Halcyon Care Homes No 1 Limited

Canterbury House Care Home

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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Canterbury House Care Home is a residential care home providing accommodation for up to 66 people requiring personal care to in one large purpose-built building. The service provides support to older people who may be living with dementia. At the time of our inspection there were 35 people using the service.

People's experience of using this service and what we found
People were not always safe living at the service. Potential risks to people's health and welfare had not been consistently assessed and there was not always guidance for staff to reduce the risks.

Accidents and incidents had been recorded and analysed but action taken had not been effective in mitigating risks and trying to significantly reduce them from happening again. Checks and audits had been completed but there was little evidence that learning from previous incidents had been used to improve the quality of the service or reduce risks.

There was not always enough staff to support people and keep them safe. Staff worked in a task-orientated way and consequently people were not always treated with dignity and respect. There were not always positive outcomes for people with more complex needs.

People were supported by staff, who did not have the skills and training to support them safely. Staff were supporting people living with health conditions such as diabetes and requiring catheter care. Some staff had no previous social care experience and they had not received appropriate training to support people with health conditions.

People were supported to eat a balanced diet, however, staff had not always acted when people had not drunk enough fluid to meet their target fluid intake. People received their medicines as prescribed, records of administration were not always accurate.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

The registered manager understood their responsibility to report concerns of discrimination or abuse to the local safeguarding authority. People were referred to healthcare professionals when their needs changed. People's end of life wishes had been recorded in their care plan.

People had been involved in activities and celebrations, people told us they had enjoyed the Easter and Mother's Day activities. The provider had a complaints procedure in place, this had been followed when complaints were received. People and relatives were invited to regular meetings where they were able to make suggestions about the service.

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

Rating at last inspection
This service was registered with us on 23 June 2021 and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about the management of risks around people's eating and drinking. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring and well led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, staffing and well-led at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

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

Is the service effective?

Requires Improvement

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

Is the service caring?

Requires Improvement

The service was not always caring.
Details are in our 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?

Requires Improvement

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

Canterbury House Care 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
The inspection was carried out by one inspector.

Service and service type
Canterbury House Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Canterbury House Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 30 May 2022 and ended on 16 June 2022. We visited the service on 30 May 2022.

What we did before the inspection
The provider was not asked to complete the Provider Information Return (PIR). This is information providers are required to send us annually with key information about the service, what it does well and improvements they plan to make. We reviewed information we had received about the service since the last inspection. We used all this information to plan our inspection.

During the inspection
We spoke with four people and three relatives about their experience of the service. We observed staff interactions with people in the communal areas. We spoke with nine members of staff including the registered manager, care manager, deputy manager, operations director, regional support manager, carers and housekeeper.

We reviewed a range of records. This included four people's care plans and all the medication records. We looked at three staff files in relation to recruitment. We reviewed a variety of records relating to the management of the service, including checks and audits.

Requires Improvement

Is the service safe?

Our findings

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

This is the first inspection of this newly registered service. This key question has been rated Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Potential risks to people's health and welfare had not been consistently assessed and there was not always guidance for staff to keep people safe. Prior to the inspection two people had experienced choking incidents and following the inspection another person had a choking experience. One person had been coughing after eating, staff referred them to speech and language therapist (SaLT) for assessment. The care plan and risk assessment were not updated with additional guidance for staff to reduce the risk of them choking while waiting for the SaLT assessment. A week later the person had a choking incident that required staff intervention and hospital admission. The provider did not complete an investigation until after the third choking incident on 2 June 2022. Following the investigation an action plan was put in place and there have been no further choking incidents.
- Some people were prescribed medicines to thin their blood. This placed them at risk of bruising and taking longer for any bleeding to stop. There was no guidance for staff about how to support people following incidents or falls and the additional risks of bleeding. Following the inspection, risk assessments were put in place with guidance for staff.
- There were some people living with diabetes who had been prescribed insulin, this support was provided by the district nurses, who attended the service daily to give the regular dose of insulin. Staff were responsible for monitoring people's health and wellbeing the rest of the time. There was information for staff about how someone would present if they had low or high blood sugar. One person had been prescribed an additional dose of insulin if their blood sugar was above a certain level. However, staff were not trained to record blood sugars to identify when this was needed. There was no information about how to assess if the person needed the insulin without blood sugar levels being taken. The care plan did not tell staff who to contact to give the insulin if needed.
- Following the inspection, the service sent us a diabetic template for staff to use as the basis of a diabetic care plan which should be altered as required to be person centred. The template states blood sugars would be taken by the community staff, however, it does not provide guidance on how when people were unwell staff would manage while community staff were contacted. Community staff would not necessarily be available to provide support quickly and staff would need to manage the person's care while unwell. The template did not address how staff would do this as they were unable to monitor blood sugar levels. The signs of low blood sugar are like how people would present if they had an infection, staff would not be able to confirm the person was unwell because of low blood sugar without recording a blood sugar level. There was a risk people would not receive the appropriate support as quickly as possible.
- When people required support with their mobility, there was not detailed guidance for staff about how to use equipment such as how to position a sling when moving people with a hoist, to keep them safe. When people's mobility needs fluctuated, there was no guidance for staff about how to assess their mobility needs

daily.
● Accidents and incidents had been recorded and analysed for patterns and trends. However, action taken had not always been effective or alternative ways to reduce re-occurrence identified. One person had rolled from their bed on one side, staff moved their bed to stop them rolling out of that side. A mattress and sensor mat had been placed on the other side of the bed. However, there were two further occasions in the month where the person was found to have rolled out of bed. There had been no further checks to make sure there were no additional measures that could be put in place to reduce the risk of the person rolling out of bed.
● Some people had fallen on multiple occasions. Measures such as a sensor mat and hourly checks had been put in place, but people continued to fall. There had not been further assessment to check if there were additional measures that could be taken to reduce the risk of falls.

The registered persons failed to assess and mitigate risks to people's health and safety. This is a breach of regulation 12(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Checks on the environment and equipment used had been completed including fire equipment and hoists.

Staffing and recruitment
● There were not always enough staff to meet people's needs. The number of care hours needed had been calculated using a dependency tool and analysis showed additional care hours had been provided. The registered manager told us, the minimum number of staff needed was seven to meet people's needs. The duty rotas showed there was always the minimum number of staff available. However, the staffing levels were variable and there were some days when there were up to 13 staff available. During the inspection there were nine care staff on duty, we observed the staff were busy and having to ask people to wait when they were calling.
● There was not always enough staff available to support people to get up washed and dressed when they wanted. People were still in bed waiting for assistance to wash at 11.30am. There was one person calling out for assistance as they had been incontinent. Staff told us, there was not always enough staff to give people their care in a timely way as there had been an increase in people requiring two staff to provide support.
● Staff told us, there was not always enough staff to complete welfare checks on people, while they were supporting people with their personal care. Analysis of accidents and incidents showed in the three months before the inspection, there had been 44 falls. There had been 38 unwitnessed falls where people were found on the floor, between 65% and 73% of these were in people's rooms. At the beginning of May 2022, the majority of falls happened when staffing levels there were ten or less during the day.
● During the inspection, we observed people spending long periods of time by themselves in their rooms, without staff intervention. Staff were also rushed and appeared to be task-orientated in order to make sure they were able to support people to get up.

The registered persons had failed to provide enough staff to meet people's needs. This is a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were recruited safely. Checks had been completed to make sure applicants were of good character to work with people. These checks included Disclosure and Barring Service (DBS) checks which provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely
● Medicines were not always managed safely. Staff used an electronic system to record administration of

medicines and supplies of medicines. Staff had received training and their competency had been checked before they administered medicines.

● However, people did not always receive their medicines at the times on the medicine administration record (MAR).. One person's MAR chart showed they were due pain relief at 9am, some staff had not given the medicine until 11am, when they were due another tablet. The rest of the tablets would have to be given later to leave the correct amount of time between doses. The deputy manager told us they would speak to the staff members about the issue. This was an area for improvement.

● Some medicines required specific storage and administration including a witness to them being administered. Both staff administering the medicine had been recorded on the electronic system. However, the recording of the stock available and administration in a register is a legal requirement. This register was not accurate as both staff had not always signed to confirm administration. This is an area for improvement.

● Medicines were stored at the correct temperature to keep them effective. The number of tablets available matched the number recorded on the electronic system.

Systems and processes to safeguard people from the risk of abuse

● There were systems in place to protect people from discrimination and abuse. Staff described different types of abuse and what signs of abuse they would look for. Staff knew how to report any concerns they may have and were confident the registered manager would take the action required. Staff also knew they could report concerns to the local safeguarding authority if their concerns were not acted on.

● The registered manager understood their responsibilities to report concerns to the local safeguarding team as required. Concerns had been reported as required and the service had worked with the local safeguarding authority to investigate concerns where necessary .

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

● The service welcomed visitors, there had been a steady flow of visitors the weekend before the inspection. We spoke with visitors during the inspection, they told us they had been able to visit how they wanted when the service did not have a Covid-19 outbreak.

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.

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff did not always receive the training they needed to support people with some health conditions. Staff received training in essential subjects such as fire training, moving and handling and infection control. Some people were living with health conditions such as diabetes and others needed a catheter. However, staff did not automatically receive training in these topics. Some staff were experienced care staff, however, there were staff who had never worked within the care sector before and did not have any experience. The registered manager told us, they would work with health professionals to decide if staff required additional training. This is an area for improvement.
- Staff received an induction when they started work at the service. This included essential training both face to face and online. Staff told us they worked with more experienced staff to learn about people's choices and preferences.
- Staff told us they felt supported by the senior care staff. One staff member said, "When they are going to do something I have not done before, they make sure I go and watch, and I can ask questions."
- Staff received supervision to discuss their development, staff who had worked at the service longer had discussed their future training requirements including diplomas.

Supporting people to eat and drink enough to maintain a balanced diet

- People were not consistently supported to drink enough fluid. Some people had targets for the fluids they should drink to remain healthy. Some people had a target of 1500mls per day, records showed in one week they had not always been offered over 1500mls of fluid each day. For example, one person had only drunk their target amount on two days during the week. Team meeting minutes reminded staff of the importance of offering fluids to people.
- Some people had specific dietary needs such as a soft diet, meals were prepared as needed. When people required assistance to eat their meals, staff supported them as required.
- People were offered the choice of eating in their rooms or in the communal dining room. Meals were plated up in the dining room and people were offered a choice of meals and drinks. People told us, they enjoyed the food and there was plenty to eat.

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

- People met with a member of the management team before they moved into the service. A complete assessment of the person's needs was completed. This included the protected characteristics set out in the Equalities Act 2010. The pre-admission assessment was used as the basis for the person's care plan when they moved into the service.

● People's health needs were assessed following best practice guidance using tools as recommended in the guidance.

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

● Staff worked the with the district nurse to support people with their healthcare needs. When people's healthcare needs changed, they were referred to specialists such as the dietician. Staff followed the dietician's guidance and dietary supplements were given as prescribed. Relatives told us, staff called the GP and emergency services when needed.

● People were supported to have access to the optician, dentist and chiropodist when required. People had been supported to attend hospital appointments. People had an oral health care plan in place to support people to keep their mouths healthy.

Adapting service, design, decoration to meet people's needs

● The service was a new purpose-built building with bedrooms over three floors. Each room had en-suite facilities that were large enough to accommodate a wheelchair easily. The furniture in the en-suites followed good practice guidance, for example, the toilet seat was a different colour so people could differentiate it from the toilet.

● The corridors were wide and free from obstacles, to support people to move easily around the service. There were various communal and quiet spaces for people to spend their time if they wished. People had access to secure outdoor space. There was signage within the building to help people find their way around.

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.

● People's capacity to make complex and simple decisions was assessed by staff. When required DoLS applications had been sent. Only one application had been authorised at the time of the inspection.

● Staff understood their responsibility to support people to make their own decisions. Staff described how they assisted people to choose their own clothes. We observed people being asked what they would like to eat or how they wanted to spend their time.

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.

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People had not always been treated with dignity and respect. During the inspection, we observed people's rooms were not always tidy, including rooms where people relied on staff to keep it tidy. The sheets on people's bed had not always been ironed. Some sheets were very creased which did not look comfortable to sleep on, creased sheets also placed people at risk of skin damage.
- People's rooms had built-in furniture, limiting how the rooms could be changed. One person's bed had been moved, the new position meant that when they were in bed, they were facing a blank wall. They were also unable to view the television or look out of the window when they were sitting in their chair. The person spent all their time in their room, this had not been taken into consideration when their bed had been moved, and how this would affect their quality of life and their wellbeing.
- We observed staff treating people with kindness when they were supporting them. Staff supported people when they were anxious and knew how to calm people.

Supporting people to express their views and be involved in making decisions about their care

- Some relatives were concerned they had not been involved in decisions about their loved one's care when they were their legal representative. One relative told us, staff had spoken to medical professionals and made decisions such as new medicines being prescribed without consulting them. The relative was unhappy as the medicines had not been appropriate and did not have a positive outcome and had to be stopped.
- People's care plans recorded who had been involved in developing the plan including people and relatives. There were records about how decisions were made if the person was not able to make their own decisions.
- People we spoke with, told us they were supported to express their views at appointments and when they saw their GP.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People who were not able to express their needs did not always receive care that was person centred and met their choices and preferences. We observed people trying to get out of bed as they wanted to get up, people had not been assisted to get up at the time they preferred.
- People who were able to express their needs told us they were supported in the way they preferred. Each person had a care plan in place, people's choices and preferences had been recorded. There was information about people's life history and family, there was were details about their family and hobbies.
- Care plans contained information about people's preferences about the carers who supported them. There were clear instructions about what support people required with their washing and dressing. People told us they were supported when they requested, one person said, "I can do a lot for myself, but they help when I need them."

Meeting people's communication needs

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 received information in the way they preferred. When required information was given in large print or pictorial format.
- Staff asked people if they needed information in a particular way such as spoken books.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People had access to activities they enjoyed. People were supported to take part in gardening and baking. Events had been held to celebrate important dates such as Easter and Mother's Day. People had made Easter bonnets and table decorations for display and there was a tea party which people had helped to make cakes for.
- People were supported to keep in contact with their families. When visits were not possible for everyone during Covid-19 outbreaks people were supported to stay in touch by phone or video technology. People had visits from their families and friends in their rooms.

Improving care quality in response to complaints or concerns

- The provider had a complaints policy in place, this was on display within the service. There had been one

formal complaint since the service opened. The complaint had been investigated and responded to following the provider's policy.

● People told us they were happy to raise any day to day concerns with staff and these were sorted out quickly. One person told us, staff always looked for her clothes if they were not in their room when they wanted to wear them.

End of life care and support

● People had been asked about their end of life wishes. When people were happy to discuss these or had advanced directives in place, these had been recorded in the care plan.

● People received end of life care from staff supported by the district nurses. People were prescribed medicines to help keep them comfortable.

Requires Improvement

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.

This is the first inspection for this newly registered service. This key question has been rated Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- The provider had a quality assurance system in place, the system had not always been effective in promoting improvement within the service. Checks and audits were completed on all areas of the service, these had been effective in identifying shortfalls. However, action taken had not been effective in reducing the risk of them happening again. Checks and audits had not produced a significant improvement in the quality of people's care plans. People remained at risk as there was limited guidance for staff to manage health conditions such as diabetes and move people safely.
- The monthly quality monitoring report identified shortfalls within the service. The actions put in place had not always been effective in responding to reducing risk quickly. For example, there had been a small reduction in the number of falls but there were still many falls within the service. People had continued to fall after action had been taken and had not been effective.

The failure to improve the quality and safety of the service and mitigate the risks relating to the health and safety of people living at the service. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. This is so we can check appropriate action had been taken. The registered manager had not consistently submitted notifications as required for example CQC had not been notified of DoLS authorisations and serious incidents had not been notified when they had happened.

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

- Outcomes for people were not always positive. Staffing levels did not always support person-centred care and positive risk management. People with more complex needs had not always been supported to have positive outcomes and reduce risk.
- Staff told us they felt supported by the management team and they saw the senior management team regularly. They felt they were listened to and could raise any concerns they may have. Staff were confident action would be taken, however, none of the staff we spoke with had raised any concerns.

Engaging and involving people using the service, the public and staff, fully considering their equality

characteristics

● People and relatives had the opportunity to attend meetings, these had not been regular due to the pandemic. They had been encouraged to raise any concerns they may have. Suggestions had been about additional handrails in the en-suite bathroom for some people. This had been put in place for the people who wanted them.

● There were regular staff meetings, including separate meetings for different groups of staff. The meetings discussed staff practice, any shortfalls identified and any actions that were needed. However, the meeting minutes were not comprehensive, which had been identified by senior management. The minutes did not provide a clear commentary on any action that was being taken or any follow up.

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

● The provider understood their responsibilities to be open and honest when things had gone wrong. Duty of candour letters had been sent to relatives when incidents had happened, explaining what action had been taken in response.

● Relatives told us they were always informed when something had happened and what action had been taken.

Working in partnership with others

● The provider worked with other healthcare professionals to provide the care and support people required.

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons failed to assess and mitigate risks to people's health and safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The failure to improve the quality and safety of the service and mitigate the risks relating to the health and safety of people living at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered persons had failed to provide enough staff to meet people's needs.