Living Ambitions Limited

Whitwood Hall

Inspection report

Whitwood Lane
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West Yorkshire
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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
Whitwood Hall can accommodate up to 16 people across three separate houses, each of which have separate adapted facilities. These houses are known as Saxon, Moore and Lodge. The home supports people with autism, learning disabilities, complex needs and behaviours which may challenge others. On the day we inspected, 11 people were living in the home.

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

Right support:
• Model of care and setting maximises people's choice, control and independence

Right care:
• Care is person-centred and promotes people's dignity, privacy and human rights

Right culture:
• Ethos, values, attitudes and behaviours of leaders and care staff ensure people using services lead confident, inclusive and empowered lives

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, Right care, Right culture. People were not being supported to access the local community in line with their assessed needs. We found there was confusion about whether agency workers were allowed to support people away from the home. This meant people were not empowered to have full control over the day-to-day routines. The provider has taken action since our inspection.

People were not supported to have maximum choice and control of their lives and staff were not enabled to support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

There had been a lack of robust oversight at this home in the lead up to our inspection. At the beginning of July 2021, a home manager from a 'sister' service had been asked to take day-to-day control of Whitwood Hall. They were being supported by two area managers who were providing intensive support.

Training completion levels were found to be low in some areas. The provider was addressing this following our inspection. Staff received formal support through supervision.

Soap dispenser units in some people's bathrooms did not have soap in them and a cover. This was addressed on the day of inspection. Staff largely wore their PPE correctly.

The premises were not in a good state of repair. The provider had identified this prior to our inspection and was taking action. However, it was evident that a regular programme of maintaining the three houses had not been suitably managed.

There were sufficient numbers of staff to meet people's needs. However, we had concerns regarding the suitable deployment of staff to ensure there was an appropriate skills mix. Staff had been safely recruited with relevant background checks.

Relatives knew how to complain if they were dissatisfied. There was no record concerning the only complaint we became aware of and how it was dealt with, although we are aware this was resolved.

People and relatives felt the service was safe and that people were protected from harm. Staff received safeguarding training to ensure they knew how to recognise and report abuse. People received sufficient amounts to eat and drink. Healthcare support was provided for people when they needed this.

People and relatives were mostly positive about the care their loved ones received. We witnessed caring interactions between staff and people living in the home. Staff were familiar with people's care needs and people's privacy and dignity was being maintained.

Medicines were mostly well managed, with staff receiving training and a competency check for this. Medication audits were being completed.

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 outstanding (published 19 March 2019).

Why we inspected
The inspection was prompted due to concerns received about staffing levels, the state of the premises, staff not receiving training, people's safety, leadership and an over reliance on take away foods. A decision was made for us to inspect and examine those risks.

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

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

You can see what action we have asked the provider to take at the end of this full report. The provider was taking action to address these areas at the time of inspection.

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

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to the suitable deployment and training of staff as well as a lack of oversight of the home.

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 safe 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 safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our safe findings below.

Whitwood Hall

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
This inspection was carried out by two inspectors. Following the site visit, an Expert by Experience made phone calls to people's relatives to gather feedback. 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
Whitwood Hall is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided. A manager from another home run by the registered provider was temporarily in day-to-day charge of the service. Two area managers were providing support to the manager.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is

information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service. We sought feedback from the local authority and professionals who work with the service. We also contacted Healthwatch for their feedback. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

During the inspection
We spoke with five people who lived in the home and seven relatives. We also spoke with the home manager, two area managers, the deputy manager and 11 support workers.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to 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.

Staffing and recruitment
• There was a high level of agency usage which was due to sickness and staff departures. People were not always supported to access the community in line with their care plans. For one person, the reason for this was recorded as 'Not enough staff' on several occasions. We have reported on this under the 'responsive' key question.
• One relative told us their family member did not want to travel with staff they were not familiar with. Two staff who were new to this person arrived to transport the person who refused to travel. The relative said this need was recorded in their care plan.
• Staff allocation to support people safely and meet their needs had not always been considered. We found an example of this on inspection which an area manager dealt with.
• Relatives told us, "There's a lot of agency staff at the moment" and "Originally, [person] was supposed to have a core team (of staff) but they don't have that now. I am happy with the care, but the staffing is a concern."

This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not being supported by teams which had been suitably deployed within the service.

• Staffing levels were provided in accordance with people's dependency levels. We looked at staff rotas covering two weeks and found these staffing levels were maintained.
• Staff were safely recruited to the service as relevant background checks had been carried out.

Assessing risk, safety monitoring and management
• An agency worker on their first shift was unsure how to evacuate the building in the event of an emergency and was unable to unlock the front door when we arrived.
• An exposed wire was found in the reception area of Lodge house. Staff were unaware whether this was a live wire and therefore a possible risk to people. A contractor subsequently tested the wire and found it was not live.
• Appropriate risk assessments and comprehensive care plans were in place which included nutrition, risk of isolation, exercise, seizures and use of rescue medicines, behaviour that may challenge others and communication. Most staff we spoke with had a good understanding of people's needs and risks.
• Appropriate equipment was in place to manage risk, for example protectors on TV screens and weighted furniture to prevent it being used as a missile. Sensory items were in place to support people. Monitors were used in people's bedrooms to assist with their safety.

Preventing and controlling infection
• We observed soap dispenser units in some people's bathrooms did not have soap in them along with a cover. We asked a staff member about this and they produced soap from a store cupboard. An area manager had asked for dispensers to be installed a few days earlier. By the end of our inspection, some dispensers had been fitted and the remainder were to be fitted shortly after.
• One person's infection control risk assessment stated staff should promote hand washing by using hand wipes. Wipes were not seen being used and this person was not supported to wash their hands. The home manager followed this up after our inspection.
• Staff were routinely observed to be wearing masks appropriately during the inspection. Two staff did not have their mask fitted correctly to their face and it had slipped down exposing their nose. We discussed this with the area managers. Staff were seen to be wearing gloves and aprons appropriately at lunch service in the Lodge house and when supporting people in their bedrooms in both other houses.

Using medicines safely
• The management of people's medicines was usually safe.
• People received their medicines as prescribed. However, one person's ear spray prescribed for lunchtime and teatime use was missing signatures for four days in July 2021. The same person's medication record showed they were not given two creams on two dates in July 2021. However, all other records we looked at showed medicines were given as prescribed.
• Staff we spoke with confirmed they received medication training and a recent competency check. Staff were knowledgeable about people's medication needs and preferences. Protocols for 'as required' medicines were in place. Regular medication audits were being carried out which showed stocks, refusals, returns were being checked. Following inspection, the area managers said all staff refreshed their medication training.

Systems and processes to safeguard people from the risk of abuse
• Systems to safeguard people from the risk of abuse were in place.
• People told us they felt safe. One person said, "I would recommend it here. I feel safe." Staff we spoke with knew how to recognise abuse and how to report any safeguarding concerns.
• Safeguarding incidents were discussed during staff team meetings. There was evidence to show these incidents were being recorded in a workbook.

Learning lessons when things go wrong
• At the time of our inspection, one person's mattress was on the floor which was based on an assessed need. However, as this posed an infection control risk, the area managers reviewed this and told us a lowered bed base would be purchased for this person.

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.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience
• We reviewed staff training completion levels and whilst a number of staff received the training needed for their roles, we found gaps where seven staff had not completed three or more subjects. Seven staff out of 42 had not received any training in the use of restraint. However, at the time of our inspection, only one person had an assessed need for the use of restraint and they were supported by staff who had completed this training. Following our inspection, an area manager told us these topics were assigned to staff and the home manager would oversee their completion.

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as not all staff received adequate support through a programme of training.

• Staff confirmed they received supervision and we saw records which showed the staff team had received a recent supervision.
• An area manager said all staff, including agency workers received positive behaviour support training. Agency workers we spoke with confirmed this happened.

Adapting service, design, decoration to meet people's needs
• The home was not in a good state of decoration and repair.
• One person's chest of drawers was broken, which an area manager told us was due to be replaced. A piece of furniture in a person's bedroom had been replaced and did not fit the same dimensions, meaning a strip of exposed flooring could be seen. Some furniture such as settees in lounges were due to be replaced.
• The painting on one person's bedroom wall had become damaged. Communal rooms were not personalised or homely. Aspects of the home had not been properly maintained.
• The provider identified these issues prior to inspection and we saw a programme of refurbishment which covered these areas. Some of these works had already commenced at the time of inspection.

Supporting people to eat and drink enough to maintain a balanced diet
• People were supported to receive a balanced diet.
• We looked at the use of takeaways in the home and whilst we saw this was ordered on occasions, this was not considered excessive. One relative told us, "They're (staff) very good with [person's] food."
• We looked in cupboards in the houses and saw fresh ingredients were in stock. We observed fresh meals being prepared on the day of inspection.
• Frequent drinks were seen to be provided on what was a very warm day. We reviewed fluid charts for two

people and saw reasonable intake for them, although no targets were recorded.

Staff working with other agencies to provide consistent, effective, timely care: Supporting people to live healthier lives, access healthcare services and support
• People received timely access to healthcare support.
• We saw care plan actions for some people were incomplete. For example, one person's care plans did not show their blood pressure had been checked twice weekly since the beginning of June 2021. The provider told us they were in contact with the GP for this person and there was no longer a need for regular blood pressure monitoring. This person's support plan was subsequently updated.
• One staff member told us people were supported to receive access to healthcare services when they needed this. They said, "As soon as someone needs a GP, they are called."
• People had health action plans in place. We saw other records which showed the involvement of health professionals. We saw evidence of people attending GP appointments, outpatient appointments and having medication reviews.

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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
• People's choices regarding outdoor activities were not always being followed. We have reported about this under the responsive key question.
• We saw mental capacity assessments and best interest decisions were completed where relevant. These were decision specific and included, for example, consent to receiving medicines and the COVID-19 vaccination.
• We saw the kitchen areas had restricted access due to an under the counter lockable swing door. Following our inspection, these restrictions have been confirmed as removed.
• DoLS applications had been made to ensure people's liberty was lawfully restricted.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• An assessment of people's care needs was carried out before they moved into the home. This ensured the provider was confident they could meet the needs of these people.

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.

At the last inspection this key question was rated as outstanding. At this inspection this key question has now deteriorated to good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Supporting people to express their views and be involved in making decisions about their care
• Where possible, people were involved in making decisions about their care.
• One person said, "They do care plans, I'm not involved, but I can read it." A further person told us they were sometimes involved in their reviews. Another person's care plan noted they had no interest in reviewing their care needs.
• We saw people had their own personal effects in their bedrooms and their areas of interest were clear to see. However, one person who lived in the home for a year told us, "This is what [my bedroom] was like when I moved in." A programme of refurbishment had started in the home.

Ensuring people are well treated and supported; respecting equality and diversity
• People received care which they and their relatives spoke positively about.
• Most staff demonstrated a good understanding of people's needs. Staff interacted with people in a kind and respectful manner. One person told us, "I love the place and I like the staff." A relative commented, "They are very kind to [person]. [Name] tested positive for COVID-19 and I was beside myself with worry. But staff called every single day to say [person] was okay."
• Other comments from relatives included, "The staff are really nice and caring. They know [person] well" and "They (staff) are really kind to [person]."
• Staff showed an understanding of the needs and preferences of one person who had been involved in a number of incidents leading up to our inspection. A staff member confidently described the action needed to help calm this person.
• We observed a staff member replacing a dressing on one person's foot. The staff member showed empathy whilst they were doing this as the person appeared frightened about this hurting them.
• We observed a person watching their iPad and saw a staff member interacting with them and taking an interest in what they were viewing. In another house, staff were supporting a person by making sounds which were described in their care plan.
• On the day we inspected, it was very warm. People had fans in their bedrooms and communal areas. Where people were sat outside, staff applied cream to them to provide protection from the sun.

Respecting and promoting people's privacy, dignity and independence
• People received care which was dignified and their privacy was respected.
• We observed a staff member knocking on one person's door before entering their room.
• One person said, "I clean my own room and do some things downstairs. I can make whatever I like to eat." Daily records indicated this person was encouraged to do as much as they could for themselves.

• One person had a monitor they asked for in their bedroom as they had a choking risk, but they did not want staff present when they were eating.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as outstanding. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• People were not always supported to access the community in line with their care plans.
• Agency workers told us they were unable to take people out into the community, unless they had a regular member of staff with them, who was employed by the provider. One person we spoke with confirmed this. The area managers told us this was a misunderstanding and agency workers could provide this support. Since our inspection, this position has been clarified and people are now reported to be getting into the community more regularly.
• One person's home visits were agreed with the provider in April 2021. Parents asked about these home visits in May and June 2021. The provider told us this person had gone home in May and at the end of August 2021. The same person's activity schedule was the control measure for reducing their risk of social isolation and becoming housebound. Their exercise support plan records stated 'not completed due to short staff' on three dates in July 2021. This person had not been supported to go for a walk for the 11 days prior to our inspection.
• We saw one person repeatedly asked through the afternoon to go out in his car. An agency worker said he was unable to take the person out. The home manager subsequently took this person out for a car ride.

This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the activity provision had not been provided in line with assessed needs due to lack of suitable deployment of staff to ensure an appropriate skills mix.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
• Care plans were regularly reviewed, but no changes were made where activities such as being weighed or going out had not been completed.
• One person's menu and sleep care plan were not always followed and bedtime was timed prior to shift change. Following inspection, this timing has been removed by the home manager.
• Care plans were largely person centred in areas such as communication, relationships, public transport, nutrition, hygiene and community participation. Most staff showed a good understanding of people's needs and risks.
• We looked at one person's sensory care plan which we observed staff followed. This included equipment the person needed as well as textures and fabrics the person liked to touch. A behavioural care plan we looked at listed the person's things the person liked to do. The same person's positive behaviour support plan recorded how they could be assisted to become calm when they were anxious.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
• One person's communication care plan was followed by two agency staff who responded appropriately to particular sounds needed to interact with this person. Both staff interacted continually with this person who we observed largely remained calm during our visit.
• Staff were familiar with people's communication needs. One staff member told us "We use a bit of Makaton with [name] and [name]."

Improving care quality in response to complaints or concerns
• A complaint was responded to, although a record had not been maintained.
• We asked for details of a complaint which was made in March 2021, as this was the only recorded complaint in 2021. An area manager told us they were unable to find a record of what this complaint was about and how it was dealt with. However, a family member we spoke with said action had been taken.
• People and relatives knew how to make a complaint if they were dissatisfied with the service provided. One relative told us, "They are really easy to approach if I had a complaint. Any one of them (staff) would put me in touch with who I needed to speak to."

End of life care and support
• At the time of our inspection, no one living at Whitwood Hall was receiving end of life care. The registered provider had an end of life care policy which identified that end of life care planning would be put in place where people were identified as having an 'advanced condition'.

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 the last inspection this key question was rated as outstanding. At this inspection this key question has now deteriorated to 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
• Before our inspection, the provider told us in their PIR that the pandemic reduced the number of spot checks and service visits they were able to conduct. They told us this was an area for improvement.
• Prior to our inspection, the Clinical Commissioning Group (CCG) visited on 2 July 2021 and found concerns. For example, a falls mat and five mattresses were soiled and had to be replaced. There was little food in the fridge and stock was not dated.
• The provider's 'Quality Audit Tool' was not completed throughout 2021. An area manager informed us this was scheduled to take place in early September 2021. We looked at the service visit record for July 2021 and saw there was no detail of findings or actions generated from the report.
• The provider created an action plan for updating the premises and some work was taking place at the time of our inspection. However, furniture and decoration had deteriorated into a poor state of repair and there had been an absence of oversight in this area.
• Accidents and incidents were being recorded, although there was no evidence of reviews to look for themes. An area manager told us that since arriving in the home, they asked a colleague to perform a thorough analysis of these events.

This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there had been a lack of oversight in ensuring systems to assess, monitor and review the service were effective.

• The service was without a registered manager since February 2021.

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
• We reviewed accidents and incidents which took place in June 2021 and found eight incidents which should have been reported to us. We have dealt with this outside the inspection process.
• The two area managers were open and candid with us throughout the inspection. Where they saw improvements were needed, they had taken action.

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

• There was a lack of regular activity taking place for people. This was recorded as due to staffing levels and there was a misunderstanding about whether agency workers could support people on their own in the community.
• One person said, "Yes, it's (the home is) well managed." A relative commented, "We'd hate [person] to be anywhere else." Most relatives we spoke with felt positive about the service and how their family member was cared for. However, one relative told us, "I've got to admit things have not been running quite as smoothly as before."
• Comments from staff included, "I usually feel supported. There have been changes and gaps in management in recent months" and "They've (management) listened to me." Another staff member told us support from management had improved.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics□□□□□□□
• Staff we spoke with felt they were receiving support from the management team at the time of our inspection.
• Staff meeting minutes for April and May 2021 included updates about PPE, COVID-19, staff recruitment and people living in the home.
• We looked at a document called '2019/2020 Family & Carers Satisfaction Survey Results'. This showed positive feedback from three relatives.

Continuous learning and improving care
• Since the CCG visited and found concerns, checks of mattresses have been added to walkaround checks in the home.
• Two area managers were regularly attending the home and a temporary home manager was in place. This was in recognition of areas of improvement and oversight that were needed.

Working in partnership with others
• Whitwood Hall worked in partnership with people's representatives, as well as professionals such as speech and language therapists, learning disability nurses, social workers and occupational therapists.

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 17 HSCA RA Regulations 2014 Good governance There had been a lack of oversight in ensuring systems to assess, monitor and review the service were effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People were not being supported by staff who had been suitably deployed within the service. The activity provision had not been provided in line with assessed needs due to a lack of suitable deployment of staff to ensure an appropriate skills mix. Not all staff had received adequate support through a programme of training.