Carecall Services Limited

St Luke's Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
St Luke's Care Home is a residential care home providing regulated activities of accommodation and personal care for up to 32 people. At the time of our inspection there were 24 people using the service.

People's experience of using this service and what we found
Risks to people's safety were not always identified and mitigated putting people at risk of harm. These risks included both environmental and personal risks to people. The processes in place to reduce the risks of the spread of infection were not effective. Staff did not always wear personal protective equipment in line with government guidance, and standards of environmental cleanliness at the service required improvement. There was a lack of learning from events and staff did not always work together to provide the safe care.

The registered manager did not have effective oversight of the service. They were not aware of all the concerns we found prior to this inspection. There was a lack of effective quality monitoring processes at the service which affected the quality of the environment, care plans and risk assessments, and the analysis of incidents and accidents.

Staffing levels did not always reflect people's needs. There was a lack of support staff in place to allow care staff to fully focus on their roles. Staff attempted to provide regular social activities for people to engage in; however, this area required some improvement. A lack of housekeeping staff impacted on the cleanliness of the service. There were several areas of the home which were not always well maintained, and some areas needed refurbishment.

The service used several agency staff to support their permanent staff. There was a lack of profile records for some of these agency staff, to assure the provider they were safe to work with the people at the service.

Staff practices around the administration of medicines were not always safe and people were not always supported effectively with their nutritional needs

People were not always supported to have maximum choice and control of their lives; the policies and systems in the service did not always demonstrate people were supported in the least restrictive way and in their best interests. Where decisions had been made for people who lacked capacity to make specific decisions, there was a lack of documented consultation with relevant family members, social workers or advocates.

Nationally recognised assessment tools were used to assess people's needs, however these were not used effectively. There was contradictory information in the assessment tools and some information in people's care plans did not reflect their needs

The provider did not always ensure they met their responsibilities to inform us of significant events at the

service as they are required by law to report to us. We are looking into this and will follow our own processes to decide on any necessary action against the provider.

People were supported by kind and caring staff who maintained their privacy and dignity when providing care. They were supported to manage their health needs. The manager and their staff team worked to ensure relationships with external health professionals affected positive outcomes for the people in their care.

There was engagement with people during our inspection, however, there was little evidence of how people were involved in any decisions made about the service.

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

Rating at last inspection
The last rating for this service was requires improvement (published 24 April 2021).
The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected

The inspection was prompted in part by notification of a specific incident. Following which a person using the service died. This incident is subject to investigation. As a result, this inspection did not examine the circumstances of the incident. The information CQC received about the incident indicated concerns about the management of people's safety and the governance of the service. This inspection examined those risks.

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

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective, Responsive and Well Led sections of this full report.

You can read the report from our last Focused inspection, by selecting the 'all reports' link for St Luke's Care Home on our website at www.cqc.org.uk.

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

We have identified breaches in relation to Regulation 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not always protected from risks to their safety and there were not always enough staff. Quality monitoring processes in place did not highlight issues of concern found at this inspection.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

St Luke's Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the 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
The service was inspected by two inspectors and an Expert by Experience undertook telephone calls to relatives during the inspection period. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service

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

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

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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 used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service about their experience of the care provided. We spoke with 11 members of staff including the manager, deputy manager, three kitchen assistants, a housekeeper and five members of care staff. Following our visit, we continued to review records and seek clarification from the provider to validate evidence found. We looked a t training data and quality assurance records. We spoke by telephone with eight relatives about their experience of the service.

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

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question Requires Improvement. At this inspection the rating for this key question has remained Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- Risks to people's safety were not always identified and mitigated putting people at risk of harm.
- We found one person's bedroom had a damaged socket with exposed wire, situated next to the person's bed. We immediately shared this concern with the manager who arranged for the person to be moved into another room. The person was assessed as requiring bedrails as they had a history of falling out of bed. However, staff did not follow instructions and moved the person to a room without bedrails. During the night the person fell out of bed. The person did not sustain serious injury on this occasion but this lack of foresight by staff put the person at risk of serious injury.
- Another person was nursed in a bed which could be lowered to the floor with a crash mattress placed beside the bed. The mattress did not meet the edge of the bed leaving a gap exposing the bare metal bars of the bed frame, putting the person at risk of head injury or entrapment. Staff had used a stuffed toy to plug the gap at the top end of the bed and had not identified this risk to the manager, so more robust measures could be put in place to protect the person.
- There was a lack of window restrictors in place on some windows at the service. One window which lacked a window restrictor opened out into a courtyard area with a prickly bush partially under the window. This posed a risk of injury to people who may try to climb out of the window which was situated on a main ground floor corridor. The manager ordered some window restrictors straight away and told us their maintenance person would fit them as soon as they arrived.
- Improvements were needed to improve people's safety in the event of a fire. There were several fire doors which did not fully close into the recesses. The manager arranged for the work on the doors to be started the next day.
- Information in the fire safety folder was not up to date as the personal emergency evacuation profiles (PEEP's) did not reflect correctly who was living in the service. A PEEP is a plan for a person who may need help to evacuate the premises or reach a place of safety in the event of an emergency. There was one PEEP missing and one PEEP in place for a person who was no longer living at the service. The manager updated the PEEP's file straight away.

Learning lessons when things go wrong

- Staff did not always work together to learn from events. The events highlighted above showed staff did not always follow management instructions to keep people safe.
- Staff did not always feel supported after significant and untoward events that were difficult for them to deal with. Following a significant event at the service a member of staff told us there had been a lack of discussion and debrief for staff to review actions and work to prevent a reoccurrence of the issue. This lack

of clear processes of reviewing events had led to poor practices which put people at continued risk of harm.

Preventing and controlling infection
● We were not assured that the provider was using personal protective equipment (PPE) effectively and safely. During our visit we saw a number of staff were not wearing masks correctly. Some staff had masks under their chins or had them sitting under their nose. This was not in line with local and national guidance and could increase the risk of infectious outbreaks. We highlighted this to the manager who addressed the concern with staff.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. During our visit we saw several communal areas were not free from dust and debris. Several toilets, raised toilet seats and bath chairs were stained with bodily fluids. The sluice and laundry room showed evidence of lack of regular cleaning with stains on equipment and on doors. We highlighted this to the manager who arranged for further cleaning to be carried out and told us the laundry room was awaiting refurbishment.

Systems and processes did not ensure people received safe care and treatment. The provider had failed to mitigate risks relating to people's health and safety. This placed people at risk of receiving unsafe care. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

Visiting in care homes
● People told us they were able to see their relatives on a regular basis. Relatives were happy with visiting arrangements. A number of them told us they would ring the service and were usually able to visit on the same day. One relative said, "We are free to come and go, but rightly they prefer us to ring and say we're coming in". The venue for visits was dependent on how many family members visiting to allow social distancing. There was use of people's rooms or the conservatory.

Staffing and recruitment
● Staff levels did not always meet the needs of people at the service. We found the provider had used a dependency tool to ensure safe numbers of care staff were on duty to support people. However, these staff were not supported by adequate numbers of ancillary staff to allow them to focus on their role of providing direct care for people.
● There were no housekeeping staff on duty after 2pm. There was no laundry assistant employed and staff schedules showed three afternoons a week there were no staff working in the kitchen to support with preparing and serving the evening meal for people. The lack of these staff had impacted on the issues highlighted above around the cleanliness of the service in key areas such as the laundry, toilets and bathrooms.
● People and relatives told us staff were attentive but there were times when they had to wait for care as staff were busy. One person told us the staff would take a long time responding to their call bell. One relative said, "The buzzer isn't always answered quickly and [Name] has said that it's much worse at night." A further relative said, "I do feel they are understaffed. They do what they need to do but they have to rush about."

The provider had failed to provide enough staff to mitigate risks relating to people's health and safety. This placed people at risk of receiving unsafe care.

Failure to ensure there were enough staff was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had needed to use a large number of agency staff to ensure care staff levels remained within their established need. A number of agency staff regularly worked at the service and we saw there were profiles in place to show their experience and training. However, there were several profiles not on file for agency staff who had been rostered to work. We highlighted this to the manager who contacted the agency to supply them. The profiles should be used to assure the manager of the agency worker's identity, training and right to work in this country.
● Recruitment processes for staff employed by the service were robust and Disclosure and Barring Service (DBS) checks were used when recruiting staff. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely
● People's medicines were not always managed safely. For example, care staff had the service's phone in their pocket and did not wear the "do not disturb" tabard available to them when administering medicines. This increased the risk of disrupting the staff's concentration during administering of medicines and increased the risk of medicines errors. We highlighted the concern to the manager and on our second day of the inspection the issue had been resolved.
● Other aspects of medicines management were satisfactory. Where people needed as required medicines there were protocols in place to ensure the medicines were given appropriately. There were no concerns with record keeping, storage, ordering and management of people's medicines.

Systems and processes to safeguard people from the risk of abuse
● People at the service were protected from risk of abuse. People and their relatives told us they felt safe. Staff showed a good understanding of the types of abuse people could be exposed to and their responsibility in protecting people.
● Staff had received appropriate training in safeguarding adults to support them in their roles and had confidence in their manager to deal with any safeguarding concerns effectively. We saw evidence of how the manager had worked with the local safeguarding team to investigate and act on safeguarding concerns raised to them.

Requires Improvement

Is the service effective?

Our findings

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

This is the first comprehensive inspection for this newly registered service. This key question has been rated Requires Improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- Nationally recognised assessment tools were used to assess people's needs. However, the tools were not used effectively. There was contradictory information in the assessment tools and some information did not reflect people's needs.
- One person who was blind required support when eating. We looked at three different assessment tools used for the person and their care plan. The information ranged from stating the person was independent with eating using an aid, to being dependent on assistance with eating and drinking. This lack of clear information had resulted in the person not receiving the support they required from staff.

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

- Overall people were supported effectively with their nutritional needs. However, we observed one person who did not receive the support they needed to eat their meal. This was because staff were not organised. We highlighted this to the manager who told us they would address this moving forward.
- However, the manager had clear processes in place to monitor people's weights to ensure they maintained a healthy weight. People's records showed they had been weighed regularly and their diets adjusted to support them maintain a healthy weight.
- The manager had clear processes in place to monitor people's weights to ensure they maintained a healthy weight. People's records showed they had been weighed regularly and their diets adjusted to support them maintain a healthy weight.
- The kitchen was well organised, and the different diets people required were highlighted. The provider used a precooked meal service. The meals were well presented, and people appeared to enjoy their meals. The day of our inspection was hot, and staff made sure people had plenty of fluids. During the afternoon people were offered iced lollies and cold drinks to help keep them hydrated.

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

- The service had been adapted to meet people's needs. However, there were several areas of the home which were not always well maintained and some areas needed refurbishment. There were areas of the service where decor looked tired. The provider told us they had an ongoing refurbishment plan in place to address these issues. We saw there had been refurbishment of a number of bedrooms and areas around the service.
- People were able to personalise their own bedrooms with their belongings.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met. People who required a DoLS had been assessed and had the relevant authorisation in place.

● Where people lack capacity to make decisions staff had completed mental capacity assessments. However, there was a lack of information to show how decisions had been made and whether this was in a person's best interests. For example, the assessment document had boxes for staff to tick to show a person's capacity but lack detail to show what level of care the person had either agreed to or what had been decided in their best interests. We highlighted this to the manager who told us they would address this and ensure relevant detail was added into people's records.

Staff support: induction, training, skills and experience
● People were supported by staff with up to date training for their roles. People told us staff knew how to provide care for them. We saw several good examples of staff supporting people safely when they required mobility equipment to move from place to place.
● The manager worked with their administration assistant to maintain a clear matrix to show training needed and sent reminders to staff when training refreshers were due.
● Staff told us they were supported with supervision approximately once every four months. One member of staff told us they would like the supervision to be more frequent. However, they told us the manager was approachable and they could go to them if they had any issues.
● Staff records we reviewed evidenced staff received an induction when they started.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were supported with their health needs. Relatives and people told us if they had any health concerns the staff contacted the relevant health professional to support them. Relatives told us staff contacted them if there were changes in their family member's health needs.
● Staff at the service worked with several external health professional teams to provide on-going support for people in areas such as occupational therapy, physiotherapy, and management of medicines to ensure people in care homes have the optimal medicines regime for them. A relative said, "Staff support [name] well and they have a good understanding of their condition. The mental health team are putting a plan together and I guess there's input from the Home."

Good

Is the service caring?

Our findings

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

This is the first comprehensive inspection for this newly registered service. This key question has been rated Good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People told us the staff supporting them were kind and caring. One person said, "I can't fault them (staff)." Relatives also told us they found staff kind and responsive. One relative said, "The carers are very friendly to [name] and me. They are lovely, they treat [name] with the greatest respect and dignity."
- Throughout our inspection we saw positive interactions between people and staff. People were relaxed with staff and staff supported them with respect. Another relative said, "When [name] is in their wheelchair they (staff) talk to them and tell them where they are going."

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

- Throughout the inspection we saw people making choices about how they received their care. One person we spoke with told us they been involved with the development of their care plan. The response from relatives was mixed, several relatives told us they were not asked about their family member's care. However, one relative told us they had been involved with their family member's care plan.
- Where people had requested specific genders of staff to support them, staff worked to ensure their requests were followed.

Respecting and promoting people's privacy, dignity and independence

- People told us staff respected their privacy when providing support for them. We saw staff working in a way that promoted people's dignity. This included knocking on doors before entering and speaking discreetly to people when offering personal care.
- People were encouraged to be as independent as they were able. One relative told us they could see their family member was doing more for themselves since they came to the service.
- Records were stored safely maintaining the confidentiality of the information recorded.

Requires Improvement

Is the service responsive?

Our findings

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

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

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Meeting people's communication needs

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

- There was detailed information about people's personalised needs in the majority of people's care plans. However, the information around people's communication needs was inconsistent.
- One person was blind and although this was mentioned in some areas of their care plan it was not made clear in their communication and moving and handling care plan. There was no Information for another person, who was blind and had some deafness, in their communication care plan on how they communicated. However, their activities care plan noted they communicated through touch.
- There was no guidance in people's care plans on how they wanted to receive information. For example, whether the two people who were blind were able to use braille to support their understanding of information.
- There was limited easy read signage around the service although there were people who would have benefited from this.
- Our findings meant staff may not always use the most appropriate form of communication for people in their care.

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

- Staff worked to try to provide regular social activities for people to engage in. However, this area required some improvement. Although the manager told us they had two activities coordinators, these two staff members were also part of the established number of staff rostered to provide personal care for people. This limited the time they had available to support people with social activities.
- , There were some activities for people to enjoy, such as an exercise class, quizzes and for the recent jubilee celebration people were supported to make decorations for the service. Several relatives said they would like to see the outside areas further developed so people could enjoy it. The manager showed us a project they were developing to support people plant flowers on the patio.
- People were supported to maintain relationships with their family and form friendships with other people in the service. Relatives told us they were able to visit their family members and felt welcomed when they

came to the service.

Improving care quality in response to complaints or concerns

● People and relatives told us they would feel confident to raise concerns to the service if they had any. Staff were aware of their responsibilities to manage any concerns or complaints so there were good outcomes for people. On the first day of our inspection the complaint policy was not displayed for people. However, the manager rectified this for the following day.

End of life care and support

● The service used ReSPECT forms to ensure people's wishes around their end of life care were documented. These forms highlight conversations people, their relatives and health professionals have held to establish people's wishes around care and treatment, to understand what matters to them and what is realistic in terms of their care and treatment. These wishes were documented in people's care plans.

● The manager told us staff were currently undergoing end of life training they had arranged.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- The registered manager did not have effective oversight of the service. The registered manager was not aware of all the concerns we found prior to this inspection. There were no effective systems in place to monitor the quality of service people received and monitor and drive continuous improvement of peoples experience of the care they received.
- The quality monitoring processes at the service required improvement. The issues reported on in the Safe section of our report relating to the cleanliness and maintenance of the environment had not been highlighted by the provider's quality monitoring systems.
- There was a lack of analysis of incidents and accidents. While there was a spreadsheet showing the number of incidents each month the information was limited and as a result did not allow the manager to look at themes and trends.
- These issues had impacted on people's safety and increased the risk of harm.

The provider failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider did not always inform us of significant events at the service as they are required to by law. We are looking into this.

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 manager, was able to give us an example of how they had ensured people's relatives were made aware following an incident or accident involving their family member. They told us it was their standard practice to ring relatives, inform them of adverse events and what the service had done to make their family member safe.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Although we saw there was engagement with people during our inspection there was little evidence of

how people were involved in any decisions made about the service. There were no resident meeting minutes and relatives we spoke with told us although staff were pleasant and welcoming, they were not asked their opinions on the care provided for their family members.

● Surveys were conducted with people around their satisfaction of the service. This was undertaken when a person was a "resident of the day". On this day the person's care plan was reviewed and there was enhanced cleaning of their room. However, some areas of this process were not effective. As reported elsewhere in this report there was conflicting information in people's care plans and the day after one person had been resident of the day, we saw their chair they used daily remained very soiled. This showed a lack of effective engagement and improvement to people's experience of the service.

Working in partnership with others

● The manager and their staff team worked to ensure relationships with external health professionals affected positive outcomes for the people in their care. We saw an example of staff working with their external health professionals to ensure a person received the right care and treatment they needed.

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 18 HSCA RA Regulations 2014 Staffing There were not always enough staff to meet people's needs and ensure their safety.

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 Systems and processes did not ensure people received safe care and treatment. The provider had failed to mitigate risks relating to people's health. This placed people at risk of receiving unsafe care.

The enforcement action we took:

We issued the provider with a warning notice for this breach of regulation

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality and safety of the care provided.

The enforcement action we took:

We issued the provider with a warning notice