Barchester Healthcare Homes Limited

Kingfisher Lodge

Inspection report

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Date of inspection visit:
19 September 2016

Date of publication:
02 November 2016

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

During August and September 2016, we received a significant number of concerns about staffing levels and care provision at Kingfisher Lodge. This information of concern was received from people's relatives, staff and from healthcare professionals who had visited the service. As a result of this information, we undertook an unannounced inspection of Kingfisher Lodge on 19 September 2016.

When the service was last inspected in November 2014, we found the provider had failed to ensure there were adequate staffing levels to meet the needs of people at the service. The provider wrote to us in February 2015 and told us how they would achieve compliance with this regulation. During this inspection, we found the provider has not ensured staffing levels were adequate to meet the needs of the people at the service.

Kingfisher Lodge provides accommodation for people who require nursing or personal care to a maximum of 60 people. At the time of our inspection in September 2016, 47 people were living at the service. The service is split over two floors, with Chaffinch unit on the lower floor and Lark unit on the upper floor. Lark Unit primarily supports people living with a dementia type illness.

A registered manager was not in post at the time of inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A general manager had assumed post in May 2016 and was currently undertaking the registration process with us to become the registered manager.

Following this inspection in September 2016, we wrote to the provider to outline the immediate concerns we identified and requested that an urgent action plan to address our concerns was produced. The provider responded to us within the requested timeframe. They acknowledged the seriousness of the concerns we had raised and the impact they were having on the quality of care provided to some people. We have since responded to the provider and requested they send reports to us at specified frequencies. These reports relate to the current staffing levels at the service in order to demonstrate to us that the service is able to meet people's assessed needs.

The provider had not ensured there was enough staff on duty to consistently meet people's needs. This placed people at the service at risk of not having their assessed needs met. Medicines were not always managed safely and medicine recording omissions made it unclear if people had received their medicines as prescribed. There were no effective systems in operation that ensured accidents and incidents were reviewed to reduce the risk of recurrence and risks to people. People were placed at risk through poor cross infection prevention practice.

There were insufficient systems to show that the service had met the Deprivation of Liberty Safeguard

(DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm. There was no evidence that the service understood the conditions attached to people's DoLS or how they were being implemented. In addition to this, the provider was not consistently providing care in line with people's consent and with mental capacity legislation.

Staff at the service were caring and people and their relatives spoke very highly about the caring nature of staff. We made positive observations of care provision, however we also received information from people and made observations of how staff were unable to be consistently caring through inadequate staffing numbers. People's clinical needs were not consistently met in relation to pressure ulcers and diabetes care. In addition we found that where people required pressure relieving mattresses to meet their needs, there was no effective system to ensure these were correctly set which placed people at risk.

There were governance systems provided, however these had not always been effectively used. There were inconsistencies between Chaffinch and Lark units and no management systems in operation that identified this. People, staff and their relatives gave mixed feedback on the management of the service. Although we noted the service had received regional support from the provider, this was not consistent. Prior to the inspection the provider had failed to ensure people's health, safety and welfare needs were met by failing to ensure sufficient management arrangements were in place during a pre-planned absence of both regular managers.

People and their relatives spoke positively about the staff at the service. Most wished to stress that although they were giving us information about negative experiences at the service, they felt the staff were very caring.

The service had safe recruitment procedures. The environment was risk assessed and there were regular systems to ensure the equipment within it were serviced and functional. Staff were supported through a training programme and supervision was completed. It was noted that supervision completion was low but the manager told us this was being addressed.

People were supported with their nutritional needs and people had access to healthcare professionals when required. There was a complaints procedure in operation however we saw the responses were inconsistent.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore 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.

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.

Staffing levels were unsafe and did not meet people's needs.

Medicine management was not consistently safe.

Accidents and incidents were not reviewed to reduce the risk of recurrence.

Infection control practice did not always follow published guidance.

Recruitment was safe and environmental checks were completed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The Mental Capacity Act 2005 was not always adhered to.

The service was not meeting the Deprivation of Liberty Safeguards.

Training to protect people and staff from harm was not currently provided.

People were supported with food and drink where required.

People had adequate access to healthcare professionals.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff could not always be caring due to inadequate staff levels.

People spoke positively about the staff that supported them.

Observations of kind and compassionate care were observed.

People's relatives spoke positively about staff.

The service had received compliments about the care provided to people.

Is the service responsive?

Requires Improvement

The service was not responsive.

People's care and treatment needs were not consistently met.

Care plans were not always person centred or accurate.

Diabetes care was not always responsive.

There was a complaints system but it was inconsistently applied.

There provider had an activities programme for people.

Is the service well-led?

Inadequate

The service was not currently well led.

Governance systems had not been used effectively.

People and relatives gave mixed responses to the service management.

Staff did not feel supported by the management or provider.

The provider had not ensured people were safe in the absence of management.

The manager felt supported by the provider.

Kingfisher Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was carried out by three inspectors, two specialist nurse advisors 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. When the service was last inspected during November 2014, we found the provider had failed to ensure there were adequate staffing levels to meet the needs of people at the service.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We reviewed the information in the PIR and information that we had about the service including statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

Some people in the home were living with dementia and were not able to tell us about their experiences. We used a number of different methods to help us understand people's experiences of the home such as undertaking observations. This included observations of staff and how they interacted with people and we looked at ten people's care and support records.

During the inspection, we spoke with 15 people who used the service, four people's relatives and nine members of staff who were providing care to people on the day of our inspection. This included nursing staff and care staff, some of which were agency staff. In addition to this, we spoke with the manager, the deputy manager, the training manager and a member of maintenance staff. We spoke with one visiting healthcare professional. During the inspection the provider's acting regional director and clinical development nurse attended the service and we also spoke with them during the course of the inspection.

We looked at records relating to the management of the service such as policies, incident and accident records, recruitment and training records, meeting minutes and governance systems.

Inadequate

Is the service safe?

Our findings

At the inspection of Kingfisher Lodge in November 2014, we found that the provider had not ensured sufficient numbers of staff were deployed in order to meet the needs of people using the service. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010 which now equates to a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.The provider wrote to us in February 2015 and told us how they aimed to achieve compliance with the regulation.

During this inspection, we found the provider had not taken the action they had planned to in order to meet this regulation and to reduce the risks to people associated with poor staffing levels. Many of the concerns we received from people's relatives and staff prior to this inspection related to the poor staffing levels at the service and how this impacted on people's care.

In addition to a continuation of the breach in staffing we found at our last inspection, we also found that people were additionally placed at risk of harm through the unsafe management of medicines and the absence of a robust incident and accident analysis. Infection control practice was not always undertaken by staff in accordance with published guidance.

We discussed the current staffing levels with the manager. They told us the provider had a staffing level dependency tool known as the 'DICE' tool. They explained how this did not always accurately calculate the correct number of staff and was therefore not always effective. The manager explained how they had recently increased the staffing levels above the suggested 'DICE' calculation. In addition to this, following a visit from the acting regional director just prior to our inspection, the number of staff was increased further above the 'DICE' tool calculation as it was evident staff were unable to consistently meet people's needs. The service currently had eight full time care staff vacancies and was actively recruiting. There was currently a large dependency on agency staff at the service which had an impact on the continuity of people's care. We were further informed that both 'Heads of Unit' had recently resigned and were working their notice period.

In the week prior to our inspection, it was established that the manager and deputy manager were both on annual leave. This resulted in no regular senior management being on duty at the service. The information of concern we had received from relatives stated that this had left the service with no leadership. We were informed by the acting regional director that staff at the service had access to support from them over the telephone or from the provider's other services in the area. The acting regional director had attended the service on the Wednesday of that week, following information of concern from the Commission, and authorised an increase in staffing levels further above the provider's 'DICE' tool calculation, but there had not been any follow up checks to establish if this was effective and if the increase In staffing had ensured people's needs were met.

We found records that showed staffing level concerns and staff dissatisfaction had previously been identified by senior managers employed by the provider. It was not evident this information had been

highlighted to more senior personnel to allow action to be taken. For example, in May 2016 an audit was completed by the provider's regulation team. Within the audit it recorded observations from the regulation team that demonstrated people's needs were not always met. One extract of the audit read, 'At 11.55am nine residents were in the lounge on Memory Lane with the television showing a programme that only one person was engaged [in]. There were no staff and some people did not have the capacity to have or to use the call bell.'

In relation to staffing at the service, the regulation team audit also stated, 'Supplementary charts were not being completed in real time and staff said this was because they were to (sic) busy too (sic) keep going to the charts to complete them.' This showed that staff had disclosed to the regulation team that staffing numbers were not ensuring accurate records were maintained which presented a risk to people at the service as this may result in unsafe or inappropriate care provision.

In addition to this, in August 2016 the provider's regional clinical development nurse had completed a care and quality support visit in July and August 2016. During a review of the supporting records of these audits, it was noted that understaffing had been identified as an issue by staff in August 2016. There was no supporting evidence to show this had been highlighted and addressed by senior managers since the audit or evidence that any action had been taken following the audits. The care and quality support visit record stated, 'Staff reported that they feel stretched and are unable to deliver care to an acceptable standard due to increasing demands. Staff reported they do not feel heard by the management team and do not feel supported, morale was very low during the visit.'

Some of the relatives we spoke with gave examples of how poor staffing levels had impacted on care provision. For example, one relative we spoke with explained how they had arrived at the service at 4pm on a particular day, and saw their relative was still in the bed. They told us that staff informed them there were not enough staff to help the person to be assisted from their bed and dressed. This relative accounted how the toothbrush of the person was always dry, giving concern to the level of oral hygiene the person received. They were unable to recall when their relative last received a shower and we did not observe people receiving a shower or bath on the day of our inspection. They explained how on a different occasion, they arrived at the service around 11am. The door to their relative's room was closed and their relative was again lying in their bed awake with no television and music on. They explained their relative was 'filthy' with dried food on their mouth and that they appeared uncomfortable. One relative we spoke with said, "Staff are just racing around all of the time." Another relative said when asked for their views, "Profit before people - that's what it feels like."

One member of staff said there was not enough staff on duty to meet people's needs. We observed during a medicines round one person asking the staff member completing the medicines round if they could get up. It was 9.50am. The staff member said, "I'll send someone, but we are quite busy." We also overheard another person calling out for help. They had also rung their call bell. We asked them if they were ok, and they said they needed the toilet desperately. We found a member of staff who said they were aware that they needed assistance and would be with her straight away. As the member of staff approached the person's bedroom, the person in the room next door came out of their room and told the staff, "This lady has been calling out, please can you help her."

We saw records that showed where inaccurate pre-admission assessments had impacted on staff deployment. For example, one person had recently been admitted to the service for short term respite care. Their assessment record stated to, 'Let her put her own earrings in.' From undertaking observations and speaking with staff it was evident that this person continually put things they were holding in their mouth. The person was also very tactile which meant they were vulnerable with at least three other potentially

aggressive residents if they touched them. The person had been found with their earrings in their mouth presenting a choke risk. A decision was made by the nurse on duty for the person to receive one to one care to make them safe. There was no extra staff to on duty to reflect this, effectively making the Lark unit another care worker short.

All of the nursing and care staff we spoke with told us the service was consistently understaffed and told us that this had a negative impact on people. Some of the staff we spoke with were very concerned about the risks poor staffing was having on people, a staff member said they felt like they, "Neglected our residents" due to current staffing concerns. Another staff member we spoke with said, "It's quite a stressful place to be, not enough staff. We are spending all day getting people up." Another told us, "It's an absolute nightmare, so overworked it's unbelievable. People not getting up until 5pm." The staff member did confirm that people were having their continence aids checked and receiving food and drink but said that staff did not have the time to get people up. Other staff commented that people's needs were not always met in relation to repositioning them in bed and that it could be up to six or seven hours before they moved people. This placed people at risk of developing a pressure ulcer and other complications associated with prolonged time in bed. Staff also told us how poor staffing levels had impacted on them being able to accurately complete daily records. This included records such as food and fluid and repositioning charts.

A bath/shower list was displayed in the nursing office. There was, on average, 10 people on the shower list each day. A member of staff told us that no one on the ground floor currently used the bath. The member of staff told us most of the time they did not shower this number of people. On the day of inspection, the member of staff was unable to tell us of anyone who had been showered. Staff commented, "People sometimes don't get to have the baths or showers they need because we don't have time." The staffing has got worse this year, this manager has brought in a lot of new residents with high needs and we just don't have the staff."

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were not always managed safely. Medicine Administration Records (MAR) had photographs of people at the front and these had been dated to indicate they were still a true likeness of people. However, people's MAR had not been consistently signed in the past to show that people had received their medicines as prescribed. We saw recording omissions in eight people's MAR where medicines had not been signed as administered. This meant there was a risk that people did not always receive their medicines as prescribed. We asked the permanent staff member what happened when recording omissions were noted, and they said that staff were informed if an omission was noted, but despite this, the recording omissions remained. Some of these gaps went back as far as 31 August 2016.

Topical medicine administration charts were also not signed consistently. For example, one person had been prescribed two topical creams. The frequency of administration had not been documented and the chart had only been signed on three occasions during September 2016. Another person had been prescribed topical creams, 'Every 12 hours or after 3 washes.' This person's chart had only been signed once during September 2016. The lack of direction for care staff on some charts and the missing signatures indicated that people may not always receive their topical medicines as prescribed.

The provider's policy stated, 'All MAR sheets are to be checked at the end and start of each shift by the 2 RN's (Registered Nurses/Senior Carers). MAR charts should be checked to ensure there are no missing signatures or codes.' The manager confirmed that this should happen. We asked the manager how frequently they audited medicines within the service and they said they had not been done as regularly as they would like.

The latest internal audit that we saw had taken place during March 2016. An external audit had been undertaken in the past by a pharmacist; however, it was unclear when this had happened as the first two pages were missing which meant the date was unknown, although the manager said that the next external audit was imminent. The recommendations from the audit included ensuring, 'opened on' dates were written on bottles of liquid medicines when opened. Additional recommendations were that evidence of fridge cleaning was maintained and that all handwritten entries on MAR charts were double signed.

Although bottles of medicines were now having the date added when opened, there was no evidence of weekly fridge cleaning and transcribing onto MAR charts with no double signatures was observed. We saw two people's charts had been transcribed and had not been signed by the person transcribing or countersigned by another member of staff to ensure they had been transcribed correctly. The provider's policy stated, 'Nurses/Senior carers must only transcribe as an absolute last resort and only if another registered nurse checks the prescription and both sign and date the MAR.' This meant there was a risk of medication errors occurring because staff had transcribed people's medicines without getting them checked and countersigned.

Medicines were stored safely in locked trolleys. However, one of the trolleys was disorganised with people's medicines not stored in an orderly manner. This meant that the agency nurse administering the medicines spent a considerable amount of time trying to find the correct medicine box or bottle. Medicines for disposal were logged in the destruction book and all entries had been countersigned. Controlled medicines were stock checked weekly and we saw that these had all been completed with nothing adverse noted. There were two medicine fridges. The temperature of both fridges was logged daily. However, the chart for monitoring the fridge temperature also informed staff the fridge should be cleaned weekly and yet the chart indicated the fridge had last been cleaned on 9 August 2016.

Accident and incident management was inconsistent and the records were incomplete. Examples of forms completed between January 2016 and June 2016 included unexplained bruising and skin injuries, unwitnessed falls, an episode of choking and physical aggression. Staff completed accident and incident forms. These provided detail of what had happened and immediate actions taken. The forms were then given to the manager. A further section on the accident form 'Section B' was for the manager to complete. This section was for recording follow up actions and information, investigations, changes to reduce risk of recurrence and other agencies that needed to be informed. Most forms had been signed but the records had not been fully completed.

There were 61 accident and incident reports in the accident and incident folder from 1 July 2016 until 10 September 2016. These included 27 falls, 10 acts of aggression and 14 bruises or other skin injuries such as skin tears. The other 10 were a combination of incidents and incidents. None of these reports had a fully completed and signed manager's review section. This meant people were at continued risk of harm because incidents were not fully investigated or reviewed for emerging trends by the management team.

The service was clean, however infection control practice was not always completed in accordance with published guidance. For example, one member of staff was moving a hoist from one room to another. A sling was draped over the hoist. The member of staff told us they shared the slings between people. They said, "Some people have their own slings but not many." They told us that people with specific needs, for example, for very large or very small slings had their own. They told us they used the medium sling for most people. They told us the sling was sent to the laundry when they thought it needed to be cleaned and they were not aware of a system in place for the laundering of slings. People's care records did not always state the size of hoist sling required for each person. The Department of Health guidance, Prevention and Control of Infection in Care Homes 2013 states, 'Slings should be laundered in hottest wash cycle allowable

according to the manufacturers' instructions and not shared between residents.' Because slings were being used communally, there was an increased risk of the spread of infection.

Risks to people were not identified and mitigated in a timely manner. One person had a pressure ulcer noted on their lower spine area on 5 September 2016. A wound dressing plan was in place. A photograph has not been taken to assist with monitoring progress or deterioration of the wound. A pressure relieving mattress was not provided for the person to help reduce the risk of further pressure ulcers developing. A blister was noted on the person's heel on 17 September 2016. We were told by care staff that the management team were arranging for the person to receive a pressure relieving mattress on the day of our visit. This meant the person was not supported with pressure relieving equipment during the two week period before the day of our visit when a pressure ulcer was first reported. The care and treatment provided did not meet the person's needs or mitigate their assessed risks.

Through our interviews with staff it was evident that current published guidance was not followed in relation to catheter care. We reviewed the care records for one person who had a urinary catheter in place. There was a care plan indicating the type of catheter, date of insertion, date for removal, balloon inflation used and specific catheter product data. However, there was nothing in the care plan to detail how to empty the bag. The catheter was a leg bag that has a sliding open / close valve and a guide on how to change the bag would have directed staff to undertake best practice in relation to infection prevention and control. We spoke with a member of staff who changed this person's. We asked them to explain how she empties leg bags. During their explanation their response included telling us they were 'wiping the drips with a tissue.' They did not evidence they used an alcohol wipe to valve or evidence how they ensured non contamination when changing the leg bags.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives gave mixed views about how safe they felt at the service. Most of the comments we received about the staff were positive, however people gave examples where they did not feel so safe as they did not always get the care when they needed it. One person we spoke with told us, "I am safe because they check up on where you are and what you do, if I use my bell, nine times out of 10 someone will come but we need more staff. The length of time you have to wait to be brought back to your room is terrible - this is worse if you have been sitting in the garden because you get really cold waiting." Another person commented, "I suppose I am safe but I am not happy I have to wait so long for staff to come when I call and need help to get to the toilet, if they do not come I get depressed and weepy." One person's relative said, "I have serious concerns for the safety of my loved one when I am not here, for this reason I spend eight to nine hours a day with them. I will not leave until I know [person's name] is safely in bed."

Safe recruitment processes were completed. Staff had completed an application form prior to their employment and provided information about their employment history. Previous employment or character references had been obtained by the service together with proof of the person's identity for an enhanced Disclosure and Barring Service [DBS] check to be completed. This DBS check ensures that people barred from working with certain groups such as vulnerable adults are identified. Where required, the service had ensured that staff were appropriately registered with the correct bodies, for example the Nursing and Midwifery Council.

The environment and equipment used within the service was maintained to ensure it was safe. The provider had systems that monitored the environment and the equipment within the service. There were systems that monitored the maintenance of the service in relation to hoists, slings and other mobility equipment

such as wheelchairs and specialist bathing equipment. The nurse call bell system was serviced to ensure it was serviceable and regular water temperatures were completed. There was fire folder that showed emergency evacuation plans for people and we saw supporting records that showed the fire alarms, emergency doors and lighting were regularly checked and tested. People also had an evacuation plan in the event of a fire. Electrical portable appliance testing was being completed on the day of our inspection.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We reviewed people's care records and found inconsistencies. People who had capacity to consent had been asked for consent to some care practices. For example, we saw some people had consented to wound photographs and to the taking of photographs for identification purposes. We did note that capacity assessments were completed but people's consent for the use of bed side rails was not always obtained. There was detail about people's mental capacity, and the decisions people were involved with in some, but not all, care records. For example, for one person, a 'Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) was completed by a doctor. The reason stated for not discussing the decision with the person was stated as, 'Lacks capacity regarding this particular decision.' The care records for the person's daily care routines confirmed they had capacity and were able to 'take the lead…doesn't like anybody to make decisions for her.' This inconsistency had not been identified by the service.

The care records were not always clear about the specific decisions some people could make, or where best interest decisions had been made, how they were determined. For one person, who lacked capacity, their care records stated, 'If [name of person] can't answer, staff will always ensure best interest.' Another part of their care plan described how to communicate with the person so they could express their wishes. Within other care records we found mental capacity assessments, but it was not clear how consent to care was formally sought. For example, in one person's plan it had been documented that they had full mental capacity. However, despite a sensor mat being in place, there was no evidence of consent for its use being sought or documented. In another person's plan it was documented "No signs of a lack of capacity". This person had bedrails in situ but the consent form for the use of bed rails had been signed by a relative and not by the person.

People within the service can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The manager had not always met their responsibilities with regards to the Deprivation of Liberty Safeguards (DoLS). Applications for six people living at the home had been made and were awaiting assessment or renewal by the local authority. Eleven people at the home had a current authorised DoLS.

The manager told us no one had a condition attached to their DoLS. We checked four current DoLS authorisations and found a condition was attached to one DoLS. The person's condition was that they were

to be encouraged to take part in social activities as they spent a lot of time alone in their room. Their care plan stated, in February 2016 that, 'Cultural, spiritual and social values are paramount when staff attend [name of person's] needs.' An activity assessment form had been completed that listed the activities the person may participate in. However, there was no record to confirm how the condition was being implemented, monitored or reviewed. In addition to this, we found staff were not always confident in their knowledge of the DoLS. Staff members were unable to tell us who had an authorised DoLS in place which placed people at risk that their rights would not be upheld

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives spoke positively of the staff, but told us although the care they got was effective when they received it, the current staffing levels did not always ensure they received care at the right time. One person commented, "People do their best to look after me, but I do not think there are enough staff, when I use my bell to call I have to wait, and I cannot always find it. This bothers me because I have to wait and cannot get up or go to bed when I want." A relative we spoke with commented on how staff were vigilant and as they know their relative so well they notice if they appear to be unwell and will call the GP. They also told us their relative saw the Speech and Language Therapist (SALT) regularly to review and revise their eating regime, they commented there were clear instructions printed in the person's room and kitchen staff were also aware.

Where required, appropriate referrals had been made to a Speech and Language Therapist (SALT) to ensure people who experienced difficulty chewing or swallowing were supported correctly. Where SALT guidance had been produced there were written instructions within people's rooms that showed this guidance. We observed this guidance was followed by staff during lunch periods to ensure people's needs were met. Care records contained nutritional assessments and people's weight was recorded monthly. People told us the food was, "Very good" and "Lovely."

People were supported with their meals and to drink throughout the day. There was a regular tea and coffee available during the morning and afternoon. Throughout the day we were aware of people being offered hot and cold drinks. People had a jug of water/squash in their room which was refreshed daily. We observed breakfast being served on Lark Unit, there was a choice of a cooked breakfast / cereals/ toast and marmalade. People could choose to eat in their rooms if they wished. People were able to choose their lunch at the time of serving, from 2 alternatives, both looked appetising and were well presented with appropriate portion sizes when we observed the lunch period.

There were systems in place to ensure staff received supervision and appraisal. We reviewed a sample of supervision records and spoke with staff. Most of the staff we spoke with told us they had not received supervision for a long period of time. This was reflected in records and the manager was aware that supervision completion was below the provider's required standard. We also saw this had been highlighted during quality reviews at the service. The manager told us this would be addressed in the near future to ensure staff received the appropriate level of support and guidance in development within their roles.

There was a training schedule that ensured staff received appropriate training to carry out their roles. Staff felt they were given sufficient training to effectively support people and meet their needs. Staff had received training in a variety of relevant topics to meet the needs of the people. This included moving and handling, health and safety, fire and safeguarding. It was highlighted to the manager and acting regional director that staff had not received training in relation to behaviour that may be challenging.

We were told that there was training in 'Distress Reaction' forecast for staff which would support them in conflict management. We did highlight this training may not always protect people and staff, as records showed some people living at the service had previously become aggressive with staff without warning requiring staff to de-escalate the situation. Training options were going to be explored in relation to this. Nursing staff within the service also had the opportunity for continual professional development. Training records showed that additional training in subjects such as venepuncture, syringe driver and catheter training had been scheduled for nursing staff.

The provider had an induction process which encompassed the new Care Certificate. The Care Certificate was introduced in April 2015 and is an identified set of standards that health and social care workers should adhere to when performing their roles and supporting people. The certificate is a modular induction and training process designed to ensure staff are suitably trained to provide a high standard of care and support. At the time of our inspection there were newly employed staff completing the certificate. All staff completed a corporate induction over the first four weeks of their employment that was tailored to their role. This included learning about the provider's visions and values, training and periods of shadowing more experienced staff.

We spoke with the home trainer who explained about the observations of care provision they undertook. They told us that in addition to supervision, observations were completed on staff to ensure that effective care was being delivered safely and in accordance with people's needs. We reviewed observation records that showed meal times and meal service completion was monitored. In addition to this infection control practice was monitored, together with moving an handling techniques and ensuring people were treated with dignity and respect. Feedback was given to staff following these observations. In addition, the provider completed a quality assurance audit into training delivery and monitored areas for development. The home trainer also attended quarterly meetings with other home trainers to discuss training plans and learning and development.

People had access to GP and healthcare professionals. One GP practice provided support to most of the people living in the home. People were referred to, and supported by, other health care professionals. We spoke with a visiting health professional who spoke positively about the service. They told us their recommendations were acted upon. For example, they were supporting one person to walk with a walking aid. On the day of our visit, they told us they were really pleased with the progress the person had made since their last visit. They told us it was evident the staff had provided the support to the person each day, as they had recommended.

There were systems in place that ensured people's needs were discussed with the relevant healthcare professionals. For example, the service held a meeting every quarter with the GP with whom all of the people at the service were registered. The supporting records for this showed that the number of admissions to the service was discussed, together with the number of people who had passed away since the last quarterly meeting. A discussion was held about emergency and scheduled hospital admissions and about people who received specific medicines. Information was also discussed about people's resuscitation status.

Requires Improvement

Is the service caring?

Our findings

We observed staff interacting in a caring manner, we saw people reacting positively when approached by staff and observed signs of affection. People were called by their preferred name using appropriate volume and tone of voice. Staff interacted with people who were unable to express their needs verbally by observing their body language and facial expressions.

People in the service that were out of bed were well kempt and wore clothing which reflected their age gender and previous life style. The majority of people we spoke with confirmed they were treated with dignity and respect. People commented to us, "This place is not smelly or grubby, lovely staff they do things as I want." Other comments we received included, "Staff are really nice - I get on well with staff," "I am treated with dignity, they know what I like," "I have one delightful young carer who is kind and gentle and makes me feel special, staff are good at what they do." One person we spoke with did comment negatively about some of the communication they had from staff. One person spoke very positively of the staff and said, "Everything about here is good, the staff are all kind and I'm lucky to be here."

We observed some positive caring interactions between staff and people using the service. For example we overheard one member of staff asking a person how their weekend had been. They chatted to the person for a while asking about who had visited them and showed an interest in what the person had to say. Some people that were being cared for in bed had the radio on in their rooms. One person's radio was set to a local radio station and when we looked in their care plan, their listening preference had been documented.

We saw one person had been incontinent of urine. They were sitting alone in one of the lounges. When a member of staff came into the room, they immediately noticed the person and crouched down to their level. They spoke quietly to them, and explained that they would get another member of staff to come and help them get changed before lunch. This was done in a caring and discreet way. During lunch in one of the dining rooms, people were eating at shared tables. It was very quiet and a member of staff said to a person, "Shall I put some music on, it's very quiet? Would you like that?" They waited for people to respond and then did put some music on when people confirmed they would like that.

Although we observed caring observations between staff and people, the current staffing levels meant that people's care needs could not always be met timely and therefore the service could not be consistently caring. For example, the feedback we received from people's relatives about people still being in bed in the early afternoon or evening demonstrated this. Staff we spoke with confirmed this, telling us that despite their best efforts and ambitions, they knew they were not currently everybody's needs. In addition to this, the feedback we received from people about staff trying their hardest but not always being able to meet their needs showed that people understood staff were trying to support them but were unable to do so through insufficient numbers. We also made observations where people were told they would have to wait a period of time for staff to attend to their needs, and on one occasion this included a person who wished to go to the toilet.

Some people were aware of having care reviews, but were unsure of when they had last had one.

A relative told us there had been a review of their relative's care recently while another family member was visiting, and expressed their views on the service provided. They did not feel the care was as they would like it to be but felt it was still early days and acknowledged this might be due to unrealistic expectations. Another relative told us they were not aware of having a formal review but as they visit daily they knew their relatives routine.

Care plans contained information for staff to provide person centred care to achieve what was important to people. People's preferences had been documented and when we case tracked people we saw that these preferences had been followed. For example, in one plan it had been documented that the person liked to keep their nails clean and painted and preferred their own company. We saw the person's nails were clean and painted. During a review of the person's needs, they and their family had been involved. During the latest review an action had been set to implement an activities diary and this had been done. In another person's plan it was documented that they took great pride in their appearance. We spoke to this person and they had their makeup and perfume on their table for them to apply.

We reviewed the compliment cards sent to the service that showed very positive feedback and was consistent with people's views about the staff employed at the service that we obtained during the inspection. For example, within one card a person's relative wrote, "My family and I would like to express our sincere thanks to you for the kindness you gave to [person's name] during his stay." Within another card it read, "Please would you share sincere thanks from me on behalf of the whole family for the care and love shown to [person's name]." One who used the service had written a letter that said, "A big thank you for the lovely birthday cake and the beautiful flowers. I was overwhelmed."

Requires Improvement

Is the service responsive?

Our findings

We found examples of the service not being consistently responsive to people's needs through person centred care planning. For example, one person was admitted to the home with pressure ulcers. The person had multiple health problems. A wound assessment and care plan was in place for the treatment of their heel. Photographs were in place and advice, guidance and support was provided by the Tissue Viability Nurse (TVN) when requested. Pain relief was provided. There was no care plan or reference to the other pressure ulcer the person had at the time of admission to guide staff as to the care and treatment required. We spoke with a senior staff member who confirmed there was no current care plan in place.

There was not always enough detail for staff on how to meet people's needs. For example, in one person's plan it was documented, 'Can get upset when things are not done straight away, but will understand with explanations from staff.' In the daily records for this person, staff had documented 'Shouted at staff, 'on the bell for a long time throughout handover period, despite reassuring her' and, 'put on a behaviour chart because sometimes she do get rude to the care team.' Despite these comments, there was nothing detailed within the plan to guide staff on how to relieve the person's anxiety or how to diffuse situations when the person shouted at staff. This meant that staff who were unfamiliar with the person may not know how best to meet the person's needs.

People had not always received responsive care in relation pressure relieving equipment. Where people had been assessed as being at risk of developing pressure ulcers, pressure reliving mattresses were in place . However, charts in rooms did not specify the mattress setting that was required. Some mattresses are set according to people's weight and therefore if set at the wrong level can be uncomfortable for the person and could cause the skin to break down. We saw that one person's mattress was set at 7.5. We asked a nurse if the setting was correct, but they did not know what the setting should be. We looked in the person's care plan and there was nothing documented to inform staff what the setting should be.

Another person was being cared for on a different brand of mattress. Their mattress was set at level 3. We asked the nurse again if the setting was correct, but they did not know. The chart that staff completed when changing the person's position had a section titled, 'Mattress setting check' and this had been ticked, but the required setting had not been documented on the chart. It was not clear how staff knew what the correct setting was because the nurse in charge, who was accountable for the care delivered, did not know. The nurse said that the maintenance team was responsible for putting these mattresses in place on people's beds. Although one mattress we looked at set automatically and adjusted to the person's weight, not all mattresses did. Because all mattress settings were not documented, there was a risk that people's risk of developing pressure ulcers could be increased. A senior member of staff began to address this area of concern during the inspection.

People were assessed before they moved into the home. However it was evident they were not always accurate. For example, we looked at two recent pre-admission assessments. We found the assessments were not always reflective of the person's needs. For one person, the pre-admission assessment done by a senior member of staff stated the person was independent, could walk and needed only one member of

care staff to support them. From speaking with staff and undertaking observations, the person needed a stand aide and 2 carers to support them for everything.

We reviewed the record for one person who had diabetes which was controlled with insulin. The care plan provided detail about acceptable lower and upper blood sugar levels for that person. The care plan provided detail about the signs and symptoms the person may display and the treatment to be given if their blood sugar levels were not within the expected ranges. The actions required for a blood sugar level higher than the maximum level (hyperglycaemia) was for the GP and the diabetes nurse to be contacted. On the 16 September 2016, the person's blood sugar was higher than the maximum level. There was no record that either the GP or the diabetic nurse was contacted as a result of this. This meant there was no supporting evidence the person had received care and treatment in accordance with their assessed need.

We reviewed the records of people who required food and fluid charts and repositioning. These records did not reflect that people's needs were constantly met. This was consistent with staff comments we received about not always being able to meet people's needs due to staffing issues. For example, we found good practice whereby each person had a specific target volume identified on their food and fluid chart. This same target volume was written on the top of the dated individual fluid record chart. However this was not always achieved and many were not actually added up to enable accurate monitoring. Fluid records indicated that people had not received the specific target and there was no evidence that this was identified and any subsequent action taken. For example, one person's record stated they required 2000mls of fluid per day. After we reviewed the totals of a 2 day period it showed on one day the person received 900mls and on the other 1025mls of fluids. There was nothing in the person's daily record to show action was taken in response to this recorded low intake.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Generally, people we spoke with felt their care was being delivered as they wished and all their needs were met. People commented that staff always provided the care they needed when they were able. A relative told us after a family member had raised concerns regarding telephone calls, in response the management of the service had purchased a number of mobile phones which enabled them to have a daily conversation with their loved one. Relatives we spoke with confirmed they were involved in all decisions regarding their loved one's care and were kept informed of any changes.

The provider had a complaints procedure available within the service. People and their relatives gave mixed feedback on the complaints process. One told us they had issues with two staff members who had been verbally abusive, this was reported to the previous manager who dealt with it sensitively. Another commented to us they felt they could talk to the manager in confidence and that their confidentiality would be respected. One person's relative commented positively about how told us as a result of them complaining about a specific staff member that the staff member no longer supported their relative.

We reviewed the complaints file. Seven complaints were recorded in the file for 2016. The provider's complaints policy was located in the front of the file. There was a lack of consistency in the management plan for each complaint and the records did not confirm the status of the complaint and whether or not it had been resolved to the person's satisfaction. One relative had complained repeatedly. There was a common theme of concerns relating to lack of provision of fluids and lack of staff.

There was a bright, well equipped activities room which was not being used on the day of our visit.
We spoke with one of the services designated activities co-ordinators who told us activities were provided

for a total of 54 hours over seven days a week by two designated activities co-ordinators. They did comment however during these hours they were expected to assist at mealtimes, and said recently this could be up to two hours daily which has reduced the amount of time they can spend on activities. They have spoken with the manager about this, and have been told to reduce the time spent on 'host' duties to one hour daily, but have found this difficult to do because of staff shortages.

There was a weekly programme of activities displayed in the home, however this was subject to change. One resident told us they would like to have a 'leaflet of activities' in their room so that they can plan beforehand if they wish to participate. There was a budget to pay for outside entertainers, however we were told it has been difficult to arrange this for residents from both floors to participate owing to a lack of staff, therefore this is not happening at the moment.
There was a church service every 2 weeks and a Music Therapist attended weekly. Both designated activities co-ordinators had completed a first aid course and we were told that as soon as they had moving and handling training specific to the use of the services minibus they would be able to take people out.

Risk assessments and care plans were completed. The care records provided detail about relative's involvement. Relatives were invited to care reviews every six months. The care plans were written in a person centred way. For example, we saw detail about how people like to be dressed, and the jewellery and make up they liked and wore. Personal preferences about getting up and going to bed times were recorded. For one person, the records stated, 'Likes to wake up naturally in the morning, the time varies.'

Inadequate

Is the service well-led?

Our findings

There were governance arrangements in place, however these were not always used effectively to monitor and improve the health, safety and welfare of people at the service. For example, there was a 'Managers Weekly Medication Check' process within the quality assurance file for Chaffinch Unit together with a Medication Administration Records (MAR) audit tool. This would help identify areas of concern in relating medicine relating to medication administration and recording. From reviewing the quality assurance file for the Chaffinch unit, there was no evidence to support the MAR audit tool had been completed since November 2015 and the last 'Managers Weekly Medication Check' had been completed in December 2015. A more frequent and robust audit may have identified the issues we identified with medicines as reported in the 'Safe' section of this report.

There were some systems that monitored care records and their content, but these had not been consistently or effectively used. A 'Care Profile Review' was completed on each unit at the service. There reviews, completed by senior staff monitored if pre-admission records were present, if people's records were person centred, if their choices were reflected and if they had been weighed monthly. In addition, it established if people's risk assessments were current, if their Deprivation of Liberty status was correct and if their life histories were present and recorded. From reviewing the quality assurance evidence folder's for both units, there was no supporting evidence that the review tool had been used since March 2016 on Chaffinch Unit.

We also found inconsistency between the two units of the service in relation to quality assurance and safety. For example, within the quality assurance evidence folder for Lark unit there was a completed monthly nutrition report for people that recorded any significant weight loss or gain and a Body Mass Index (BMI) total. There was a safety device reporting system that reported which people, if any, used equipment such as bed rails, lap belts or harnesses. There was a tissue viability report that showed the information relating to people's wound care. This included the severity of any wounds, any current treatment and the healing progression. This information was not always present or current in the quality assurance evidence file for Chaffinch unit. The completed audits within the folder for Chaffinch mostly showed they were last completed in November 2015.

There was no current system that ensured records relating to the clinical needs of some people were effectively monitored by senior management. There was a clinical governance audit completed and relevant information submitted to the regional clinical development nurse who maintained a record of people's clinical needs. For example, a record showing how many people had a pressure ulcer, if they had any skin tears or had experienced a significant weight loss. However, this audit didn't establish if the daily clinical records relating to these people were correct and if their clinical needs had been met in between the monthly audit periods. There was no review of the records that staff had completed within this audit. An audit of this depth would have identified the recording omissions we identified and helped ensure people received care that was safe..

Systems that monitored the quality of service provided were not always used effectively. The service had a

'Resident of the Day' scheme in operation to ensure people were happy with various different aspects of their care and support. For example, the nominated 'Resident of the Day' would be visited by various different departments throughout the service. For example, somebody from maintenance would visit to ensure people were happy with their room, a chef would visit to ensure people were happy with the meals provided. A member of the activities staff would ensure people were satisfied with activities and housekeeping staff would ensure the person's room was at a cleanliness standard that was satisfactory. The person would also be visited by care staff and a nurse to ensure their care and support needs were met. We saw from records that this had resulted in care records and preferences being updated. Although this system was due to be used daily, we found no supporting evidence that this had been completed on Lark unit since January 2016 or since December 2015 on Chaffinch unit.

The provider had not ensured that sufficient management and governance arrangements were in place to ensure the health safety and welfare of people at the service was monitored in the absence of the regular management. As reported within the 'Safe' section of this report, in the week prior to our inspection the general manager and deputy manager were both on annual leave. The provider was aware of these conflicting dates at the time of the appointment of the deputy manager, however had failed, even with sufficient notice, to ensure suitable arrangements were in place to manage the home in their absence and ensure people's welfare and safety. The manager told us that if required, the heads of unit had access to telephone advice and support from two neighbouring services operated by the provider. These two neighbouring services also have new managers in post that are new to the Barchester group, and neither of which are currently formally registered with the Commission as a registered manager. The two neighbouring services were also currently under enforcement action with the Commission for being unable to meet the regulations.

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

People and their relatives gave us mixed views of the management of the service. One person we spoke with commented, "All the managers are ladies, they are excellent and friendly. I often see the managers but I could not name them." Another person said, "[Manger's name] the manager often comes and has a chat, I would go to her if I had a problem." However other people's perceptions did not always reflect this. For example, one person told us, "The manager [manager's name] is always away, I have spoken to her, but [staff members name] who works in the office is a lovely person and is better to go to." A similar comment was received from one person's relative who told us, "I met [Manager's name] the manager before my loved one came here, I find [Deputy Manager name] the deputy manager helpful. But my first port of call would be to the admin staff who are very approachable."

Staff we spoke with did not comment positively on the management of the service. It was evident that nursing and care staff were disappointed at the support they had received from the management of the service and the provider in relation to the current staffing shortfalls. Staff said that when they reported concerns about staffing to manager they got unhelpful comments such as, "What do you want me to do about it?" and, "My hands are tied." Another staff member told us, "This is a beautiful place, the staff are amazing, but management can't seem to get it right. The unit manager (staff member's name) is leaving now , she is always getting told she can't have things she requests. It is worse than it used to be, it had been slowly improving until three months ago." Staff also felt the management of a recent significant admission of new people with high needs from a local care provider that was closing wasn't managed well as there were insufficient staff to meet the needs of the new people. Staff felt that there were people on the ground floor who should be upstairs in Lark unit due to their higher level of need. They told us they felt this impacted negatively on the care of others .

Messages were communicated to staff through meetings. Different levels of meetings were held at the service. For example, meetings involving all staff were held that discussed matters such as working together, supporting people, policies, staff changes and communication. Additional meetings were held for nursing staff that discussed ward rounds, handovers, communication and professional support. Additional matters such as supervision, Deprivation of Liberty, continence aids, accident and auditing had been discussed at a more recent meeting in June 2016.

External quality monitoring had been completed. We reviewed records that showed the local authority had completed a quality assurance and contract review in June 2016. This reviewed all aspects of the service, for example the service environment, care planning and delivery, medicines, infection control and the management of the service. The record showed that as a result of the review actions were required to ensure the service adhered to contractual requirements. These included improving record keeping accuracy, an improvement at staff handovers, an improvement in some areas of cleanliness and an increase in supervision. We saw a supporting record that showed the manager had produced an action plan and was completing the specified actions.

The manager had received support from the provider's regional and national staff at the service. A range of auditing had been completed at the service since the new manager has assumed post. For example, in July and August 2016, the provider's regional clinical development nurse had completed a care and quality support visit. These focussed on the presentation of the home and welcome documentation. The presentation of people at the service and interactions with people was also reviewed together with an observation conducted of people's mealtime experience. A hospitality visit had been completed by the provider in July 2016. This focussed on areas such as the housekeeping, the laundry, the kitchen, the meals on offer and the dining experience. This audit did not identify concerns.

A 'Quality First' audit had been completed in June 2016 which was based on the key questions asked by the Commission during an inspection. We saw that this had identified areas for improvement in relation to wound care recording, the requirement to complete monthly nutrition meetings and to ensure the service did not include medicine administration as part of the lunchtime dining experience. We did observe during the inspection that some people were still receiving their medicines whilst eating their lunch. The provider's regulation team had completed an audit in May 2016 to support the manager. This was also based on the five key questions the Commission ask during an inspection process. A business manager's visit in May 2016 was also undertaken by the provider. This focussed on accounting, petty cash and other financial matters. An overview of recruitment files was also completed.

The manager and newly appointed deputy had recently introduced unannounced service visit systems to monitor the quality of service and care provision in the home. Unannounced visits were completed to ensure that people still received a high level of care and support when the manger or other senior staff were not present. These focussed on areas such as if the service was running safely, observations of care provision and that staff were appropriately dressed in accordance with the provider's policy. A sample of records, for example food and fluid monitoring records and turn charts were reviewed and any actions requiring attention were recorded.

The manager told us they felt supported by the provider in their role. They confirmed they had received support through quality assurance visits and additional clinical support through the provider's regional clinical development nurse.

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	The care and treatment of people was not always appropriate or did not meet their needs. Regulation 9(1)(a) and 9(1)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The provider was not always providing care in line with people's consent and with mental capacity legislation. Regulation 11(1) and 11(3)

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	The provider had not done all that was reasonably practicable to mitigate risks to people following an accident or incident. People's medicines were not managed safely and infection control practice placed people at risk. Regulation 12(1),12(2)(b), 12(2)(g).and 12(2)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

Treatment of disease, disorder or injury	The provider had not ensured clinical governance systems were used effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. The absence of adequate management arrangements had placed people at risk. Regulation 17(1) and 17(2)(b).

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 The provider had failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed in order to meet the needs of people at the service Regulation 18(1)