protect people at risk. A physiotherapist told us staff had been very proactive in arranging for a specialist chair to be provided for a person who needed this.

The head of operations told us they had recently identified more staff were required in the home after a recent staffing assessment. Recruitment was ongoing and we met two staff who had recently started working at the service. Staff told us unallocated shifts were covered by staff working overtime and using bank or agency staff. One relative told us, "I know they're short staffed now and they use agency, but they are recruiting." We observed staffing levels were sufficient on the day of our inspection as staff were able to provide care to people promptly and according to their needs.

Is the service effective?

Our findings

Staff were not always supported or trained appropriately to carry out their roles and this meant people were not always protected against the risks of receiving poor or inappropriate care. The new head of operations told us they had recently identified staff had not received frequent or regular supervision where they were able to discuss issues such as their responsibilities and training needs. The provider had put a system of supervision in place and staff confirmed they had received a recent supervision. One staff member told us, “Supervision wasn’t regular, but it has improved recently.” It was too early to determine whether this new system would be consistently maintained and be effective in supporting staff.

There were no effective systems to consistently identify when staff required refresher training. Training records showed staff received refresher training infrequently and inconsistently. For example, some staff had not received infection control training for several years. None had received training in first aid in the last 4.5 years and so may be unable to deal with first aid emergencies which may occur. Staff were unsure how often each training topic should be refreshed. Some staff thought safeguarding training was provided annually, others thought every two years. We requested a policy to clarify how often the organisation required staff to receive supervision and refresher training in each subject but were told there was no such policy in place. Although there was a training and development plan in place from the previous organisation this was ineffective in ensuring staff received the right training to meet people’s needs.

These issues were in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not ensure people’s weight was monitored regularly where this was required. This meant staff may not identify changes in people’s weight which would indicate concerns about their nutritional state. For example, in one person’s health action plan (HAP) a need to ‘monitor weight’ was identified. Their HAP stated their last recorded weight but not the date it was recorded. There was no evidence their weight had been monitored at all since. Another person’s care plan stated they should be weighed regularly. Staff had recorded they had lost a stone, but

there was no evidence of the timeframe of this weight loss. There was no evidence of weight recording for another person who was on a supplement due to concerns about their eating and drinking.

These issues were in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Discussions with staff showed they did not all have a good understanding of the requirements of the Mental Capacity Act 2005. Records showed not all staff received training in this and there was no system in place for refreshing staff knowledge. However, there was evidence of some best interests’ decisions being made in line with legislation when people lacked capacity to decide themselves. This was in relation to decisions about whether people who lacked capacity to decide should have certain medical interventions.

The service was meeting their requirements under the Deprivation of Liberty Safeguards (DoLS) and had applied for authorisation to deprive several people of their liberty as part of keeping them safe. They had also notified CQC of the applications and the outcomes as required by law.

Although monitoring of people’s weight was poor, when staff observed other concerns about people’s eating and drinking they took the necessary action. This included supporting them to visit the GP and other health care professionals such as a speech and language therapists (SLTs). Guidance from SLTs to reduce the risk of people choking on food and drink was in place. We observed a mealtime and saw staff followed this guidance well to reduce the risk of a person choking. Staff also administered supplements to people as prescribed when there were concerns about their weight. Staff encouraged people to eat a healthy and balanced diet and support plans contained information about people’s dietary requirements.

People received support to maintain their health. One person told us, “I see a doctor when I need to, and a dentist.” A relative said, “My relative has [a particular health condition] and the staff manage this well.” The physiotherapist told us people were regularly supported to attend physiotherapy groups which Woodbury ran, as well

Is the service effective?

as swimming and hydrotherapy. Records showed people had regular appointments with healthcare services such as psychiatry, epilepsy and the local authority challenging behaviour team.

People gave us positive feedback about the food and told us they had choices about what they wanted to eat. Staff supported people to choose their food using communication tools including pictures. One person told

us, “The food is lovely; I can eat what I like. I like sausage and mash, fish and chips and beef burgers.” Another person said, “This is a ham sandwich, it’s nice.” A third person said, “I’m going to have a pickle sandwich, I chose it.” Information about the food and drink people liked was detailed in their support plans and staff were aware of this information.

Is the service caring?

Our findings

Whilst staff showed a caring attitude when dealing directly with people, they did not always show enough concern for people's wellbeing in caring way and did not respond to some of their needs quickly enough. For example they did not ensure appropriate arrangements were in place to monitor people's nutritional state adequately where people were at risk, to make sure they were having enough to eat and drink. They also did not ensure appropriate action was taken when people had bruises to rule out the possibility that people could have been abused.

People who could communicate were positive about the staff who supported them. One person said, "I like the staff and my keyworker." One relative told us, "The staff are wonderful; it's a lovely place for people to be." Another relative said, "The staff are very caring." The physiotherapist and psychiatrist said they found staff to be kind and caring. We also observed staff treated people with kindness, dignity and respect. For example, during mealtimes staff who were supporting people to eat explained what they were about to do, took care so that the mouthfuls were not too big and the person was able to eat at their own pace. When people required personal care staff took care to support them to leave the room discreetly, so as to protect their privacy and dignity. When staff spoke and wrote about people they did so in respectful language.

Many staff had worked in the service for several years and our discussions showed they knew a lot about people's likes, dislikes and their backgrounds and could support them appropriately. One relative told us, "Staff know [my family member], very much so!" The psychiatrist told us staff knew a lot about the person they were visiting and their background knowledge was very helpful. The physiotherapist also told us staff knew people well.

People were encouraged to be as independent as they wanted to be. One person told us, "I sometimes make

sandwiches." Another person said, "I make a piece of toast sometimes." A relative told us how their family member was encouraged to do tasks such, as making a cup of tea for themselves. People's support plans detailed how staff should support them while promoting their independent living skills. For example, one person stated they were able to feed myself independently but needed encouragement to do so. The support plan also detailed they needed a plate-guard and apron to help them eat independently. At mealtime, we observed staff followed this support plan closely so the person maintained their independence.

Staff communicated with people in ways most suitable for them so they understood the information and could make decisions. For a person who could not speak staff communicated in Makaton, a basic form of sign language useful for some people with learning disabilities. We observed communication between staff and the person was smooth as staff communicated with them well. We observed staff adjusted the way they spoke depending on the person they were with and their preferred way of communicating.

People were involved in the Kingston learning disability parliament. This was a user-led group focused on improving the lives of people with learning disabilities in health, employment, transport and friendships. People attended sessions run by the parliament to learn about issues such as travel training, shop accessibility and employment.

Staff supported people to maintain relationships with people that mattered to them. Relatives told us they were able to visit at any time and staff were always warm and accommodating. One relative said, "I know I can turn up there anytime and I'd be welcomed." Relatives told us staff kept them well informed of their family members' lives. One relative said, "If [my family member] falls and goes into hospital they always call me, then do a follow-up to tell me their conclusion as to what happened."

Is the service responsive?

Our findings

Each person had a 'person-centred plan' which they were involved in creating as far as possible. This detailed information about their backgrounds, hopes and dreams and how staff should support them to achieve these. They also detailed people's likes and dislikes gathered from people directly where possible, staffs knowledge of people over time and information from relatives. They were created to be accessible to people with learning disabilities and included pictorial information such as photographs from activities they enjoyed. Guidelines were in place for staff to follow as to the best ways to communicate with individuals. For a person with a visual impairment guidelines were in place as to how staff should approach them so not to startle them, and to be seen most clearly by them. Staff frequently reviewed people's support plans so these contained up-to-date information about them. Relatives told us their family members had regular reviews led by social services at the care home which they were invited to attend.

Staff supported people to access activities they enjoyed and people had activity programmes individual to them. One person told us, "I go to a day centre and workshops." Another person told us they enjoyed going to a social club each week and staff explained how this helped them avoid social isolation. Relatives told us their family members had

activities they enjoyed planned most days. During the inspection people attended a range of activities outside the home, including a sensory group. Staff supported people to go on day trips to places of interest and to visit theme parks, pubs and nightclubs. Recently people went on a boat trip and theatre trips took place at points during the year. People were supported to go on holiday and a recent holiday was to apartments specially adapted for people with physical disabilities on the coast. A musician visited regularly to entertain people and a masseur provided massages to people in the home. The care homes garden had swings and was accessible to wheelchair users and people with mobility needs. One person told us, "I like the garden and swings."

Relatives had confidence the service would investigate and respond to any complaints they had reason to make, although none had made any. One relative told us, "If I was to say something they would take it seriously, but everything seems to go smoothly [so I haven't had to]". We saw an advocate had supported a person to complain about issues they found unsatisfactory about the service and records showed the complaint had been investigated and responded to. The complaints policy had been made accessible through a leaflet encouraging feedback, complaints and compliments. This leaflet was on display in a communal area for people and relatives to refer to.

Is the service well-led?

Our findings

People were not protected against the risks of poor and inappropriate care because the provider did not have effective systems in place to assess, monitor and improve the service and they did not ensure records were always well maintained. The registered manager had retired a few days before our inspection and a senior staff member was the acting manager until a permanent manager was recruited. We observed an advert for the manager's post on the providers' website and the acting manager told us shortlisting had taken place.

The provider had a number of ways to monitor the quality of the service, but these were not effective as they had not picked up the concerns we found during our inspection. For example systems in relation to medicines management were ineffective. Records showed medicines audits were carried out quarterly by management, and audits were also carried out when the CEO visited to inspect the home quarterly. However, these audits had not identified the issues in relation to omissions in administering medicines, inaccurate stock balances and homely remedies.

The audits the senior managers carried out looked at a range of areas across the home, including care documentation and people's finances. However, these audits had not identified the issues we found in relation to safeguarding, risk assessing people's needs, recruitment, weight monitoring, training and accidents and incidents management. Although the manager submitted basic information about safeguarding incidents, accidents and injuries and near misses to senior managers for review, this system had not identified the issues we found in relation to accidents and injuries. There were no other auditing systems in place to promptly and effectively identify and rectify the range of issues we found.

When we checked supervision records, the acting manager told us the some records were held on senior staff's personal electronic files which they were unable to access. This meant we could not evidence supervisions as the records were also inaccessible to us.

Records in relation to the management of the service were not always maintained securely. A Legionella risk assessment had been carried out around 18 months before our inspection which identified a range of actions

necessary to reduce the risk of Legionella infection, some of which were urgent. However, during the first day of inspection records showing these actions had been taken were unavailable. This meant the provider could not, at this stage, evidence they had taken the necessary steps to keep people safe. During the second day of inspection the acting manager told us the work had been carried out and they showed us evidence they had since obtained from the contractors.

Other records in relation to the running of the service were not easily available due to recording systems in place. For example, staff told us monthly meetings were held with people using the service to gather their views on the service and involve them in running the home. However, staff were unable to locate the folder with minutes showing the frequency and content of these meetings.

These issues were in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were involved in developing the service. The organisation recently set up a staff forum which representatives from the home attended to discuss issues affecting the organisation as a whole. Staff told us they also regularly attended staff meetings where they were able to discuss all aspects of the service. Staff felt listened to at these meetings and said that suggestions they made were considered seriously and actioned where possible.

The service had a whistleblowing policy which staff were aware of. Social workers told us the provider had responded appropriately to allegations of abuse raised anonymously by staff recently. They commented the investigation was very thorough and the provider took immediate action to keep people safe. As part of this investigation the provider identified actions necessary to change the culture so that staff felt more listened to and to improve the way in which staff were encouraged and supported to raise concerns. However, it was too soon to assess how the service responded to these identified actions.

The provider was aware of their regulatory responsibilities. This included submitting notifications to CQC, as required by law, of incidents such as allegations of abuse promptly after becoming aware of these.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The registered person did not provide care in a safe way for people by assessing the risks to the health and safety of people of receiving the care and treatment, doing all that is reasonably practicable to mitigate any such risks and ensuring the proper and safe management of medicines.

Regulation 12(1)(2)(a)(b)(g)

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

People were not protected from abuse and improper treatment through systems and processes established and operated effectively to prevent abuse of people.

Regulation 13 (1)(2)

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The registered person did not have effective systems to assess, monitor and improve the quality and safety of the services and risks relating to the health, safety and welfare of people, including mitigating these risks. The registered person did not maintain an accurate, complete and contemporaneous record in respect of each person and records relating to staff and the management of the service.

Regulation 17(1)(2)(a)(b)(c)(d)(i)(ii)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Staff did not receive appropriate training and supervision to enable them to carry out the duties they were employed to perform.

Regulation 18 (2)(a)