Care UK Community Partnerships Ltd

Harry Sotnick House

Inspection report

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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

We carried out an unannounced inspection of this home on 8 and 9 November 2016. The home provides accommodation, nursing and personal care for up to 92 older people, most of whom live with dementia. Accommodation is arranged over two floors with stair and lift access to all areas. A third floor of the home accommodated office space for staff. At the time of our inspection 77 people lived at the home.

The home had a history of non-compliance with the required Regulations of the Health and Social Care Act 2008 between the dates of February 2013 and September 2015.Reports from these inspections can be found at www.cqc.org.uk. We served Warning Notices on the registered provider in February 2015 for breaches in five Regulations. We inspected the home in May 2015 and found it was not compliant with all the Regulations. We placed the home into special measures and placed a condition on the home to prevent any admissions without the express permission of the Commission. This condition was lifted by the Commission following an inspection of the service in September 2015 when we found the registered provider was compliant with all the Regulations although practices needed embedding in the home. At this inspection we found the registered provider was again not compliant with all the Regulations.

It is a requirement of the registered provider's registration to have a registered manager in post at the home. 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.

There was no registered manager in post. The service had been without a manager registered with the Commission between May 2014 and February 2016. A registered manager worked in the home between February 2016 and June 2016. An interim manager was appointed to the home in September 2016 however they had not registered with the Commission. At the time of this inspection the interim manager had been in post for six weeks. The registered provider advised the Commission a new manager was due to start working at the home and would be making an application to the Commission to become registered as the manager as soon as they arrived. They could not confirm the date this person would start employment. Following our inspection the registered provider advised us this person was no longer going to be joining the home and they were interviewing further suitable candidates for the role.

We have identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 during this inspection.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special Measures'. The purpose of special measures is to:

□□Ensure that providers found to be providing inadequate care significantly improve.

□□Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
□□Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

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 time frame 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will continue to be kept under review and if needed could be escalated to urgent enforcement action.

Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

There were insufficient staff available to meet the needs of people. Staff were not always available to support people to mobilise safely and so some people remained in bed. There were a high number of unwitnessed falls and a high number of agency staff used who did not always understand or have sufficient information to ensure they knew how to meet the needs and preferences of people. Staff did not feel supported to complete their roles efficiently and effectively due to the lack of staff. The interim manager told us this was under review.

Whilst medicines were stored safely they were not always managed in a safe and effective manner.

The risks associated with people's care needs had not always been accurately assessed and plans of care were not always informed by these. For people who were at risk of falling from their bed, assessments for the use of bed rails and floor mats had not been completed and plans of care were not informed by these risks.

People were supported by staff who had a good understanding of how to keep them safe, identify signs of abuse and report these appropriately. Processes were in place to check the suitability of staff to work with people. Staff received training to develop the skills to meet the needs of people.

Health and social care professionals were involved in the care of people and care plans reflected this. They told us staff knew people well at the home and understood how to meet their needs.

Staff ensured people who were able to consent to their care were involved in making decisions about their care. Staff were guided by the Mental Capacity Act 2005, however where Deprivation of Liberty Safeguards were in place for people, conditions attached to these safeguards were not always met and records did not reflect the reason these were in place.

People's nutritional needs were met in line with their preferences and needs although records did not always reflect this. People who required specific dietary requirements for a health need were supported to manage these. Records of people's weights and dietary and fluid intake were not always accurately recorded however this was being addressed.

Care plans in place for people did not always reflect their identified needs and the risks associated with these. People and their relatives told us they were involved in the planning of their care.

Complaints were recorded and responded to in line with the registered provider's policy.

There was a lack of strong and consistent management in the home to provide guidance and stability for staff and safe governance of the home. Staffing structures had not been effective in ensuring all staff received supervision and support to maintain their roles. This was being addressed by the interim manager.

Care records were not always up to date and in some instances were inconsistent or conflicting. There was a lack of consistency in the application of quality assurance systems and processes which the registered provider had in place to ensure the home was compliant with all the Regulations. Not all actions identified by the provider through their quality assurance processes had been completed in a thorough or timely manner.

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.

Risk assessments had not always been completed to support staff in mitigating the risks associated with people's care.

Staff had been assessed during recruitment as to their suitability to work with people. However there were not sufficient staff available to meet people's needs.

Medicines were not always managed in a safe and effective manner.

Systems were in place to support staff in recognising signs of abuse and they knew how to report these.

Is the service effective?

Requires Improvement

The service was not always effective.

Where people could not consent to their care staff were guided by the Mental Capacity Act 2005. However the home was not meeting all the requirements of the Deprivation of Liberty Safeguards.

Staff had received training to develop and allow them to meet the needs of people.

Staff knew people well and could demonstrate how to meet people's individual needs.

People received nutritious food in line with their needs and preferences

Is the service caring?

Requires Improvement

The service was not always caring.

People and their relatives said staff were caring and supportive of people's needs. Health and social care professionals said staff were caring and supportive of people and knew them well.

Staff knew people well and respected their dignity. They cared for people in a kind and empathetic way, providing time and support in a relaxed and friendly manner. However, people's privacy was not always respected by others who mobilised in the home unsupervised.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not always reflect the identified needs of people and the risks associated with these needs.

Activities were available for people although areas of the home created to provide space for people to interact were not used.

Systems were in place to allow people to express any concerns they may have although feedback we received suggested these may not always be used.

Is the service well-led?

Inadequate

The service was not well led.

There was no registered manager in the home. Interim arrangements for the management of the home had led to uncertainty and inconsistent approaches in the leadership of the home. Staff did not feel supported in their roles.

The registered provider had systems and processes in place to monitor and review the quality of care in the home. However, whilst areas of concern had been identified these had not been addressed effectively to ensure the safety and welfare of people.

Care records were not always clear or accurate and some held conflicting information.

Harry Sotnick House

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.

Three inspectors and an expert by experience completed this unannounced inspection on 8 and 9 November 2016. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home, including previous inspection reports. We reviewed notifications of incidents the registered provider had sent to us since the last inspection. A notification is information about important events which the service is required to send us by law. On 6 October 2016 the registered 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 improvements they plan to make. We reviewed the PIR for this home. This information helped us to identify and address potential areas of concern.

We spoke with six people and five relatives to gain their views of the home. Some people who lived at the home were not able to talk with us about the care they received. We observed care and support being delivered by staff and their interactions with people in the home. We spoke with staff, including the interim manager, the deputy manager, three registered nurses, seven members of care staff, two activity coordinators and a member of kitchen staff.

We looked at the care plans and associated records for eleven people and sampled two others. We looked at medicine administration records for 77 people. We looked at a range of records relating to the management of the service including records of complaints, accidents and incidents, quality assurance documents, nine staff recruitment files and policies and procedures.

Following our visit we received feedback from three health and social care professionals who supported some of the people who lived at the home.

Inadequate

Is the service safe?

Our findings

People, their relatives and staff told us there were not always enough staff available to meet the needs of people who lived at the home. People and their relatives told us whilst they felt the home was a safe place there were not always enough staff available to meet their needs.

The home provided an environment which allowed people to move freely between different areas of the home. Some people received one to one support from a member of care staff which allowed them to mobilise freely in the home whilst ensuring their safety and welfare, and that of other people. However we saw some people mobilised around the home, walked into other people's rooms and touched their belongings. Staff were not present to monitor this and take action and ensure the safety and welfare of these people. Staff told us they were aware people entered other people's rooms but that there were not enough staff to monitor these people closely throughout the day.

Whilst a number of people mobilised independently around the home, we saw many people remained in bed during the day. One member of staff told us, "We could do so much more for the residents if only we had the staff. This is their home and a lot of the time they stay in bed because we are rushed off our feet." Another told us they believed the lack of staff in the home had resulted in people not receiving the level of care they needed. They told us about two people who had not been assisted to change their position frequently enough to prevent them developing pressure wounds. We identified from care records that these two people had been treated for low grade pressure wounds.

We observed staff were busy and their duties revolved around tasks related to people's care needs. Care records showed many people were at risk of falls or required regular monitoring to ensure their safety and welfare as they were unable to use a call bell. 'Welfare Check Charts' were in place to record when staff supported people or interacted with them and these were maintained by staff. However, whilst these were completed we saw staff had very little time to spend with people providing interactions and 'Meaningful Activities'. Staff activities were limited to providing nutrition, fluids, repositioning people and assistance with continence needs.

One person was in bed at lunchtime and calling out in an agitated way to staff to help them put on their trousers so that they could get out of bed. A member of staff went into their room to deliver their lunch on a tray, encouraged them to have their lunch in bed and reassured them they would help them after they had eaten their lunch. This person calmed down and agreed to leave their trousers off until a later time. We asked this member of staff why the person was not able to have their trousers on before their lunch or when they had been helped with their personal care that morning. They told us, "[Person] will try to get up and mobilise and we can't observe [person] at the moment." They told us this person needed close supervision as they tried to get up and were unable to mobilise independently due to their medical condition. They told us there were not sufficient staff to monitor the person at this time but that they would help them after lunch if they still wanted this.

On the afternoon of the second day of our inspection we found one person on the floor in a state of undress

in another person's room. Care records identified this person was at very high risk of falls and was regularly found on the floor. We saw they required the assistance of two members of staff to get up from the floor. There were two members of staff working together on the unit at this time. We went to find them and alerted them to this incident. We were concerned for the safety, welfare and dignity of this person and others and staff responded promptly to our concern. Staff told us this person was on 30 minute observations to monitor their whereabouts in the home during the day as they were at a high risk of falls. However, whilst this person had been monitored every 30 minutes, there were not sufficient staff available to have an awareness of this person's whereabouts to ensure their safety and welfare at other times.

Whilst staff attended this person another person called out for help and one member of care staff went to help them. The person required the support of a registered nurse as they were in pain. There was no registered nurse present on this unit or the unit immediately next door to provide support for this person. A member of care staff left the unit to find a registered nurse. We were later advised the registered nurse for this unit was in another area of the home and came to support staff with the two incidents.

Following our inspection the registered provider sent us information from a satisfaction survey which was dated July 2016 and November 2016. Whilst this information was not made available at the time of our inspection, we saw that feedback from relatives was largely positive about available staffing levels at the time the survey was conducted. However, some relatives we spoke with had concerns about the number of staff available and in particular the high use of external agency staff.

One relative told us they had visited the home during the weekend before our inspection. On the Saturday there had been four members of care staff on the unit where their loved one lived. Whilst this was the allocated number of staff for the unit, they told us three of the four members of staff were from an external agency or were new and did not understand how to meet the needs of their loved one. On the Sunday of the same weekend they said only two members of care staff were available on the unit at the time of their visit. Two members of care staff had also told us there had not been enough staff in the home on this weekend to meet the needs of people. Staff rotas and allocation sheets showed the allocated number of staff available on the Saturday was not in line with the requirement from the registered provider, although they were on the Sunday.

Records showed a high number of external agency staff worked at the home to support staffing numbers. The interim manager told us this had been identified by the registered provider and was being addressed by a workforce redevelopment team from their head office and recruitment of permanent staff was on-going. The registered provider provided information to confirm this following our inspection and this identified that there were significant numbers of vacancies for both care and nursing staff at the home. Following our inspection the registered provider confirmed they were working with local recruitment agencies to maintain consistent members of staff to support people at the home whilst they continued to recruit permanent staff.

Following a serious incident at the home, concerns had been raised with the registered provider in December 2015 by the coroner's office with regard to the number of staff available to support people in communal areas of the home when these were in use. The registered provider had responded to these concerns at the time and identified a dependency tool was in place to ensure there were sufficient staff available at all times to meet the needs of people. This tool was computer generated and gave guidance on the number of staff required to meet the assessed needs of people.

The interim manager told us they did not know how this tool identified staff numbers. This meant they did not have the information required to challenge or to inform any needed changes to the number of staff working at the home or utilise the tool. They said they were provided with specific numbers of care staff

allocated to each of the six units in the home and this was how they ensured staff numbers were in line with the registered provider's requirements. Staff allocation sheets and rotas showed there were the allocated numbers of staff for most shifts available in the home. The numbers they worked to equated to a ratio of one member of staff for either four or five people on each unit. However staff told us they felt the complexity of people's needs were often not recognised when allocating staff numbers to work in the home. We were not assured the registered provider had taken steps to ensure the number of staff available to meet people's needs was sufficient.

The lack of sufficient staff in the home to meet the needs of people and ensure their safety and welfare was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks associated with people's nursing and care needs had not always been identified and assessments which had been completed had not always been used effectively to inform plans of care for people and ensure their safety and welfare. For example, for one person a risk assessment identified they were at high risk of skin integrity breakdown however their plan of care stated they were not at risk of skin breakdown. For a second person records showed they presented with a particular infection control risk for themselves and others. There was no information in their care records to identify this risk or the steps staff should take to mitigate this risk and ensure the safety and welfare of people. The lack of complete guidance about the risks associated with peoples care posed a risk to people. Staff did not always recognise or have a good understanding of these risks and how to reduce these. Agency staff would not have any pre-existing knowledge of people they were caring for and were reliant on clear records and information from staff about the risks associated with people's care.

Assessments were not always in place to identify the risks associated with specific physical health conditions. For example, for one person who lived with diabetes the risks associated with this condition had not been identified and did not inform their plans of care in place. For another person who lived with a long term breathing condition and required the administration of oxygen therapy, risk assessments and plans of care were not in place to identify and support the risks associated with this need. There was no risk assessment in place to identify the safety risks associated with the use of this gas in the home. Whilst a warning sign was displayed on this person's bedroom door, there was no other signage or information in the home to alert others to the risks associated with this substance in the home in the event of an emergency and ensure the safety and welfare of people. The registered provider had a medicines management policy in place which directed staff to complete a risk assessment on the use of oxygen and to refer to local policy for individual home storage guidance. These actions had not been completed and we were not assured this risk was being managed well to ensure the safety and welfare of people.

For people who were at risk of falls a risk assessment (FRASE) was completed. However, the information within these assessments was not always fully informed by the care people needed or received. For one person a FRASE had been completed which showed they were cared for in bed and had been assessed as at medium risk of falls. We saw this person was fully mobile and their care plans, updated on 27 July 2016 stated they were able to mobilise independently. The assessment of the risk was not accurate as they were not cared for in bed and were able to mobilise putting them at risk of falls. The risks associated with this persons needs had not been accurately assessed and appropriate actions identified to mitigate these risks.

On the second morning of our inspection we saw, of 59 people we were able to observe in bed, 31 had cushioned mats placed on the floor next to their bed to reduce the risk of harm if they fell from their bed. Two people had bed rails in place. Assessments for the use of equipment such as bed rails to ensure their safety had only been completed for three people.

The registered provider had in place a policy on the use of bed rails to reduce the risk of harm to people who may fall from their bed. This identified they discouraged the inappropriate use of bed rails however it also stated the home manager should ensure, "A documented risk assessment is completed on CareSys [computer system for care records] to determine whether a resident requires the use of bed rails." We asked the deputy manager if the use of bed rails or other equipment had been considered for people. They told us the home did not often use bed rails as they preferred to use cushioned mats by people's beds as a less restrictive means of supporting people who fell from their bed. There were no risk assessments in place to reflect the risks of falling from bed had been assessed and appropriate actions taken to mitigate these risks.

For one of the three people with risk assessments in place, an assessment completed on 24 March 2016 identified that the use of bed rails may be appropriate. Despite this assessment there were no bed rails in place for this person. A cushioned mat was in place, however this would not prevent a fall, only reduce the risk of injury should they fall. Care plans in place showed this person was at high risk of falls from bed.

Whilst staff were aware of the risks to people who may fall from their bed, not all assessments had been fully completed to ensure all appropriate actions were being completed to reduce the risk of falling from bed and ensuring the safety and welfare of people.

The lack of risk assessments in place to identify and mitigate the risks associated with people's care was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks associated with people's mental health conditions had been identified and care plans in place reflected the actions staff should take to reduce these risks. For people who displayed behaviours that might present a risk to themselves or others, the behaviours and triggers to these had been identified. Most staff had an understanding of people's needs and the risks associated with these behaviours although external agency staff did not always have a good understanding of these. For example, one member of agency staff approached a member of the inspection team requesting information as to how to support a person as they were having difficulties. We directed them to other members of staff for guidance. For two people who could display aggressive or challenging behaviour towards others, staff were able to give us clear information on how they supported these people to maintain their safety and that of others. They told us how they supported people to remain calm, access other areas of the home and express their concerns, or provided one to one support to maintain people's safety.

Medicines were stored safely in a locked clinical room and medicine trolleys were closed and locked when unattended in the home. Medicines were administered by a registered nurse who wore a red tabard which identified they should not be disturbed. One registered nurse told us this gave them time to ensure they were able to administer medicines in a timely and safe way without being interrupted, although they were always available for emergencies.

The deputy manager explained they had introduced a new process for ordering medicines to ensure that there were always enough medicines for people. They told us they were working with local GP surgeries to reduce the number of different surgeries people were supported by and improve the continuity of care in relation to medicines for people. Whilst this process was in place staff told us there were regularly times when people did not have sufficient medicines to ensure people received their medicines in a timely way. One registered nurse told us, "It's a regular problem, medicines which haven't been sent, I am not really sure why we can't get it sorted, but it happens all the time, no medicines to give people." An audit dated 8 November 2016 showed some medicines which were not available for people as stock had not been replenished in time.

Medicine administration records (MAR) were not always clear or accurate on the medicines which had been administered or offered to people. There were gaps in the recordings of medicines and it was unclear if medicines had been unavailable, omitted, not signed for or disposed of. Some entries on MAR required the registered nurse to document the dose of a medicine given, such as 20mls, or one or two tablets. These had not always been documented. This meant staff were not always aware of the accurate dose of medicine a person had received during a day. For people who had medicines which were required to be administered once per day, there was no record the registered nurse had attempted to administer these medicines at another time of the day if they were refused during a medicines round. This meant people did not always receive the full amount of medicines which had been prescribed for them.

For medicines which were prescribed 'as required' we saw protocols were in place for most of these medicines although staff had not always documented the times these were given or the effectiveness of these medicines. However, one person required the administration of oxygen as required to maintain their blood oxygen levels at a specified range. There was no protocol in place for this medicine. An 'Administration of medicines' care plan for this person did not identify they were prescribed the use of oxygen on an as required basis. A 'Breathing' care plan showed the person was on long term oxygen therapy and staff should monitor their respiratory rate and blood oxygen levels continuously to maintain a specific blood level of oxygen. A registered nurse told us staff did not monitor this person's blood oxygen levels routinely, only if they became unwell or staff noticed any symptoms of breathlessness. The MAR showed this person had required the administration of oxygen only twice in a period of 28 days. However, there were no records to show why this medicine was required, for how long it had been administered or the effect this had had on the person. We could not be assured the person received this medicine as it was prescribed or required to ensure their safety and welfare. We spoke with a registered nurse about our concerns with the administration of this medicine and they said these would be addressed immediately.

Registered nurses completed a medicine handover record twice per day to identify any concerns with the administration of medicines during the previous shift. We saw these audits were not always effective in ensuring MAR were an accurate reflection of the medicines people had received. Daily stock audits were completed; however these did not always correlate with the number of medicines which should have been available for people.

The lack of clear and effective systems in place to monitor and record the proper and safe management of medicines to ensure the safety and welfare of people was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The deputy manager told us two people received their medicines covertly. Covert medicines are those given in a disguised form, for example in food or drink, where a person lacks capacity to make a decision about not taking a medicine. Records showed the home had ensured families and health care professionals had been fully involved in a best interests decision making process in line with the Mental Capacity Act 2005 to ensure the safety and welfare of these two people.

For a third person their daily care records identified they were to have medicines administered covertly although there was no plan of care in place to reflect this. We asked the deputy manager to confirm this information and they told us this was an error in the person's care records, they were not receiving covert medicines and this would be addressed immediately.

Homely remedies were available for registered nurses to administer if these were required. These medicines are available for people to buy over the counter at a pharmacy and were used to support people who may have symptoms such as pain or constipation. Pain assessment charts were in place and used to encourage

staff to observe and identify signs and symptoms of pain in people who may not be able to tell staff they were in pain.

There were safe and efficient methods of recruitment of staff in place. Recruitment records included proof of identity, two references and an application form. Criminal Record Bureau (CRB) checks and Disclosure and Barring Service (DBS) checks were in place for all staff. These help employers make safer recruitment decisions to minimise the risk of unsuitable people working with people who use care and support services. Staff did not start work until all recruitment checks had been completed. The interim manager told us of a recent recruitment drive by the registered provider which had resulted in many staff interviews being held in the weeks prior to our inspection with other interviews planned.

People who work in the United Kingdom as nurses must be registered with the Nursing and Midwifery Council (NMC) and have a personal identification number (PIN) for this. Providers must ensure all registered nurses provide the relevant documentation to show they have this registration. This information was held on file for registered nurses employed at the home.

Staff had a good understanding of the safeguarding policies and procedures which were in place to protect people from abuse and avoidable harm. They said they were confident to report any concerns to the interim or deputy a manager who they said would take any necessary action immediately. Staff had received training on safeguarding and were able to identify the types of abuse they may witness and how to report this both in the service and externally to the local authority and CQC. A small credit card reminder had been provided for all staff to support them in identifying any safeguarding concerns. Records showed any safeguarding concerns which had been raised in the service had been addressed by the deputy manager and they had worked with the local authority to investigate and learn from these events. Staff were aware of the provider's whistleblowing policy and said they would be happy to go to more senior management if they felt their concerns were not addressed appropriately by the interim or deputy manager.

Requires Improvement

Is the service effective?

Our findings

People who were able to express their wishes felt they were involved in their care and were offered choices and support to maintain their independence. One person said, "I get good treatment here and the staff give me choice and encourage me to be independent." Relatives told us they were very involved in the care their loved ones received and worked with staff to ensure they received choice in line with their needs and preferences. People and their relatives spoke highly of the food choices available to them. Health and social care professionals felt staff requested their support appropriately and followed guidance provided for them to ensure the safety and welfare of people.

Where people had the mental capacity to consent to their treatment, staff sought their consent before care or treatment was offered and encouraged people to remain independent. Whilst people were not always able to verbally agree to their care, staff had a good understanding of how people expressed their wishes and consented to their care. Staff were aware of the communication skills people used to demonstrate they did not wish to receive the care. For example, for one person who disliked intimate personal care and could become very agitated at this time, staff understood the need to allow them time to complete this care as much as possible independently.

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Where people lacked the mental capacity to make decisions the home was guided by the principles of the MCA. The deputy manager and staff had an understanding of the processes required to ensure decisions were made in the best interests of people. However, care records did not always hold all the information staff may require to identify people who had the legal authority to make decisions on behalf of another person.

People 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 MCA. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards. For most of the people who lived at the home an application had been made to the local authority with regard to them remaining at the home to receive all care or leaving the home unescorted. Many of these applications had been approved and were identified in people's care records as having a Deprivation of Liberty safeguard in place. However, records did not always provide information as to what this deprivation was and any conditions which had been attached to it. We asked the deputy manager how many people at the home had a Deprivation of Liberty Safeguard in place and which of those had conditions which staff were required to meet. They were unable to tell us as this information was being reviewed at the time of our inspection. They told us they were not aware of any conditions but that they would review this.

For one person a Deprivation of Liberty safeguard had been granted for the person to remain at the home and receive care and treatment on 11 August 2016. However this deprivation was subject to two conditions.

We saw these conditions were not being met or addressed at the time of our visit. The records for this person did not identify the conditions to ensure this person was safeguarded and recorded that there were no conditions attached to this. This incorrect information for staff and the lack of action taken to address the attached conditions meant we were not assured this person was being deprived of their liberty lawfully.

For a second person a deprivation of liberty safeguard had been granted for the person to remain at the home and receive care and treatment on 24 May 2016. However this deprivation was subject to one condition. Care plans and records did not reflect the condition attached to this deprivation of liberty safeguard. The lack of action taken to address the attached condition meant we were not assured this person was being deprived of their liberty lawfully.

We found the home was not meeting all the requirements of the Deprivation of Liberty Safeguards. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection of this service in September 2015, a program of staff supervision sessions and appraisals was in place. This ensured staff had the opportunity to share their views and experiences of the service, understand their roles and responsibilities in the home and to discuss the learning and development available to them. However, at this inspection staff told us this program had not been sustained following the registered manager leaving the service in June 2016.

Staff told us supervision was "Sporadic" and they did not feel supported, particularly by clinical lead staff. Three members of staff told us they had not received supervision for over six months. Staff felt a lack of strong leadership in management had resulted in a lack of support for them.

We spoke with the deputy manager and interim manager about the lack of supervision and appraisal available for staff. They told us these had not been available for staff in the past few months due to the lack of support available for management in the service. This was being addressed by the interim manager although a new manager was due to join the service soon and it was unclear how staffing structures may change to support this.

The lack of regular supervision in place for staff was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Two new members of staff were completing an induction program during our visit. A clear program of induction and training was in place for staff. This ensured people received care and support from staff with the appropriate training and skills to meet their needs. A training coordinator provided support for care staff to encourage them to develop and train in new skills and empower them to develop to their full potential. Staff told us they were able to access any training to expand their skills and knowledge to meet their own needs as well as those of the people who lived in the home.

Training records were held electronically and reported to the registered provider's head office to monitor staff training. These showed staff had access to a wide range of training which included: moving and handling, fire training, mental capacity and deprivation of liberty, dementia awareness and health and safety. All staff had been encouraged to develop their skills through the use of external qualifications such as National Vocational Qualifications (NVQ) and Care Diplomas. These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. Registered nurses were supported to remain up to date with current practice and able to meet the requirements of their registration with the Nursing and Midwifery Council (NMC).

People told us the food provided at the home was very good and they enjoyed a variety of foods in line with their preferences. One person said, "The food is lovely, we have a good choice and I really enjoy it, the puddings are also lovely." We saw people had a choice of nutritious meals at each meal time and were supported and encouraged to enjoy a sociable experience at mealtimes. There were six main areas of the home where meals were served, one on each unit in the home and some people chose to eat in their room. Some people remained in bed and required staff to support them with their meals. Nursing, care staff or relatives sat with people in each area of the home to support them with their meals if they required this. Other staff including managers, maintenance staff, kitchen and domestic staff were present in communal areas of the home at mealtimes. Whilst they did not support people to eat, they provided encouragement and interaction for people during mealtimes. There was a high level of engagement between people and staff at mealtimes in dining areas of the home.

A member of staff was appointed to be the nutritional link person in the home. They worked closely with nursing, care staff and the cook to ensure they all had a good awareness of people's special dietary needs, preferences and dislikes. Care plans identified specific dietary needs, likes and dislikes of people and the nutritional link person maintained records for kitchen staff to ensure the dietary needs of people were updated and reflected in their meal choices. Meals which were pureed were displayed in an appetising way to encourage people to enjoy a wide range of meals.

An assessment of people's nutritional status was reviewed each month or more frequently if this was required. For people who were at risk of choking, information in care records clearly identified the need for staff to thicken fluids to reduce this risk. Records identified people's weights should be recorded weekly, fortnightly or monthly; we saw this did not always happen. The nutritional link person told us that this was often due to there not being enough staff to facilitate this and they were looking to improve this and address this issue with all staff.

Team leaders and registered nurses were responsible for ensuring food and fluid charts which identified how much people had had to eat and drink were monitored and any concerns identified. However we found these charts were not consistently completed. We address poor record keeping concerns in the well led section of this report.

An audit of nutritional assessments and records had been completed by the nutritional link person and they told us they were working to ensure these records were an accurate reflection of people's needs and actions staff needed to take to meet these needs.

Records showed health and social care professionals including GP's, speech and language therapists, social workers, specialist nurses and community psychiatric nurses visited the home to provide advice and support as this was required for people. Health and social care professionals said a registered nurse was always available to support them on their visits and staff at the home knew people well. They felt staff had a good understanding of how to meet people's needs especially those with dementia and those who presented with behaviours which may put themselves or others at risk. We saw actions had been taken to incorporate instructions from health and social care professionals into people's care plans. For example, for one person who lived with complex mental health problems we saw a specialist nurse had advised on their care and staff were supporting these actions.

Relatives were assured people received prompt attention from health and social care professional if they required this. One relative told us, "They [staff] know when [person] is not well and always get the advice from the GP or psychiatrist if they need it." However, for one person who had been identified in August 2016 as requiring an assessment by an occupational therapist for a suitable chair, records showed whilst staff had

made a request for this assessment this had not been completed and no further action had been taken to ensure this assessment was completed. The deputy manager made arrangements to have this assessment completed immediately following our visit.

Requires Improvement

Is the service caring?

Our findings

People and their relatives said staff were very caring and had a good understanding of their needs. One person told us, "Staff here are 100%, they work so hard to help us and look after us. " A relative said, "The staff are so good, I really can't fault anything…" People were valued and respected as individuals and appeared to be happy and contented in the home, although some disliked the intrusion on their privacy of people who mobilised independently into their rooms. Health and social care professionals said staff had good caring relationships with people.

Staff knew people well and used good communication skills as they addressed people by their preferred name and took time to recognise how people were feeling when they spoke with them. For example, one person was calling out from their bedroom as they lay in bed. A member of staff went to their room and spoke calmly, quietly and slowly with them, reassuring them they were there to help and encouraging them to express themselves. The member of staff recognised why the person had become agitated and supported them to be comfortable whilst reassuring them they would not leave until they felt better. A second person was very distressed in their room and staff recognised the need to help them have something to eat and then rest before they were supported with personal care. They understood the routine this person needed to feel safe and comfortable and supported them to do this.

Whilst staff were very busy, people who had been supported with personal care and remained in bed appeared well groomed and comfortable. People had been supported to have teeth cleaned and their hair brushed and bed linens were clean and fresh.

Health and social care professionals said staff were caring and kind and provided good support for people, particularly those who were coming to the end of their life. One health care professional told us how staff had worked with them to ensure one person was able to return to the home to die as was their request. They spoke of staff who knew people well and understood how to meet their needs and preferences.

Staff had a good understanding of the need to ensure people were treated with respect and dignity at all times. One person told us, "The staff are very respectful; they always knock on my door and stay outside the toilet whilst I need to use it. They encourage me to be independent and when I have a shave they always help me hand over hand." Another person said, I'm the boss really, I tell them what I want to do and where I want to go." They said staff always ensured they were covered up when they were supporting them with personal care and treated them with respect. We saw whilst staff were supporting people with personal care in their rooms, small signs were available to hang on bedroom doors to ensure people were aware they should respect the person's privacy.

However, whilst people were able to personalise their rooms, several people and their relatives told us of their concerns that others were able to walk into their rooms and remove their belongings or disturb them whilst they were in this personal area. They felt this lack of privacy was an accepted behaviour at the home and little could be done about this. One told us, "I don't really like them [other people] coming in my room, but there is nothing I can do about it." Another person told us, "..I do worry as there are some people that

come into my room. I think it's unacceptable but what can I do?" A relative told us, " ..one day there were four wandering residents in my [relatives] room." We asked this relative if they had raised these concerns with staff or managers. They told us, "I haven't done as I am not sure what the management can do about it." We saw some people did walk around the home independently and enter other people's rooms without invitation.

Staff were aware people walked around the home independently and entered other people's rooms during the day and night. During our visit one member of staff was looking for a prescribed soap for a person which was kept in their room. They were unable to find it and told us, "Someone who wanders must have taken it." There were no care plans or records in place to identify the risks associated with people who mobilised independently into other people's rooms without invitation or information for staff on how this should be monitored or addressed.

People were not provided with sufficient support and action taken to ensure their privacy, and this was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives were involved in providing information to inform their care plans. Care records showed staff interacted with people to understand their needs, views, preferences and dislikes. Relatives were involved in the planning of care for their loved ones and health and social are professionals were consulted to ensure plans of care fully reflected people's needs.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives were encouraged to express their views and be involved in making decisions about their care. Staff knew people very well and understood how to support them to be as active and independent as possible whilst maintaining their safety and wellbeing. Health and social care professionals said staff knew people well and understood their needs.

People were assessed by the deputy manager prior to their admission to the home and these assessments were discussed with the clinical leads for the home to ensure the staff were able to meet the person's needs. This assessment then helped to inform care plans. Health and social care professionals were involved in assessments of people prior to their admission to help identify their physical and mental health needs prior to admission to the service. People's preferences, their personal history and any specific mental or physical health needs or care needs they may have were documented. This allowed all staff to have a clear understanding of the person's needs and how they wanted to be cared for. Information was available in each person's care records to identify specific likes and dislikes and the personal abilities of people to manage their own care. They also noted people who were important to them although they did not always identify who needed to be involved in their lives and in helping them to make decisions.

Staff had a good understanding of the need for clear and accurate information which reflected people's needs. Each person had a nominated keyworker. This was a member of staff who took a key role in coordinating and promoting continuity of care for the person. Care plans were reviewed and updated monthly or more frequently if care needs changed, however we found these records were not always up to date or contained conflicting information about the care people required. For example, for one person who required support with moving in bed two different pieces of equipment were described in their care plans for staff to use to support this need and it was unclear which was the correct one. Staff were able to identify the equipment they used for this person. For another person who was at high risk of falls their care plan did not reflect this; however staff were aware of this risk and how to support this person.

Care plans in place guided staff on how to meet the needs of people with specific mental health conditions such as dementia. However, some care records lacked personalised information on physical health conditions such as diabetes or a breathing condition. Whilst staff understood the needs associated with these conditions, care plans were not always personalised and fully informed by these. For example, for one person who lived with diabetes there were no care plans in place to reflect this condition and the risks associated with this. For another person who had a breathing condition and required the use of oxygen to maintain their safety and welfare, care plans in place for this person held conflicting information and lacked instruction for staff on how to support the person with this condition. Whilst staff were aware of these needs, the lack of personalised information as to how these conditions may present or affect these people meant care records were not always accurate and reflective of people's needs. We have addressed the issue with regards to records in the well led section of this report.

During the mornings of our inspection day's people mostly remained in their rooms and some watched television whilst others listened to the radio or music. Three activity coordinators worked at the home

through the whole week including weekends to support the coordination and management of activities for people. They told us mornings were allocated to provide one to one interactions and support for people in their rooms. Afternoon sessions in a communal area of the home included music from entertainers, games, drama groups, church services and art and craft. Activities were also themed around specific times of year such as Christmas, Halloween and Easter. Activities were planned and displayed in a variety of areas in the home and in people's rooms to help identify activities people may be interested in attending. Whilst significant adaptations had been made to areas of the home to encourage people to interact with others and be involved in activities away from their rooms such as a 'Sweet Shop', a 'Tea Room' and a 'Bar area' we saw these areas were not used during the time of our inspection. A member of staff told us these areas were not used very often, although staff could not tell us why. Staff told us some people were able to attend activities whilst lying on a bed or in wheelchairs to encourage them to participate and interact with others. The complaints policy was displayed in the entrance to and around the home. People and their relatives were aware of the policy and felt any concerns they raised with staff would be dealt with. One person told us, "I don't need to complain, but if I have concerns I chat with the staff and they sort things out. I think they have this place up to perfection now." One relative told us, "[Relative] isn't the type to complain but between myself and [another relative] we do feel able to be involved and speak up on [relatives] behalf and we get good results from staff."

Complaints which had been logged on a computer system were dealt with by the interim or deputy manager in line with the registered provider's complaints policy.

Staff welcomed visitors in a warm and friendly way and encouraged them to express any views about the service their relatives received. Relatives told us of 'Resident/Relatives Meetings' which occurred every three months and provided a forum for people and their relatives to air any views, make any suggestions for improvement and discuss any new changes in the service. Minutes from these meetings showed people and their relatives were advised of changes in the management of the home and had the opportunity to discuss any concerns they may have with staff.

Inadequate

Is the service well-led?

Our findings

People and their relatives said they felt able to talk to staff and managers if they had any concerns and that these would be dealt with promptly. They were aware there had been changes in the management of the home. Staff told us they did not feel they received the support they needed from managers to do their job effectively. They felt managers did not listen to their concerns particularly around staffing.

Whilst a management structure was in place at the home, this lacked consistency and a strong leadership presence was required in the home. At previous inspections of this home the registered provider had failed to ensure consistency in the leadership and management of this home. A registered manager had not been in post between May 2014 and February 2016. The home had been inspected by the Commission nine times during this period. Between March 2013 and September 2015 the home had failed to consistently meet all of the required Regulations. This led to enforcement action by the Commission including Warning notices, a Fixed Penalty Notice and the prevention of admissions to the service for a period of time between August 2015 and December 2015. Our inspection in September 2015 found the service had a manager who had provided consistency of management in the home and whilst the home was compliant with all the Regulations, some work had been required to embed practices in the home.

There was no registered manager in place. A registered manager had left the service in July 2016. They had been registered with the Commission for three months although they had been the manager in the home for over a year. The deputy manager had been supported by management staff from the registered provider's head office to provide management and clinical leadership in the home following the departure of the registered managers. However, this arrangement had failed. The registered provider had not ensured that the day to day management of the service maintained appropriate systems and processes to ensure full compliance with all of the required Regulations, such as adequate support for staff, effective audits of care plans, risk assessments and medicines and effective management of staffing levels. We have outlined the impact of these shortfalls in the other domains in this report. As a result of this staff had not always received the support and guidance they required to fulfil their role, meet the needs of people and ensure their safety and welfare.

An interim manager had been in post for six weeks at the time of our visit and was not due to remain in post. The interim manager had identified several areas of concern which they were trying to address in the home including the lack of a clear support structure for staff, staffing levels in the home and recruitment. They told us they had appointed a new clinical lead to join two other members of staff in the clinical leadership of the home. The deputy manager would then be able to provide management leadership for people as this was their role. A business manager and an administrator were also available to support the running of the home. They were able to support the interim manager in the use of computer systems which the registered provider had in place for care records and also monitoring the quality and effectiveness of the service. However, further work was required to clearly identify management staff responsibilities in ensuring systems and processes such as audits, supervision and appraisal sessions and review of staffing levels were completed.

Following our inspection, the registered provider told us a manager who had planned to join the service and register with the Commission was no longer joining the home and that the deputy manager was leaving their post. They told us they were actively recruiting to both of these posts and that senior managers with the registered provider's head office would be supporting the service during this time of change.

There is a lack of consistent leadership in the home and this is a recurring concern for the Commission about this service. The lack of consistent and effective leadership in the home has had a direct impact on the ability of the registered provider to be consistently compliant with all the required Regulations and ensure the safety and welfare of people.

Registered nurses were responsible for the day to day running of each unit in the home and the clinical leads' role was to provide support and clinical leadership for all staff. Team leaders worked in different areas of the home to provide support and guidance to care staff. However, care staff and team leaders told us they had not received supervision and guidance to ensure they were able to fulfil their roles effectively. Registered nurses said they had not received the support they required to ensure there were adequate staff available to ensure the safety and welfare of people. Staff morale was low and whilst some staff had left, others told us they were leaving the home as they did not feel they were supported sufficiently.

The interim manager and the deputy manager promoted an open and honest working culture in the home. They told us they had identified the need to work with staff who were concerned about the constant change in leadership in the service and promote stability. They recognised this was a challenge as the interim manager was not in a permanent post in the home. Staff told us the interim manager had made a difference in the time they had been in the home. One told us, "Staffing levels are not getting better but [Interim manager] has done everything she said she would." Others told us the management of the home, "needs to improve", and, "Can't keep changing like this." One told us, "We raise concerns [about staffing and risks] but they [managers] are not listening". The interim manager said the staff at the home worked very hard and knew people well but that a lack of consistent leadership had left them feeling unsupported and vulnerable.

A planned programme of staff meetings was in place to provide an opportunity for all members of staff to discuss developments in the service and any concerns they may have. A weekly deputy manager and clinical leads' meeting was held to discuss any changes in the service. New admissions, any concerns which had been raised with regard to incidents, accidents, safeguarding or any audits which had been completed were discussed. The interim manager described how senior staff were supported daily during a 'Flash' meeting each afternoon to discuss any issues current in the service that day. The deputy manager and interim manager had taken steps to provide staff with the opportunity to share their concerns in the service and work with senior staff to address these. Supervision sessions for all staff were being planned and implemented at the time of our visit although further work would be required to embed this practice in the home when a new manager arrived.

Care records were held securely in a computerised system however these did not always provide a clear and accurate reflection of people's needs; information held within these was not always up to date and was at times inconsistent or conflicting. Medicine administration records were not always completed accurately and audits of these records consistently showed this concern. Nutrition and weight assessments did not always contain accurate information

The registered provider had a programme of audits to be completed at the home each month to ensure the safety and welfare of people. It was unclear from the records we were provided with which of these audits had been completed, although in October 2016 we saw an audit for infection prevention and control and an audit on nutritional assessments for people had been completed. The deputy manager told us they had

completed monthly managers' report to send to the registered provider which included an audit of some care records, incidents in the service and other information to inform the registered provider of any concerns in the home for that month.

The registered provider had a system of internal audits in place to review compliance with the Regulations in the home. An internal audit of the home was completed in June 2016 by the registered provider and assessed the home to see if it was safe, effective, caring, responsive and well led. This identified many of the concerns which we found during this inspection including; the poor documentation of mental capacity assessments and Deprivation of Liberty safeguards, poor risk assessment process for the use of bed rails in the home, staffing concerns and the lack of effective management and leadership impacting on all areas of the home.

Following the support of managers from the registered provider's head office to address these concerns, a follow up review of the service was completed in September 2016. This showed the registered provider had identified some areas had improved although the home still had areas of concern to address and this informed a service improvement plan. (SIP) We asked to see the SIP for the home however the interim manager and deputy manager were unclear where this was. We did not review this.

Whilst the registered provider had identified some of the concerns we found during our visit, they had failed to take actions to ensure the service was compliant with all the regulations. A copy of the SIP was forwarded to the Commission on 6 December 2016 and this showed that in June 2016 actions were required to address many of the concerns we had identified at our inspection. The registered provider had failed to address these concerns in a timely way to ensure the service was fully compliant with all the Regulations.

Incidents and accidents which occurred in the home were recorded and reported in a computer system (CareSys) by all staff. We asked the interim manager how they reviewed these events on a daily basis and how they monitored any trends in these. They told us they reviewed all incidents and accidents which were reported on CareSys each day when they arrived at work. This information was reviewed, any actions identified and then this was shared with staff at handover or at the daily 'Flash' meeting and information would be updated in care records.

The interim manager told us the data on incidents and accidents was held on a different computer system for the registered provider and this information was then collated to show trends of incidents and accidents at the home. They told us they had not reviewed this collated information since they arrived at the home. It was unclear when this information of incident and accident trends was last reviewed or monitored to ensure the safety and welfare of people as the person managing the home on a day to day basis had not had this information.

We looked at the accident and incident records reported on CareSys between 1 July 2016 and 9 November 2016. We found there had been a total of 65 unwitnessed falls in the home during this time. Many of these falls were for people falling from bed on to mats by the side of their bed although 16 of these were unwitnessed falls in communal areas of the home such as a lounge area or corridor of the home. They showed a total of 25 people had fallen at some time in the home without these being witnessed by staff. In addition to this other falls were witnessed by staff or relatives.

There was no information available in the home to show any actions which had been taken to address any patterns in unwitnessed falls. Whilst some individuals had information in their care plans to advise staff on the steps to take to reduce their incidence of falls this was not consistent. For example, between 1 October 2016 and 9 November 2016 one person was reported to have fallen 12 times in their bedroom and in

communal areas of the home. Care plans in place did not contain any information to show this person was at high risk of falls, except to say they required a mat by the side of their bed and did on occasions place themselves on the floor. Their records held conflicting information as to how this person should be supported to mobilise safely.

Whilst data was being collated to identify any trends or patterns in incidents and accidents this was not being used to inform the care people received in the home.

There was a lack of consistent leadership in the home. Whilst systems were in place to assess, monitor and improve the quality of service for people these had not been effective in ensuring the service was compliant with the regulations. Records were not always clear, accurate and complete. The risks associated with the health, safety and welfare of people were not always being monitored and assessed.

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

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 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	People were not always provided with sufficient support and action taken to ensure their privacy.

The enforcement action we took:

Two conditions were imposed on the registered provider's registration for this location to provide regular information and feedback to the commission on actions being taken to address this breach

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	There was a lack of risk assessments in place to identify and mitigate the risks associated with people's care. There was a lack of clear and effective systems in place to monitor and record the proper and safe management of medicines to ensure the safety and welfare of people.

The enforcement action we took:

Two conditions were imposed on the registered provider's registration for this location to provide regular information and feedback to the commission on actions being taken to address this breach

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The home was not meeting all the requirements of the Deprivation of Liberty Safeguards.

The enforcement action we took:

Two conditions were imposed on the registered provider's registration for this location to provide regular information and feedback to the commission on actions being taken to address this breach

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

personal care Treatment of disease, disorder or injury	governance There was a lack of consistent and effective leadership in the home. Records were not always clear, accurate or complete and the risks associated with the health, safety and welfare of people were not always monitored and assessed.

The enforcement action we took:

Two conditions were imposed on the registered provider's registration for this location to provide regular information and feedback to the commission on actions being taken to address this breach

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 There were not sufficient staff available to meet the needs of people and ensure their safety and welfare. There was a lack of supervision in place for staff to ensure they were supported in their working role.

The enforcement action we took:

Two conditions were imposed on the registered provider's registration for this location to provide regular information and feedback to the commission on actions being taken to address this breach