Spectrum (Devon and Cornwall Autistic Community Trust)

St Erme Campus

Inspection report

St Erme
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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
St Erme Campus is a care home providing personal care for people with autism. At the time of the inspection 14 people were living at the service. The service can support up to 20 people.

Accommodation is on a campus style development and is based in three separate houses known as The Lodge, The House and St Michaels. There is also a small office building on the campus. Campuses' are group homes clustered together on the same site. They may share staff and some facilities. The service is part of Spectrum (Devon and Cornwall Autistic Community Trust) which has several services in Cornwall providing care and support for autistic people and/or people with a learning disability.

People's experience of using this service and what we found
We expect health and social care providers to guarantee autistic people and people with a learning disability with the choices, dignity, independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

This service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right support:
The service was not maximising people's choices, control or independence. People's lives were being restricted because of low staffing levels.

Right care:
There was a lack of person-centred care and people's human rights were not always upheld. Staff told us that due to the low staffing levels, they did not feel they or people were always safe during incidents of behaviour that challenged. The way people were able to use their home was sometimes restricted to try to reduce the risk of such incidents.

Right culture:
Lack of action by leaders to ensure the service was well staffed meant people did not lead inclusive or empowered lives. Staff told us people regularly asked to go out but could not because of insufficient staffing levels.

The provider had not ensured staffing levels at The House and The Lodge were always safe or sufficient to meet people's needs. Staffing levels in The Lodge had frequently fallen below what the provider had deemed acceptable only in an 'extreme emergency'. The Lodge had been operating on this level of staffing for some time and future rotas showed it would continue to operate at the same levels. Staffing levels at The House were below what was needed for people to live full and active lives.

As a result of the low staffing levels, people's lives were restricted, and they were not able to live meaningful lives that included control, choice, and independence. One staff member told us, "People are effectively under house arrest."

The low staffing levels not only impacted on people's lives, but also on the day to day running of the service and on staff morale.

The lack of oversight of staffing levels and related risks had placed people and staff at risk. The provider had not taken enough action to ensure there were sufficient staff at the service.

Staff told us they did not think the situation was safe and did not always feel safe supporting people. Staff told us that because people could not easily go out, they became frustrated and were more likely to experience incidents of behaviour that challenged the service. During incidents of behaviour that challenged, people sometimes required support from more staff. Due to the low staffing levels this could mean other people were left without staff support.

Staff did not always wear PPE correctly. When asked, the provider did not provide evidence they had checked staff were completing the required number of COVID tests per week.

The risks of a closed culture developing within the service and organisation had not been mitigated by the provider.

Insufficient learning had taken place to ensure people were not exposed to the risk of unsafe, poor quality care. The commission had previously found breaches for staffing at this service and had found breaches for staffing at four other services belonging to the provider, in the last year. The commission found a breach for staffing again at this inspection.

Staff told us they had raised concerns about the staffing levels but did not feel listened to or that action had been taken as a result.

The provider had not been open and honest with the local authority or the commission about the risks the ongoing low staffing levels were creating in the service.

Following the inspection, we raised safeguarding alerts with the local authority. The local authority asked the provider to continue sharing information on staffing levels, so they could check they were safe.

The provider shared rotas for the week following the inspection showing staffing levels at the service would be safe. The local authority continued to seek daily assurances from the provider that the service was operating above minimum safe staffing levels.

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

Rating at last inspection
The last rating for this service was requires improvement (published December 2020).

Why we inspected
We received concerns in relation to low staffing and the impact this was having on safety and on the quality of care people received. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

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.

The overall rating for the service has changed from Requires Improvement to Inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe and well led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for St Erme Campus on our website at www.cqc.org.uk.

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.

We have identified breaches in relation to staffing, how risks were mitigated, safeguarding from abuse; and how the provider monitored the quality of the service and implemented learning to improve the service.

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

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

Follow up
We will request an updated action plan for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the registration. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

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

Is the service well-led?

Inadequate

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

St Erme Campus

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 Care Act 2014.

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
Three inspectors and one assistant inspectors.

Service and service type
St Erme Campus is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager in place but they were not yet registered with the Care Quality Commission. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We reviewed information that we held about the service including

information shared by people, relatives and/or staff. We used all of this information to plan our inspection.

During the inspection
We met with four people who used the service and observed how staff supported and engaged with them. We spoke with 11 staff members, this included the provider's Deputy Head of Operations and an area manager.

We reviewed a range of records. This included four people's care records and one person's medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service were reviewed.

After the inspection
We continued to seek clarification from the service to validate evidence found. We spoke with five more staff by phone. We spoke with six relatives by phone.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

At the last inspection we recommended the provider considered current guidance on the successful recruitment and retention of staff. At this inspection we found the service did not have enough staff to ensure people living in the service were safe.

●Staffing was not at a safe level in The Lodge and not sufficient in The House to enable people to live individualised lives based on their preferences. The provider had identified that the minimum safe staffing level in an extreme emergency situation at The Lodge, was five staff during the day. On the morning of the inspection, the service had operated with three staff from 8am to 9.10am. Staff members told us, "First thing this morning there were only three staff and that is not the first time that has happened" and "Most days at the moment, we are on four." Planned rotas for the rest of the week showed that on most days there would be less than the provider's minimum safe level of five staff at the service.

● At the time of the inspection, The Lodge had eight full time vacancies on their staff team and the House had three and a half full time vacancies. The service used bank staff regularly and full-time permanent were also working longer hours; however people were still not receiving the correct level of staffing. Staff told us that at times staff had worked through the night and then the next day, or a 14 hour shift then slept at the service and then done another 14 hour shift.

● The ongoing lack of staffing was having a negative on people and the staff team. Staff told us, "People cannot go out. We don't have enough staff to take people out, we don't have enough to get food or to collect prescriptions. We do not have enough staff to support people if they had to go to hospital. It is very rare that […] is able to leave the house. We are neglecting them when there are not enough staff. It has been months since the last time we were fully staffed. Since Christmas we had five on most shifts but lately it has often been four" and "In all honesty, its gut wrenching. I see my team members working themselves to death. They are doing their best. I am tired but I will always try to pick up the slack and cover for the team."

● There were seven people living in The House who should all have been receiving one to one support throughout the day and three of whom required the support of two staff when going out. The provider had assessed that for people's needs to be met, The House required ten staff members during the day. Records at the service showed people rarely received the level of support they required. Staff told us despite needing one to one support, people often had to share staff. Comments included, "Sometimes one staff member might leave at 3pm and the next comes in at 5pm, so we're even shorter.", "Even when we have seven staff, though that doesn't happen often, we still are just getting by. It doesn't really enable them to do much." Following the inspection, the provider shared further information about staffing levels at The House. These records showed that during April and May 2021, there were three occasions when the service operated on

five staff for part of the day, even though everyone living at the service was present. The records also showed that on 28 days over this time period, the service operated on less than seven staff for part of the day and on less than seven staff for the whole day, for a further nine days.
This is a breach of Regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Following the first day of the inspection the commission made a safeguarding alert. This is being investigated. The local authority offered additional staff support to the provider and the local authority safeguarding team sought daily assurances from the provider that the service was operating above minimum safe staffing levels.

● People were supported by suitable staff. Recruitment records showed appropriate checks were undertaken to help ensure the right staff were employed to keep people safe.

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse
● People living at St Erme sometimes experienced behaviour that challenged staff and other people. People's planned staffing levels reflected the amount of support they required to stay safe and to live as full a life as possible and achieve the best possible outcomes. Staff told us that the low staffing levels meant they could not always keep people safe. Comments included, "Not safe if I am honest. Some need two staff and they are not getting it. Three quarters are not getting their two to one support", "We are left in unsafe positions working alone with people who need two staff", "I think it is dangerous as we are lone working with people. If they go into incident it is dangerous. It is a challenging unit", "People are getting hurt and there is physical damage" and "No, it isn't safe. I feel their behaviour is a lot more challenging at the moment."
● When someone experienced behaviour that challenged, they often required the support of more than one staff member. Due to the low staffing levels, this could leave other people with no support. Data about one person's incidents of behaviour that challenges showed that over the previous three months, they had experienced 20 incidents that required the support of three staff members and 28 that required two staff members. Staff told us, "There are two staff in the lounge for three people, so if one needs two staff to support them because of their behaviour, the other two will get nothing. That's not unusual."
● Sometimes when people showed behaviour that challenged, staff had to restrain the person to stop them injuring themselves or others. Staff were trained to do this safely, but one staff member told us, "We do not have enough staff to safely do a two person restraint."
● When people are not able to live as full a life as possible, the risk of incidents of behaviour that challenges is likely to increase. Staff members told us, "Obviously, we cannot get out with the guys and it is becoming a bit unsafe", "They can't go out. Lockdown and not having enough staff has been a nightmare. It is not safe" and "There are more incidents in house because they are bored. They just don't get enough interaction. Some people haven't been out for weeks." Staff described the impact this was having on people; "[…] will have an incident, injuring himself. He beats the hell out of himself, bites his arms and face. He just reaches boiling point and has an incident" and "People don't get to go out, especially […]. He will ask to go out every day and basically, we have to say 'no' just about every day and that can aggravate him understandably."
● Some people found it difficult to be supported by staff they did not know well. This could also increase the risk of incidents of behaviour that challenges. Staff told us that the day before the inspection one person was supported by two staff members who didn't know them. This resulted in behaviour that challenged and put the staff in physical danger. Staff told us they had concerns about the impact on people when new staff started. Comments included, "New staff immediately find themselves in the position of supporting people who should have 2:1. Very new staff are often left to look after the guys very soon after they start. They are left with the person on their own. They just leave."

Failing to ensure people received safe care was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Information regarding risks to people and what support they required was contained within their records.
● Records describing what support people would need during an emergency evacuation was available.
● Staff told us they had received safeguarding training. Information about how to raise a concern was available in the staff office.

Learning lessons when things go wrong
● Despite clear evidence of the impact of low staffing levels on people, action had not been taken so things did not continue to go wrong. A staff member told us, "It has got increasingly bad where we are short every day. We rarely make our contingency; staff have been working well over their contracted hours.
● Accidents and incidents were recorded and the data used to produce information about trends. However, staff told us they were not aware of updates or things changing as a result of incidents or accidents.
● One person's care plan stated, "[…] benefits from accessing the community in the mornings as he will worry about others going out and he is not" and "[…] loves to be out in his community." Staff told us the person did not go out regularly as they needed two staff to support them when out and there were not enough staff. This person regularly experienced incidents of behaviour that challenged, and these had been increasing; however not enough action had been taken to ensure they were able to go out regularly. One staff member told us, "I can't remember the last time […] went out."

This is a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Preventing and controlling infection
● We were not assured that the provider was using PPE effectively and safely. We observed staff removing their mask from their face when talking, wearing masks below their noses and walking through the service with their mask down or not on.
● We were not assured that the provider was accessing testing for people using the service and staff. PCR tests were collected from The House twice weekly. Guidance says that tests should be sent on the same day they are taken. However, staff were completing the tests whenever they were in the service which was sometimes three days before the tests were due to be collected. We requested evidence that the provider was checking that all staff were completing the required number and type of test each week in line with the provider's policy. However, none was provided.

This contributed to the breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. Due to low staffing levels, housekeeping tasks had not all been completed as planned.
● 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 understood how to admit people safely to the service; However, they told us they were not currently intending to admit people.
● 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.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Using medicines safely

● Records detailing when people's medicines had been administered had been completed.
● Regular counts of people's medicines were completed to check the medicines administration records (MARs), were correct.
● Staff told us they had received training and felt confident administering people's medicines.
● People's care plans described what medicines they took and why.
● Relatives told us they were involved in reviews of people's medicines, where appropriate.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The oversight and governance of the service had failed to ensure the service met with regulations. Various checks and audits were completed but despite showing low staffing levels over a prolonged period of time; insufficient action had been taken to increase staffing levels and improve people's lives.
- Systems for identifying and managing organisational risks had been ineffective. Registered managers from each of the provider's services took turns to contact each service every day to check on staffing levels and support with any operational concerns. We were provided with 20 logs of these calls between 5 and 27 May 2021. The provider had identified five staff was the minimum staffing level for extreme emergencies for The Lodge. Each log showed staffing at The Lodge was five or less for all, or part of each day. Despite the logs being sent each day to various senior staff, insufficient action had been taken to ensure the staffing levels at the service met people's needs. A senior manager told us they had believed the minimum level at The Lodge was four.
- Staff told us, "The team are working hard to keep it all together and we get no help. We keep saying in advance we are going to be really short and it makes no difference." Staff in The House told us they regularly did not get the rota on time, which made it more difficult to get all shifts covered. One staff member commented, "There's no rota beyond next week, so how can staff pick up the shifts that need filling? It's been like this since December."
- The risks of such low staffing levels had not been recognised or properly planned for. Despite using bank staff to cover shifts and full time staff working beyond their contracted hours, the service was still unable to cover all shifts. Two of the provider's senior staff told us the service had been managing until some full-time staff had to take time off. They had not foreseen that, (as they were already having difficulty meeting minimum staffing levels), staff needing time off would create a high risk at the service. Staff members confirmed, "Three staff does happen at the moment. Because we are on four most days, anytime someone is sick we are on three staff."
- Staff described how low staffing levels not only impacted on people, but also affected other aspects of the running of the service. Comments included, "Staffing is such a huge issue and so many problems would be solved, if that improved", "My job is no longer looking after people with autism, it is trying to find staff all the time", "Keyworkers aren't getting time to update records. Records aren't getting done properly, but how can we when we're supporting two different people? We are reprimanded for not doing the correct records but sometimes we're too busy" and "Staff haven't been always able to get the food shopping on time so we're trying to scrape together things for people to eat."
- There were several indicators of closed cultures within the service. For example, the service supported

people who were less able to speak up for themselves without good support from the service, and the impact of the low staffing levels created further risk factors. These included risk factors, the way premises were being used had led to increased restriction or lack of choice for people, people not being safeguarded against discrimination, harm and abuse, failing to engage and respond to recommendations of external agencies and professionals, staff working excessively long hours or overtime and constant staff shortages. The provider had not taken sufficient action to mitigate the risk of these indicators affecting people's care and support. The failure to understand, recognise and take action to mitigate the risk of a closed culture left people in receipt of poor-quality care.

● Several records we requested were not provided.

Continuous learning and improving care

● The service has been inspected six times in the last six years. It has only been rated as 'good' overall twice in this time. The commission found breaches of regulation in relation to staffing in two of these inspections (February 2017 and March 2020). In the last year, four other services belonging to the provider have also been found to have breaches in relation to staffing. The concerns found during this inspection showed the provider had not used learning from these inspections to improve the service.

● Staff raised concerns that low staffing levels at the service had been an ongoing problem that had not been resolved. Comments included, "We've always struggled with staff", "This has been ongoing, in the last four years it was only last summer that we were ever close to being fully staffed. This is not the worst for The House but it is pretty dire in The Lodge. It does seem to have been an issue for quite some time now."

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

● All staff we spoke with raised concerns about the staffing levels at the service and the way it impacted on them and the people living at the service. Staff told us they had raised these concerns with senior staff but did not feel listened to or supported. Comments included, "We don't feel like they support us or answer our concerns. Many staff have made many suggestions, but nothing has come back. We raise it but it's not dealt with", "We have begged them for more staff but nothing changes", "We are able to raise concerns, but it does not always get a result. Please help us!" and "We raise concerns. We get told things are going to improve but it does not. It has been a slow descent generally over many months."

● Staff told us morale was low. Comments included, "Spectrum do not look after the good staff", "Morale has dropped away, picking up extra shifts all the time, it's strenuous. The staff are trying to work together but it's hard going when you're so short", "Morale is through the floor and you feel beholden to the house even on your time off. I am not going to go and leave them on dangerous numbers", "It is just really stressful for us all having to do so much overtime. Everyone is leaving as they are exhausted. We are all knackered" and "We have a relatively high level of sickness that may be a result of the pressure put on the team through the staff shortages."

● Staff raised concerns for their own safety whilst supporting some people. Data showed six staff members had been injured the month before the inspection. Staff comments included, "I have not been hurt but I don't feel comfortable", "Some staff aren't comfortable going out in the bus with […]. He can throw things and staff don't want to put themselves at risk" and "Staff are nervous working in a flat on their own with people. You can't be watching two people in two separate flats, staff aren't there to support you with any incidents." A senior staff member told us, "There is a culture forming that if staff are down to work with a particular person they will phone in sick. We are asking people to come in and the first thing they ask is, 'Who is it going to be with?'" The senior staff member had not understood the level of concern staff had about supporting people who could experience behaviour that challenges without the right staffing levels.

Working in partnership with others; 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 had failed to raise staffing levels as an area of high risk to the local authority or the commission. They had not sought help or support which had left people in receipt of poor quality care.
● One relative told us their family member, who lived in The Lodge, required two to one support and that this was always available. However, there were four people who lived in The Lodge, three of whom required two to one support and one of whom required one to one support. There were frequently only four staff members available; therefore, it was not possible that people had two to one support throughout each day. The person's relative had not been made aware of this.

The provider had not had sufficient oversight of the service or taken action to ensure people experienced good outcomes. This was a breach of 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
● Relatives told us they were happy with the communication they received from the service about their family member. They told us they were updated about any accidents or incidents.
Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People were not supported to live meaningful lives that included control, choice, and independence. The lack of staffing in the service meant people's options were severely restricted. At St Erme House, the provider had identified that to enable people to complete their individual community activities with their commissioned staffing levels, ten staff were required during the day. Records showed that there were occasionally eight staff on shift, for part of a day, however most shifts had between five and seven staff members. Staff told us, "People's welfare is so compromised at the moment", "People are effectively under house arrest" and "You can tell people are suffering mentally and emotionally. It is easily more than a week between people's opportunities to go out just for walk round the village; but even then we are constantly watching the clock as we have to get back. It is stressful and I would not want this to be the existence for my child." We asked for evidence that the provider had oversight of how people spent their time, but none was provided.
● Staff interactions with people were not always respectful or promoting choice and engagement. We heard staff regularly calling people "the boys", even though they were all adults, and telling people where to go; for example, "We'll go up to your lounge to watch it. You're not watching that down here", "You'll have to go upstairs then, instead of doing something nice" and "If you're not calm down here, you can go upstairs." One staff member told a person they would have to pay for something they had broken, even though this was not the case.
● We observed staff using unauthorised restrictive practices. Staff told us they restricted the number of drinks some people had so they could avoid incidents of behaviour that challenged with another person whose drinks had to be restricted for medical reasons. We raised a safeguarding alert about this with the local authority.
● People were not always able to use their home how they wanted to. The low staffing levels in the service meant that staff were limiting where people could go to try to reduce the number of incidents of behaviour that challenges. One staff member told us, "[…] loves to be in the lounge and communal areas but is constantly sent back to his lounge in case it results in an incident."

This was a breach of Regulation 13 (safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
● The service was not well maintained or clean throughout. A staff member explained, "Cleaning when you are one to one is a bit difficult. We try to get it done but it is very difficult. I need to spend my time supporting my person. It is a case of getting the basics done and trying to do more if you get a chance. It is filthy and they have no staff to do it."

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensure staffing levels kept people safe, or that risks to people were mitigated.

The enforcement action we took:

Impose conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured people were free from unnecessary restrictions.

The enforcement action we took:

Impose conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not recognised or highlighted the significant risk low staffing levels had on the quality of people's life and the safety of the service.

The enforcement action we took:

Impose conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured there were sufficient staff working to keep people safe and meet their needs.

The enforcement action we took:

Impose conditions