Longridge Care Home Limited

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Inspection report

Levedale Road
Dunston
Stafford
Staffordshire
ST18 9AL

Tel: 01785714119

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: Longridge Care Home Limited is a residential care home providing personal and for up to 32 people. There were 22 people, some of whom were living with dementia, living at the location at the time of the inspection.

People's experience of using this service:
People did not consistently receive safe care. Medicines were not managed safely. Staff were not always available to support people when they needed it. Staff were not always recruited safely and consistently trained.

People were not consistently receiving effective support. People did not always have a choice of meal. People did not consistently receive caring and responsive support. People's individual preferences and diverse needs were not consistently considered.

The systems in place to monitor the quality of care were not effective and actions were not driving improvements. This was the sixth time the service had been inspected and had failed to achieve a good rating and people had been exposed to poor care.

People felt safe and comfortable living at the home. Risks to people's safety were managed. People's health needs were met and they had access to health professionals.

People were supported by caring staff. People's privacy and dignity was maintained. People were supported to maintain their independence. Staff were responsive to people's needs. People could make a complaint.

The service met the characteristics of Inadequate in most areas and was rated Inadequate overall.

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

Rating at last inspection: At the last inspection the service was rated Requires Improvement (report published 5 April 2018).

Why we inspected: This was a planned inspection based on the rating at the last inspection.

Enforcement: Full information about CQC's regulatory response to the more serious concerns found and appeals is added to report after any representations and appeals have been concluded.

Follow up: The overall rating for the service is inadequate and the service will be placed in special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant

improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures. We will continue to monitor intelligence we receive about the service until we return to visit.

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 safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Longridge Care Home Limited

Detailed findings

Background to this inspection

The 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 checked 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.

Inspection team:
The inspection was carried out by one inspector 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:
Longridge Care Home Limited is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. A registered manager is legally responsible for how the service is run and for the quality and safety of the care provided, along with the provider.

Notice of inspection:
This inspection was unannounced.

What we did:
Before the inspection visit, we checked the information we held about the service. We reviewed other information we held about the service, such as notifications. A notification tells us information about important events that by law the provider is required to inform us about. For example; safeguarding

concerns, serious injuries and deaths that had occurred at the service. We also considered information we had received from other sources including the public and commissioners of the service. We used this information to help us plan our inspection.

During the inspection we spoke with seven people who used the service and two visitors. We did this to gain people's views about the care and to check that standards of care were being met. We observed care to help us understand the experience of people who could not talk with us. We spoke with the provider, the acting manager, five care staff, a cook and domestic staff member.

We looked at the care records of five people who used the service, to see if their records were accurate and up to date. We also looked at records relating to the management of the service. These included staff recruitment files, training records, incident reports, medicines administration records and quality assurance records.

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Using medicines safely:
• At the last inspection people's medicines were not always being managed safely, medicines stock was not monitored, and people had been without their medicine. At this inspection we found the provider had failed to ensure action to address these concerns.
• We checked to see if people had their medicines administered safely. We found one person had not had their medicine for a period of 10 days as it had run out. The person was left at risk of harm as they did not receive their medicine and there was no record of the provider seeking advice. In another example one person had not received their topical medicines on several occasions. This meant the person was at risk of having their health deteriorate.
• Medicines guidance was not consistently in place for staff. One person required a topical medicine to be administered. The records gave no guidance to staff on how, where or when to administer this medicine. This meant the person was at risk of not having their medicine as required.
• Medicine stock checks were not effective. We found differences between the stock counts carried out during the inspection and the medicine administration records (MAR) stock counts recorded. This meant people were at risk of not having their medicines continually available.
• Medicines were not consistently stored safely. We observed the medicines trolley had been left unattended in a corridor and although this was locked it was not secured to the wall.
• People's MAR charts had gaps in recording the administration of medicines. We found one person's MAR chart had a gap in recording on seven separate occasions. There was no evidence the person had received their medicine, and this had not been investigated or escalated to a medical professional. This meant the person was left at risk of their health deteriorating.

Assessing risk, safety monitoring and management:
• At our last inspection we found the provider was not effectively assessing and managing risks to people's safety and action wasn't consistently taken to reduce the risk of accidents reoccurring.
• At this inspection we found there were still concerns with how accidents and incidents were monitored, and risk management plans were not always followed and updated when needs changed.
• People's risk assessments were reviewed regularly. However, where significant events had taken place these had not always been considered in the reviews. For example, where people had an accident their falls risk assessment had been reviewed but there was no reference to changes with risks associated to their care.
• There was no analysis of accidents and incidents completed to look for trends which needed to be considered. This meant action was not taken to prevent incidents from happening again.

• These issues constitute a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Despite these concerns people told us staff supported them to stay safe. One person said, "The staff will not let me move around on my own because I am prone to falling."
• We did see some risk assessments were in place and followed by staff. For example, where people used a hoist to support them with transfers this was fully documented in people's care plans and staff were aware of the guidance which we saw they followed.

Supporting people to stay safe from harm and abuse, systems and processes:
• People were not protected from potential abuse. We found two people had been reported by staff as having unexplained bruising to their bodies.
• Staff had recorded these bruises but there had been no investigation and no referrals to the local safeguarding team.
• In a further example two people had been without medicines for a period of time. These incidents had not been investigated or referred to the local safeguarding team.
• We spoke to the acting manager about these incidents and they told us they would be reported to safeguarding following the inspection.
• This meant the provider had failed to follow procedures which ensured impartial investigation of potential abuse and people were left at risk of harm.

• These issues constitute a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong:
• The interim manager told us when incidents occurred they reviewed the incident form and where required follow up action was taken with regards to the individual incident. For example, if people needed a referral to a health professional this was completed. However, there were no processes in place to consider the wider review of incidents and learn lessons.

Staffing levels:
• People and relatives did not feel there was always enough staff available. One person said, "The staff help me move around and I always have my buzzer, sometimes it takes a while for them to come, so I know now and usually call as soon as I need something." One visitor told us, "There are times when they could do with some extra staff and I hear the buzzer going for a while, but I have never seen anything unsafe."
• Staff also told us they felt there were times when there were insufficient staff available which meant they were sometimes unable to spend time with people and people had to be asked to wait for their care needs to be met.
• On the day of the inspection we saw there were enough staff to keep people safe. However, there were large periods of time when staff were busy and unable to spend quality time with people.
• Recruitment polices were not consistently followed. The providers policy was to complete a disclosure and barring service (DBS) check for all newly appointed staff. DBS checks are made against the police national computer to see if there are any convictions, cautions, warnings or reprimands listed for the applicant.
• We found this had not consistently been applied. One person had started employment without a new DBS being requested in line with the policy. There were also no previous employer references in place for this staff member.
• A risk assessment had been done and regular supervision had been put in place. The interim manager confirmed there had been no issues with the staff member during their employment.
• The provider assured us this would now be addressed, and an application made to DBS for the staff member.

Preventing and controlling infection:

• The home was found to be clean and we saw there were cleaning schedules in place and checks were carried out to maintain the home.
• There was guidance in place for staff on how to minimise the risk of cross infection.
• Staff were observed following the procedures and using protective clothing such as gloves and aprons when supporting people.

Requires Improvement

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.

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

Staff skills, knowledge and experience:
• The provider told us in the PIR, staff had access to an induction and a range of training some of which was provided by the provider through a train the trainer approach. This included diabetes training, medicines management and moving and handling.
• However, records showed some training was out of date and had not been completed. For example, there were gaps in people receiving some of the mandatory training such as Manual Handling, SOVA, infection control and food hygiene. This meant people may be at risk of receiving support which was not effective.
• Records showed that some training had not been offered to staff. For example, COSSH training had not been completed by any of the current staff members. People were left at risk as staff had not received training in handling substances which may cause a hazard to health.
• We found there was no training in place for staff on providing for people's individual needs. For example, staff had not received training in catheter care, despite people living at the service requiring support to maintain their catheter. We observed two people with catheters which were not attached correctly and were dragging on the floor. People were left at risk of not receiving the care they needed.
• The provider told us the previous registered manager had provided the training had now left the home and there was not a trainer in place at the time of the inspection to update staff training.
• This meant there were gaps in staff skills and the provider had not sourced training. The provider confirmed during feedback that external training would be sought to ensure all staff had the required skills for their role. We will check this as part of our next inspection.

• These issues constitute a breach of Regulation 18 (2) of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

• Despite these concerns the staff told us they felt supported in their role by the interim manager. Staff said there were regular opportunities to discuss their role and records confirmed staff had access to team meetings and supervisions.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
• At our last inspection we found there was a new system being implemented to assess people's needs. At this inspection we found this had been put in place, but improvements were still needed.
• People had individual assessments of their needs, a risk assessment and care plan in place to meet their needs. Each one had guidance for staff on how to keep people safe and provide effective care.
• There was guidance from other professionals included in the plans for people where needed. For example, information from health professionals involved in nutrition and hydration plans.

• Plans were reviewed monthly and any changes to people's needs were considered, however these were not always accurately completed. For example, one person had a fall, and this was not referenced in the review of the person's mobility plan.
• People's protected characteristics were not considered in the assessment process and there was no reference to people's needs in relation to their culture, religion or sexuality for example. However, staff were aware of the support people needed and could describe this to us. The interim manager said they would consider how to include this in future assessments and care plans.

Supporting people to eat and drink enough with choice in a balanced diet:
• People had mixed views about the food. One person told us, "The food here is mostly very nice." Another person told us, "The food so far has been Okay, but I did have to send mine back at lunchtime as it was cold." A visitor told us, "The meal yesterday was inedible, the liver was too hard to eat and the vegetables were stone cold." Whilst another visitor commented, "[Person's name] is eating much better and has put on weight."
• People told us they were not always given a choice of meal. Staff confirmed this was sometimes the case.
• The cook told us the menus offered a choice of main meals at lunch time and there were always alternatives available at other meal times.
• Our observations confirmed people were not asked about what they wanted for their meals. We saw people asking what the meal was at lunch time as staff put it on the table. One person said they didn't like the meal on offer and staff had to return to the kitchen to look for an alternative, whilst the person had to wait.
• We saw one person ask for a chicken sandwich at teatime. The person was told there were none left and offered egg as an alternative which they accepted.
• People had their needs assessed and plans put in place to meet them for food and fluid intake.
• One person was at risk of choking. We saw there was a risk assessment and plan in place. Guidance had been sought from the Speech and Language Therapy Team (SALT) this was included in the plan and we observed staff following this guidance whilst the person was being supported.
• However, where people's risk assessments identified they needed to have regular checks on their weight we found whilst people's weights were checked there was no analysis completed to confirm if there had been any significant weight loss or any actions taken. This meant people may be left at risk of continued weight loss and malnutrition.

Staff providing consistent, effective, timely care:
• There were written handover documents used to share information with staff coming on to a shift.
• Staff told us they found this was effective in keeping them up to date about changes to people's care needs.
• However, staff told us they sometimes found it hard to provide care which was timely. Staff told us the current numbers of staff meant people had to wait for support.

Adapting service, design, decoration to meet people's needs:
• The service design had been adapted to meet people's needs. For example, adapted toilets and bathrooms were available.
• We saw the building had handrails in place and a lift for people to access the first-floor areas.
• However, we found there was no picture signage to assist people living with dementia to locate areas within the home.
• There were no items available to provide stimulation from touch, sight or smell for people living with dementia.

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

• The 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 with appropriate legal authority. 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. Where people did not have capacity to make decisions, they were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.
• At the last inspection we found the principles of the Mental Capacity Act (MCA) had not consistently been applied. At this inspection we found some improvements had been made but more were needed.
• When a person was being deprived of their liberty, the service had applied for the appropriate authority to do so. However, there was no system in place to monitor when the applications needed to be renewed and applications required updating. We found some people's DolS required an application to renew their authorisation.
• We found there were people who had recently been admitted that may have lacked capacity. However, their capacity had not been assessed to determine if they could give consent to some aspects of the care. The interim manager told us they had received training in MCA and would ensure where people had not had the capacity assessment completed and where needed applications would be made to the authorising body.

Supporting people to live healthier lives, access healthcare services and support:
• People had access to support with their health and wellbeing.
• People told us they had access to health professionals including doctors, district nurses, opticians and dentists.
• Records showed people had been referred promptly for specialist health advice including from the SALT team and Doctors where needed.
• Where advice was given we saw this was incorporated into people's care plans and followed by staff. For example, SALT advice.

Requires Improvement

Is the service caring?

Our findings

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

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported:
• At our last inspection we found improvements were needed to the engagement between people and staff. At this inspection we found improvements had been made, however more were needed.
• People told us staff were kind and caring. One person said, "The staff are great, and I am very happy with what they all do for me." Another person told us, "I have been here years and find them all very nice." However, one person told us, "The staff often say they are short staffed and do not have time to sit and talk to me."
• Staff were observed to be busy and sometimes missed opportunities to engage with people. For example, we saw at some points during the morning staff were sat in communal areas with people however there was little interaction.
• We did see some positive interactions between people and staff. Staff appeared to know people well and engaged them in conversations. People were observed smiling and joking with staff.
• We saw staff were respectful and polite when speaking to people. One staff member was seen giving encouragement to a person whilst they walked and were not rushing the person.
• People had their communication needs assessed and planned for. Staff understood how to communicate effectively with people and were observed following the guidance in people's individual plans.

Supporting people to express their views and be involved in making decisions about their care:
• At the last inspection people were not consistently supported to make choices. At this inspection we found people were still not consistently offered a choice and involved in their care.
• People told us they were not aware of their care plan and could not recall being involved in developing this. People also told us there was not always a choice at meal times. Our observations confirmed this.
• We saw staff were not always offering a choice. For example, people were not offered a choice of meals, despite menus being in place which offered alternatives.
• Staff told us people could choose when to get up and go to bed and people's comments supported this. We saw people could choose where to spend their time.
• People were encouraged to maintain their independence. People told us they were able to do things for themselves and staff supported them with this. We saw staff were patient and allowed people time to complete things for themselves.

Respecting and promoting people's privacy, dignity and independence:
• People told us they had their privacy and dignity respected by staff and were happy living at the home. One visitor told us, "Everyone is polite and caring and we have no issues with privacy and dignity."
• However, we did see one person had their clothing displaced whilst staff were supporting with hoist. We

spoke to the interim manager about this and they said they would speak to staff to check people's dignity was protected when being transferred.
• We saw two people that had catheters which were incorrectly positioned exposing them for people to see and impacting on their dignity.
• Staff were observed knocking doors and ensuring people had their privacy maintained. Staff were respectful in how they spoke with people and about them.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means that services met people's needs.

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
• At our last inspection people had not been involved in their care plans and reviews were not completed and people's diverse needs were not consistently considered.
• At this inspection we found some improvements. Staff were responsive to individuals needs and reviews had been undertaken.
• However, people's diverse needs had not been considered within their care plans. Staff were aware of people's individual preferences, life histories and information about culture and religion for example, but care records lacked detail which meant there was a risk of inconsistent support.
• People told us they were bored and there was little time spent with staff and few activities. One person said, "I did like the music and singing yesterday – it would be nice to have lots of things like that." Another person told us, "I am lucky I can still read and do puzzles so I stay in my room."
• Staff told us there was little time to provide opportunities for people to engage in activity and they had no time to take people out into the community.
• We saw there was no activities with people during the inspection. People spent all day sat in communal areas without much engagement from staff unless they required support.
• People told us staff did respond to their requests. One person said, "If I need something, I ask one of the carers and they always sort it out for me." Another person told us, "I would soon speak up if I wasn't happy but so far, they have all been very responsive when I have asked for anything."
• We saw staff responded to requests. For example, one person asked for a blanket and staff fetched this straight away.

Improving care quality in response to complaints or concerns:
• People told us they understood how to complain. One person said, "I would have no hesitation to complain if I thought there was a need but there hasn't been." A visitor told us, "I did complain once and this was sorted out and all is ok now."
• There had been complaints received since the last inspection. We saw these had been investigated and a response given to the person. Complaint records showed actions had been taken to prevent the situation from occurring again.

End of life care and support:
• At the time of the inspection no-one was receiving end of life care.

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.

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:
• The provider has consistently failed to implement systems to deliver person-centred, high-quality care.
• At our previous five inspections carried out in June 2015, June 2016, May 2017, October 2017 and April 2018 we found that improvements were required in aspects of people's care and that regulations had been breached. On two occasions during 2017 the provider was rated as Inadequate and placed in special measures. This means people have been exposed to poor care for an unacceptable amount of time.
• At our last inspection the provider had made some improvements however they had failed to reach an overall rating of good.
• At this inspection we found the provider had not sustained the improvements made and other areas of improvement were now needed which meant people had not had sustained improvements in the quality of care they received.
• The provider had failed to ensure the system to monitor medicines administration was effective. The provider had an audit process in place, however this was not consistently completed and had failed to identify the concerns we found with stock control, a lack of guidance for administration and people had not received medicine which they needed, placing them at risk of harm.
• The provider had failed to ensure a system to effectively monitor accidents and incidents was in place. This meant there was no analysis completed to look for trends and enable action to be taken to prevent reoccurrence leaving people exposed to the risk of harm.
• The provider failed to ensure the system for monitoring people's weight was used effectively. This meant there had been no analysis of weights for a three-month period and no actions had been identified to address any concerns with weight loss. This meant people were exposed to the risk of harm.
• Systems had also failed to identify where people required an MCA assessment to determine the capacity to consent and where an application was required to renew a DoLS there was no system in place to monitor this.
• The provider had failed to implement a system which ensured incidents of possible abuse were reported to the local safeguarding team. There was an incident form in place which was reviewed by a manager, however the provider had failed to report the incidents for external investigation.
•The provider had failed to ensure staff received training required to carry out their role and meet people's needs safely. Despite a system being in place to monitor the training staff there were gaps in the training records which showed staff training was overdue and in some cases, training had not been given to any staff.
• The provider had failed to ensure checks were carried out on staff suitability to work with vulnerable

people. The provider had failed to recognise where employer references had not been obtained and a current DBS had not been applied for. This placed people at risk of being supported by staff that may not be safe to work with vulnerable adults.
• We found the provider was aware of their responsibilities for submitting notifications of incidents that had occurred at the service, which is required by law. These may include incidents such as alleged abuse and serious injuries. However there had been safeguarding concerns and notifications had not been received for these incidents.
• The evidence above showed that the systems in place to monitor and mitigate risk to people were ineffective. The provider had not ensured that improvements were identified and sustained at the service.

• This meant there was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff:
• People and relatives were asked for their views about the quality of the service.
• We saw there was a survey used by the provider to ask people and relatives questions about the service.

Continuous learning and improving care:
• The provider told us they used a train the trainer approach to learning. However, the trainer had left their employment and at the time of the inspection there were no other arrangements in place.
• The provider has since confirmed training has been arranged for two other staff members to become trainers to enable staff learning and development.

Working in partnership with others:
• The interim manager told us they worked in partnership with other professionals. For example, working with the SALT team to support people effectively.
• Staff confirmed people were referred to other health professionals when needed. Records supported this.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to administer medicines safely and manage risks to peoples safety. Exposing them to the risk of harm.

The enforcement action we took:

Notice of proposal to cancel the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The providers governance arrangements had failed to identify improvements to the quality of the service people received.

The enforcement action we took:

Notice of proposal to cancel the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure there was suitably trained staff

The enforcement action we took:

Notice of proposal to cancel the providers registration.