Lotus Care (Finch Manor) Limited

Finch Manor Nursing Home

Inspection report

Finch Lea Drive
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Finch Manor Nursing Home a residential care home providing personal care and nursing care for up to 89 people. The service provides support to older people and younger people requiring nursing care. At the time of our inspection there were 84 people using the service.

People's experience of using this service and what we found
People's safety was not always appropriately managed. Identified risks to people were not always considered or planned for. Equipment needed by people was not always available or not used effectively. Staff supporting people were not familiar with individuals' needs and there was a lack of guidance and support available to these staff. Cleanliness and infection prevention and control procedures were not effective, with many areas of the service requiring cleaning.

Detailed information about people's eating and drinking needs and preferences was not always available. This resulted in staff supporting people not being aware of people's dietary needs and preferences. Newly recruited staff and agency staff were not aware of people's needs and wishes, and the majority of staff had not completed their updated training for their role.

People were not always supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice.

Information available to staff was limited and failed to give sufficient information on how to engage with people. This was reflected in staff carrying out tasked based work and not involving people in making choices or decisions. Food choices were not always available or consistent for everyone.

People's care and support was not planned in a person centred way which promoted their choice, control or preferences. Staff supporting people did not have access at all times to effective, person centred care plans.

Records were not always fit for purpose and put people at serious risk of not receiving the care, treatment and support they needed. Audits and checks in place had failed to identify areas of improvements needed identified during this inspection. Staff were not always clear about their roles and the support people needed. No systems were in place to ensure that people were supported by staff who had the skills to meet the needs of people.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 6 May 2021).
At this inspection we found the provider was in breach of regulations and rated inadequate.

Why we inspected
We undertook a focused inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about staffing and the management of the service. A decision was made for us to inspect and examine those risks.

We inspected and found there was a concern, so we widened the scope of the inspection to become a comprehensive inspection which included all 5 key questions.

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.

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We have identified breaches in relation to person centred care; staffing; safe care and treatment; safeguarding; meeting nutritional needs and good governance at this inspection.

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

We have also made a number of recommendations to the provider to improve the quality of care people receive with regards to safe management of medicines, assessment and review of care, assisting people to orientate around the service and to ensure full compliance with the Mental Capacity Act 2005.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.
Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.
Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.
Details are in out caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.
Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.
Details are in our well-led findings below.

Finch Manor Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

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 3 inspectors and a nurse specialist advisor.

Service and service type
Finch Manor Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and personal care as a single package under one contractual agreement dependent on their registration with us. Finch Manor Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post. However, they were not available at the time of this inspection.

Notice of inspection
This inspection was unannounced on all three visits to the service.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought and considered feedback from the local authority. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 14 people who used the service and 4 visitors about their experience of the care provided. We spoke with 14 members of staff including care staff, the chef and 4 members of the senior management team. We reviewed a range of records. This included people's care and medicines records. A variety of records relating to the management of the service, including monitoring and reviewing information. After the inspection we reviewed additional information sent through to us by the senior management team.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Systems in place to identify, assess and monitor risk were not effective.
- People did not have access to equipment they needed at all times. In one area of the service people did not have access to the nurse call system. This put people at risk of not receiving care and support when needed. In another area of the service the nurse call bell sounder system was not working. This resulted in staff not being alerted when people had called for assistance.
- Systems in place for the monitoring of people's air pressure mattresses were not effective. The monitoring failed to check that the mattresses were inflated to the correct setting for people to receive appropriate pressure relief.
- Safety monitoring and management of the environment was not effective. For example, an external fire exit was blocked by car tyres and a bush.
- People's meals were seen to be transported around the building uncovered. In addition, a hot food trolley was seen unplugged with food to be served on top and uncovered.
- Identified risks to people failed to demonstrate that all areas of the person's needs and wishes had been considered when assessing people's care and support. Information recorded was contradictory, not complete or missing from the risk assessments in place.

Effective systems were not in place to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- There were shortfalls in the management of prevention and control of infection.
- Cups and plates were seen to washed in small sinks around the building with no appropriate drying facility. Staff were seen to dry the cups and plates with paper towels.
- Areas of the service were visibly unclean. Communal bathrooms and designated sluice rooms were being used to store items of equipment and continence products. In addition, during two visits, dirty toilet brushes were requested to be disposed of by inspectors.
- Soiled laundry was seen being stored inappropriately in bathrooms and corridors.
- A staff/training room had a kitchen for staff to use. The kitchen was unclean; dirty crockery stacked up with containers containing food debris. There was no soap for washing the crockery or hands in this area on two days of the inspection.
- A room used for the safe storage of medicines was unclean and had debris on the floor. At the time of our first visit this room was being deep cleaned.

Effective systems were not in place to prevent and mitigate risks of infection control. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● People were not supported by a sufficient number of experienced and supported staff.
● The service was reliant on a high number of agency staff to meet the needs of people. We saw examples of agency and newly recruited staff working with a language barrier, no direction or guidance as to how to meet the needs of people.
● On occasions we saw that the deployment of staff around the service did not meet the needs of the service. For example, whilst people were waiting for meals, three staff were seen to be waiting in a dining room awaiting instruction and guidance.
● Recruitment procedures were in place, however, records failed to demonstrate that all of these procedures had been followed.
● Insufficient staff were on duty to meet the domestic and laundry needs of people on the first day of the inspection. Following discussion, the senior management team made arrangements for agency staff to be employed.

Systems were not in place for the safe recruitment; support and deployment of staff. This placed people at risk of harm. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were happy with the care they received from regular staff. A number of people raised issues about language barriers and also the skills of the agency workers.

Systems and processes to safeguard people from the risk of abuse
● Systems in place to protect people were not always effective.
● Safeguarding concerns raised by the service and other agencies to the local authority had not been reported or recorded as required.
● Monitoring records failed to show what actions had been taken following an incident being reported. A number of concerns had not been reported to CQC.
● Training records showed that the majority of staff had not completed their annual safeguarding training.

Systems and process in place monitor and record safeguarding concerns were not effective. This placed people at risk of harm. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● People's medicines were not always managed safely.
● Liquid medicines did not always have the date in which the bottle was opened recorded.
● Prescribed thickener for use in drinks and a tub of flammable skin cream were not stored appropriately.

We recommend the provider consider current guidance on the safe management of medicines and take action to update their practice accordingly.
● All medication administration chart entries had been signed following administration of the medication. The provider had recently highlighted issues relating to the recording of administration. Steps taken to address this issue included a daily audit by a registered nurse.
● People who were prescribed 'as required' or PRN medicines had protocols which give clear guidance of

how and when to give these medicines. We did however observe that the review period for these documents had been exceeded by several months.

● Staff responsible for the administration of medicines had completed medicines training and had their competency checked.

Learning lessons when things go wrong

● The senior management team had recently introduced a new system for recording and reviewing incidents and accidents within the service.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question requires improvement. The rating for this key question has Changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Supporting people to eat and drink enough to maintain a balanced diet
- People did not always have their nutritional needs and wishes met.
- Catering staff were not aware of all people's dietary needs. There was a reliance on staff to complete information each morning to request what specific dietary needs people had. Not all staff did this. For example, information in the kitchen stated that 9 people required a specific modified diet preparing, however, the number of people requiring a modified diet was 23.
- Specific dietary guidance was not always followed for people. For example, 1 person's records stated that they required a 'soft' diet. This contradicted guidance in a letter from the Diabetes Service. Other guidance referred to in people's care plans could not be located.
- People were not always supported to eat and drink enough. For example, 1 person's care plan indicated they needed encouragement to eat. Their meal was left with them and no encouragement was provided. On one occasion, 9 people were seen eating a meal and no staff were available to support in the dining room.

Effective systems were not in place to ensure people received support with their nutritional intake. This placed people at risk of harm. This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
- People were not always supported by staff who had the relevant skills, communication, training and experience to meet their needs.
- Information about the agency staff training and support was not always available.
- Records showed that the majority of staff had not completed their training scheduled by the provider. This included update training to ensure that staff maintained best practice.
- We saw examples of staff not being aware of, or seeking information around people's needs and wishes.
- Newly recruited and agency staff were not familiar with the people they were caring for.

Effective systems were not in place to ensure people's care was delivered by appropriately trained, skilled and experienced staff. This placed people at risk of harm. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- People's needs and wishes were not always assessed in full.
- People's needs were not fully assessed, reviewed or documented to inform staff of what care and support

they required.
● Assessment information provided by other agencies involved in people's care and support was not always considered in the development of care plans.

We recommend the provider consider and implements current guidance and best practice for the assessment and ongoing review of people's needs.

Adapting service, design, decoration to meet people's needs
● People's living environment was not always planned effectively.
● There was insufficient seating in the lounge and dining areas around the service. Dining tables and chairs were limited and people were not encouraged to sit comfortably. For example, we saw 2 people sitting sideward on to the table when eating their meals.
● Internal doors were opened by keypads which prevented people moving around the service fully.
● There was a lack of signage and direction within the building which created a lack of orientation for both people using the service and visitors.

We recommend the provider consider and implements current guidance and best practice for orientation around the building and considers best use of the space available to support people using the service.

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 MCA 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● We found the service was generally working within the principles of the MCA. However, associated documentation was difficult to locate and at times gave conflicting information.
● A system had been developed to track people's DoLS applications and status. We found the information on the tracker was not effectively capturing all of the information required.
● There was evidence of on-going assessments of capacity and best interest meetings occurring. However, we found that not all best interest decisions had included the views of significant others.

We recommend the provider consider and implements current guidance and best practice for the implementation of the MCA.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Systems were in place for people to have access to the healthcare support they required. GP services and associated health care professionals visited the service on a regular basis to monitor people's health.

● Advice and guidance provided by health care professionals following people's appointments was not always incorporated or available in people's plans of care.

Requires Improvement

Is the service caring?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant people were not always well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

- People had not always been treated or spoken to with dignity and respect.
- People were being supported by a number of staff who did not know them well and there were barriers with communication.
- Information available to staff was limited and failed to give sufficient information to staff of how to engage with people. This was reflected in staff carrying out tasked based work and not involving people in making choices or decisions. For example, we saw 1 person being asked what they wanted for lunch. The person said chips. Staff failed to offer any further items that were available to be served.
- Food choices were not always available or consistent. Staff told us that in 2 areas of the service sandwiches were available for supper. In the other 2 areas, people were offered cake and biscuits. Staff commented that there were no treats in one particular area as there were a lot of people with diabetes.
- People's recorded choices were not always considered, 1 person was seen with soup at lunchtime, however their care plan stated that they did not like soup.
- People were not always well treated. People told us they were served cold food and communal living areas were unclean.
- People wishes were not always considered. For example, a member of staff was supporting a person and they became anxious. This anxiety was reduced when the support was provided by another member of staff with a different gender. Arrangements for the support had initially failed to consider the person preferred staff of a certain gender.

Respecting and promoting people's privacy, dignity and independence

- People's privacy was not always maintained. We saw a member of staff and a health care professional carrying out a review in a communal lounge in front of 8 other people.
- People's personal information was not stored appropriately. Care planning documents were seen in lounges and open cupboards that were accessible to all.
- The majority of bedrooms did not have any form of usable privacy locks.

Effective systems were not in place to ensure people's dignity and respect were maintained. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant people's needs were not always met.

Meeting people's communication needs; Planning personalised care to ensure people have choice and control and to meet their needs and preferences
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People's care and support was not planned in a person centred way that promoted their choice, control or preferences.
- Information about people's care and choices was not always recorded, was inconsistent or out of date. Information available was not sufficient and could prevent staff delivering people the care and support they needed. Records that were available failed to demonstrate people had received the care and support they required consistently.
- Staff supporting people did not have access at all times to effective, person centred care plans.
- People did not always have access to information that met their needs. For example, menus were in small print, and not always available for people to make choices from.
- People were not always supported by staff who understood their communication needs or have an understanding as to how people expressed their needs.

Systems were not in place to ensure people's needs were assessed and planned for in a person centred way. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- A complaints procedure was in place.
- The senior management team had introduced a monitoring log to record complaints received about the service. This included responses to complainants and actions taken.

End of life care and support

- The care planning format gave the opportunity to record people's information as to how they wanted to be cared for at the end of their life.
- Where there was a Do Not Attempt Resuscitation (DNAR) directive was in place, the information was available in the individual's care plan.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- People did not receive care and support that was person-centred or that was planned to achieve good outcomes.
- Records relating to people were not fit for purpose and put people at serious risk of not receiving the care, treatment and support they needed. Records failed to demonstrate the care and support people had received or been offered. On occasions, written information was not available, legible or consistent. This included information relating to staffing; the monitoring and management of people's skin; identified risks; nutrition and people's rights under the MCA.
- Abbreviations were used on care records. These abbreviations had several meanings and staff were not always aware of what they meant.
- Audits and checks which were in place failed to identify areas of improvements identified during this inspection.
- An internal home improvement plan had been developed by the senior management team. The monitoring of this improvement plan was not effective as it had identified that some areas of improvement had been achieved. However this was not evident during the inspection.

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

- Staff were not clear about their roles and this put people at risk of not receiving the care and support they needed.
- There was no effective leadership throughout the service. Staff tasked with the management, oversight, directing and monitoring of staff teams were located in offices away from the areas that support was being delivered.
- No systems were in place to ensure that people were supported by staff who had the skills to meet the needs of people.
- There was a lack of awareness by those responsible for reporting specific incidents to CQC. This included the timeliness of reporting incidents and knowledge around the MCA.
- The provider did not demonstrate oversight to ensure people received high quality care in a safe environment.
- We were not assured that all accidents and incidents had been recorded and managed appropriately.

This was due to the lack of or limited information recorded.

● We saw incidents when opportunities to improve care were not acknowledged. This included failure to act on areas brought to staff attention during this inspection including the removal of specific equipment; ensuring people had access to a call bell whilst they were in bed and a lack of frequency for pressure relief.

The registered provider had failed to assess and monitor the service for quality and safety; deploy and manage staff delivering care and support; maintain accurate records for people and staff; ensure appropriate training was available and mitigate risks to people. This 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, fully considering their equality characteristics

● Surveys had taken place with people to gain their thoughts and opinions on the food and service available to them.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Systems were not in place to ensure people's needs were assessment and planned for in a person centred. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	Effective systems were not in place to ensure people's care was provided with dignity and respect. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Effective systems were not in place to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Effective systems were not in place to prevent and mitigate risks of infection control. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and process in place monitor and record safeguarding concerns were not effective. This placed people at risk of harm. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Effective systems were not in place to ensure people received support with their nutritional intake. This placed people at risk of harm. This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to; assess and monitor the service for quality and safety; deploy and manage staff delivering care and support; maintain accurate records for people and staff; ensure appropriate training is available and mitigate risks to people. This was a breach of Regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Systems were not in place for the safe recruitment; support and deployment of staff.

This placed people at risk of harm. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.