

Florence Care Homes Limited

# The Oaks Residential Care Home

## Inspection report

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27 February 2023

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## Ratings

Overall rating for this service

Inadequate 

Is the service safe?

**Inadequate** 

Is the service caring?

**Requires Improvement** 

Is the service well-led?

**Inadequate** 

# Summary of findings

## Overall summary

### About the service

The Oaks Residential Care Home provides personal and nursing care in one adapted building for up to a maximum of 30 people aged 65 and over, including people living with dementia. At the time of our inspection there were 21 people using the service.

### People's experience of using this service and what we found

People's relatives told us they felt their loved ones received good care and were safe. Staff showed compassionate care and warmth when interacting with people, however care was delivered intuitively and not driven by best practice.

The lack of maintenance of the environment, including people's bedrooms and en-suite facilities compromised people's dignity and did not show respect. The standards of hygiene and infection prevention and control (IPC) measures were poor, which placed people at risk of acquiring infections and associated implications to their health.

Risks to people's health, welfare and safety had not been adequately assessed and managed which placed them at risk of harm. This included failure to identify the risk to people from unguarded radiators, a window with no restrictor and insufficient information to ensure people could be safely evacuated in the event of a fire.

Staff had not been provided with training they needed to meet the specific needs of people using the service. This included, how to support people with dementia, and associated behaviours, in a positive way and those at risk of choking or aspirating when eating and drinking. This could have serious consequences to their health and put them at risk of avoidable harm.

Induction of staff, especially those new to care did not ensure they were adequately trained to carry out their roles. Recruitment practices needed to improve to ensure all relevant documentation was obtained, and available for inspection to ensure fit and proper staff were employed to work with people using the service.

Staff were not routinely provided with the appropriate supervision and appraisal to enable them to carry out the duties they were employed to perform and ensure they were competent to meet people's specific needs.

There was not enough skilled and experienced staff deployed throughout the day to meet people's needs and keep the service clean. Staff told us early morning and evenings needed additional staff to ensure they had time to provide personal care to those who required 2 staff, as well as ensure people in communal areas were safe.

People's medicines were well managed. However, improvements were needed to ensure protocols were in place to guide staff when to administer medicines prescribed to relieve anxiety, on an as needed basis and

ensure these were only administered as a last resort. Where people lacked capacity to consent to their care and medicines, relatives had been involved in making decisions in their best interests. People were supported to have maximum choice and control of their daily lives and staff supported them in the least restrictive way possible and in their best interests.

The service was not well-led, and governance and oversight systems were poor. Staff were aware the provider had a set of values they should adhere too, to deliver good care, but were not clear what they were. There was no effective system in place to check staff understood these values and ensure they were embedded into practice, and staff morale was low.

Systems to assess and monitor the quality and safety of the service were ineffective. Auditing processes did not provide an accurate overview of the service; ensure proper monitoring and review, identify shortfalls or inform an ongoing plan for improvement. Whilst it is recognised the registered manager took immediate action to make improvements, the governance arrangements had failed to identify the compromised quality and safety of the service.

There were no formal systems or processes in place to ensure incidents and accidents were reviewed and monitored to make sure action was taken to protect people, promptly escalate concerns to the relevant external bodies, such as safeguarding, remedy the situation or make improvements to prevent further occurrences.

#### Rating at last inspection and update

The last rating for this service was good (published 01 April 2021). Prior to this inspection this service has been rated requires improvement or inadequate for the last five consecutive inspections.

#### Why we inspected

This inspection was prompted by a review of the information we held about this service. We received concerns in relation to poor infection prevention and control (IPC), the environment, staffing and the management of the service. As a result, we undertook a focused inspection to review the key questions of safe, caring and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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

The overall rating for the service has changed from good to inadequate based on the findings of this inspection. The improvements made at the previous inspection in March 2021 had not been sustained and we have found evidence that the provider needs to make improvements. Please see the safe, caring and well led sections of this report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Oaks Residential Care Home on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

#### Enforcement

We have identified breaches in relation to safe care and treatment, staffing, recruitment of staff and governance arrangements at this inspection. You can see what action we have asked the provider to take at the end of this full report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

## Follow up

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

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

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not safe.

Details are in our safe findings below.

**Inadequate** ●

### Is the service caring?

The service was not always caring.

Details are in our safe findings below

**Requires Improvement** ●

### Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

**Inadequate** ●

# The Oaks Residential Care Home

## Detailed findings

### Background to this inspection

#### The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

#### Inspection team

The inspection was carried out by 2 inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

#### Service and service type

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

#### Registered Manager

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations. At the time of our inspection there was a registered manager in post.

### Notice of inspection

This inspection was unannounced. Inspection activity started on 16 February 2023 and ended on 27 February 2023. We visited the service on both days.

### What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

### During the inspection

We used observations to gather evidence of people's experience of care. We spoke with 4 people using the service, 7 relatives, and 9 members of staff including 2 seniors, 3 carers, 2 activities staff, laundress and the chef. We also spoke with the registered manager and nominated individual responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records, including 3 people's care plans and associated risk assessments and a variety of records relating to the management of the service.

# Is the service safe?

## Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate.

This meant people were not safe and were at risk of avoidable harm.

### Preventing and controlling infection

- The premises were unclean and unhygienic, with a build-up of dirt and stains on the skirting, flooring and walls. Walls and radiator cover's had paint scratched off down to plaster and wood beneath, preventing effective cleaning.
- People's en-suite facilities, communal toilets and bath / shower rooms were dirty. We found organic matter underneath bath chairs, toilet raisers and commodes and evidence of rust.
- Toilet brushes contained organic matter and were sitting in dirty contaminated fluid, all of which increased the risk of spreading infection.
- Toilets in communal areas and en-suites had no toilet roll covers which are designed to prevent contamination from droplets from the toilet when flushed.
- The laundry was in poor condition; paint was peeling off the walls and the flooring was stained and dirty. The sluice washing machine was out of action which meant washing may not be cleaned properly which could increase the risk of cross infection.
- Not all masks, gloves and aprons were kept in enclosed wipeable dispensers, increasing the risk of contamination before use and cross infection.
- Despite having previous COVID-19 outbreaks there were no enhanced or more frequent cleaning schedules in place to minimise risks to people and staff.

Infection prevention and control (IPC) measures were poor, which placed people at risk of acquiring infections and associated implications to their health. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Immediately after the inspection the registered manager arranged for a deep clean of the premises. We noted by the second day of the inspection the service was visibly cleaner, and action had been taken; for example, purchase of covered toilet roll dispensers, and plastic wipeable containers for PPE.

### Visiting in care homes

- During the recent COVID-19 outbreak, visiting had been restricted to 1 visitor, however these restrictions were now been lifted. People's relatives and loved ones were now able to visit whenever they chose.

### Assessing risk, safety monitoring and management

- Risks to people's health, welfare and safety had not been adequately assessed and managed which

placed them at risk of harm or avoidable harm. Uncovered radiators in corridors and toilets were hot to touch presenting a burn risk to people if they fell or had prolonged contact.

- The staff and visitor's toilet door was secured only by a slide bolt, and easily accessible by people using the service. This had a large window with a significant drop to the ground outside. No restrictor had been fitted to prevent the window opening wide enough for a person to exit.
- Personal Emergency Evacuation Plans (PEEP's) intended to identify the equipment and level of assistance needed to safely evacuate people had not considered all factors that may affect a safe evacuation. For example, night sedation which may cause drowsiness and difficulties rousing the person had not been considered or reflected in their PEEP.
- Records showed there had been high numbers of incidences of anxiety which had been poorly managed resulting in heightened levels of verbal and physical aggression towards other people and staff.
- Four people had been assessed by the Speech and Language Team (SaLT) as requiring special diets, including pureed and soft bite sized meals as described in the International Dysphagia Diet Standardisation Initiative (IDDSI) guidance. Staff told us, and training information confirmed, none of the staff (including the cook) had received training about swallowing difficulties (Dysphagia) and the risks associated with food aspiration.
- Although there had been no choking incidents in the service, failure to ensure staff had been trained to ensure food and fluid was prepared in line with the IDDSI guidelines at the correct consistency, placed people at increased risk of choking.

Systems were either not in place or robust enough to manage safety effectively. This placed people at the risk of harm, or avoidable harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Immediately after the inspection, the registered manager confirmed they had sourced training about dysphagia, taken action to secure the window and place a more robust lock on the visitor's toilet. Covers had been replaced over the radiators, and PEEPs were being updated.

#### Staffing and recruitment

- The registered manager used a dependency tool to assess the staffing levels, however feedback from relatives and staff identified there were not enough staff available to give people the care and support they needed, keep them safe, cook and keep the service clean.
- At the time of the inspection there were 21 people, with a staffing ratio of 1 senior and 3 care staff during daytime hours, with 2-night staff and a sleep-in member of staff. Additional staff each day consisted of 1 activities person, 2 housekeepers and a cook.
- Observations and conversations with staff confirmed there were not always enough staff on duty, at certain times of the day to have oversight of people who were mobile and walk with purpose. One staff member told us, "There are not really enough staff, we have a lot of people who walk with purpose, if we have to do double ups, it leaves 1 staff and the senior to do singles, we could do with a 4th staff member where people are wandering around and not safe."
- Relatives told us staff were not always visible. Comments included, "The staff let you in and out, then you don't see them much," and "Sometimes they're are not around, they may be in meetings or somewhere else around the home."
- Relatives and people complained of other people entering their rooms uninvited. One person told us, "The other night a [Person] came in my room about 3am and tried to get into bed with me. I pressed the buzzer and staff were here within 30 seconds, but problem is, they only have 2 staff at night, if they are upstairs, they can't be with him all of the time." This placed people at significant risk of harm and did not uphold their human rights.

Systems to assess numbers of suitably qualified, competent, skilled and experienced staff have not ensured there are sufficient staff deployed to meet people's needs. This is a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- Review of 7 staff files found they lacked evidence to show all the required recruitment checks had been made to ensure the member of staff was fit to be employed.
- The files lacked evidence to confirm the staff's identity, a detailed history of employment, exploration of gaps in employment, and the most up to date Disclosure and Barring (DBS). Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions
- The files of staff recruited from overseas did not contain all the relevant documentation, including the certificate of sponsorship, DBS and references.
- After the inspection the nominated individual told us the recruitment records were on their computer. These were not made available on or after the inspection to review.

Failure to have robust recruitment systems in place to ensure staff are of good character and are fit to work with people due to either their age, fragility or dementia related needs are more vulnerable to abuse. This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong; Systems and processes to safeguard people from the risk of abuse

- Systems for reviewing and investigating incidents and events when things go wrong needed to improve. Although incidents and accidents, including falls had been logged, there was no analysis to look for trends, triggers and root causes to identify measures to prevent reoccurrences and improve outcomes for people.
- Although people's care plans described how each person expressed themselves when agitated, distressed and resistant to care, these did not tell staff how to support them at these times.
- Staff were aware of what constituted as abuse, and who and how to report concerns.

Using medicines safely

- Systems were in place to ensure people's medicines were managed safely. We observed people were receiving their prescribed medicines in a supportive way.
- A sample check of people's medicines, including controlled drugs was carried out and was found to be correct.
- Improvements were needed to ensure medicines prescribed on 'as needed' (PRN) basis or given covertly were administered appropriately.
- People's care plans contained insufficient information to support staff to know when to administer 'as needed' medicines (PRN), particularly medicines to relieve anxiety.
- There were no PRN protocols in place to guide staff on the steps to take to de-escalate a situation prior to consideration of administering sedative medication.
- Where people had their medicines administered covertly (disguised in food or drink) MAR records did not indicate this.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests

and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

- People's care plans contained MCA assessments for each area of their care and support needs. These contained a good level of detail determining their capacity to make day-to-day decisions such as what to eat or wear.
- Where people had been deemed to lack capacity to make more significant decisions about their health, welfare and finances, relevant people including their Lasting Power of Attorney and health professionals had been involved.
- MCA assessments had been completed with the relevant persons to make a best interest decision where people needed to take their medicines covertly. These had been authorised by the GP, for non-compliance with medication and by the pharmacist to say the medicines prescribed could be safely crushed and given in this way.
- Routine DoLS applications had been made where needed to deprive a person of their liberty for their own safety.

# 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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

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

- The provider did not ensure staff had the right skills to give people the level of support they needed, including how to support people with dementia, and associated behaviours, in a positive way. A relative told us, "Staff seem to know about basic needs, but not about my [Person's] condition."
- Both days of inspection, people were observed entering a state of confusion late afternoon, and early evening, referred to as Sundowning. Sundowning can lead to people pacing or wandering, and cause different behaviours, such as confusion, anxiety, aggression or ignoring directions. There was not always enough staff available to respond to people's changing needs and ensure they received the care and support they needed to stay safe.
- Staff confirmed 8 people required the support of 2 staff to provide their personal care and assist them to get up and go to bed. This left 1 carer and the senior to oversee the lounge and dining area as well as provide personal care and support to other people. A member of staff told us, "1 senior and 3 care staff was not enough when all the service users are distressed and anxious."

Respecting and promoting people's privacy, dignity and independence

- Staff treated people kindly, and we observed some nice interactions between them and people using the service. Although staff showed compassionate care and warmth when interacting with people, care was delivered intuitively and not driven by best practice.
- Staff were not always respectful towards people referring to them as 'kicking off', wanderers, double ups, and singles.' While this terminology, may not be intentional, it reflects a lack of respect for people in their care and dehumanises them.
- Staff understood the need to make sure that people's privacy and dignity was promoted and maintained whilst delivering personal care, however the lack of maintenance of the environment, including people's bedrooms and en-suite facilities compromised their dignity and did not show respect.

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

- Relatives provided mixed feedback about being kept up to date and included in the loved one's care. One relative commented, "They (staff) always let me know if there are any changes to my [Person's] medication."
- However, other relatives told us they did not feel informed about their loved one's medicines. Comments included, "I am concerned the staff do not keep me up to date on what medication [Person] is on," and "I would like to know more about the medication my [Person] takes and how it affects them but cannot get hold of the manager to get answers."

- Minutes of 'residents meetings' showed people had been involved in discussing their choice of activities and had been consulted on changes to the layout of the lounges and asked their opinion on colour schemes.
- The registered manager told us, they had started to include people using the service in staff interviews, so they were involved in having a say who worked in the home.
- The registered manager had informed people at the 'Residents / Relatives' meeting in November 2022 about DoLS applications being submitted and the legalities behind it. They had informed families they would be contacted so their views and opinions were considered, with a best interest decision maker from the local authority.

# Is the service well-led?

## Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- Systems to assess and monitor the quality and safety of the service were ineffective. This led to a lack of resources, investment and oversight to improve the service.
- The registered manager did not have the level of support they needed to effectively manage the day to day running of the service. They currently have no administrative support or a deputy manager to assist them.
- The shortfalls in the service found at inspection had not been identified through the provider's quality monitoring processes. These had failed to identify and address concerns about the cleanliness and hygiene, poor recruitment practices, lack of training and a failure to identify and manage risks to people.
- Audits undertaken by the provider and the registered manager were carried out in isolation and did not form part of an overarching quality monitoring cycle to demonstrate ongoing improvement and development of the service.
- Audits provided were tick box, in response to a set of standards to show these were correct or had been dealt with. There was no robust analysis of the information to identify the strengths and weaknesses of the service. Trends, themes or root causes to incidents, were not looked for.
- The environment looked tired, needed redecoration and lacked any distinguishable features to enhance the lives of people living with dementia. Relatives commented, "The environment is basic and functional," and "Décor is variable, [Person's] room was decorated last year, but looks worse now than it did before."
- Although plans to redecorate the service were provided, there had been little progress at the time of the inspection.

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

- People, relatives and staff spoke positively about the registered manager. Comments included "I know who the manager is, and I think they manage well. The manager and staff are approachable and there was a homely feel to the service," and "I have met the manager; they are very sociable."
- Although relatives gave positive feedback about their experience of the care provided, staff told us morale within the service was low. Comments included, "Staff morale is not good, it would help if we had a better working environment, and an extra member of staff and more training," and "Staff here don't always work as a team."

- The philosophy of care set out in the provider's service user guide included a commitment to provide 'Individualised care with courtesy and compassion, to maintain dignity and privacy and promote choice and independence.'
- Staff were aware the service had a set of values they should adhere too, to deliver good care, but were not clear what they were. There was no effective system in place to check staff understood these values and ensure they were embedded into practice.

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

- Relatives provided mixed feedback about communication between them, and the service. Some felt communication had improved, others felt there was room for improvement.
- Positive comments included, "The communication has improved; I get emails if [Person] has an appointment date or if the chiropodist coming or they will ring us," and "They send videos of activities I get a lot of communication from them."
- Comments where relatives felt there was room for improvement included, "The only communication was a newsletter with the invoice. The administration of the home is not good," and "They moved [Person] to another room without informing us, the room was smelly, the carpet needed cleaning or replacing, and the toilet was leaking. It was a bland room with no memories in it. I was not happy."
- Relatives spoken with told us there were relatives' meetings, and newsletters giving details of activities, but they had not seen any questionnaires or surveys to give feedback. One relative commented, "Occasionally they keep us informed of what is happening in the home, but we are not encouraged to give feedback, no questionnaires or surveys."

All of the above demonstrates a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager was able to provide results of a 'Residents / Relatives' survey dated October 2022. This reflects 19 out of 20 surveys were completed, with positive feedback about the care staff provided, and where the service could be improved, including the quality of activities, and the décor of the home.

Working in partnership with others

- The registered manager had taken immediate action following the first day of the inspection to reach out to other providers rated good and outstanding for advice on how to improve the service.
- They had also engaged with the local authority and had registered with a range of provider and manager forums to learn and develop new ways of working.
- Information in people's care records confirmed the service worked well in partnership with professionals, including SaLT, dieticians, dementia services and the GP to ensure people's health needs were met.
- The registered manager was aware of their responsibilities to report concerns to the local authority safeguarding team. However, they had not always escalated concerns to the relevant external bodies, such as safeguarding and CQC as required under the relevant regulations.

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 19 HSCA RA Regulations 2014 Fit and proper persons employed  Failure to have robust recruitment systems in place to ensure staff are of good character and are fit to work in the service places people at risk of harm or abuse.

This section is primarily information for the provider

## Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment  Infection prevention and control (IPC) measures were poor, which placed people at risk of acquiring infections and associated implications to their health.

**The enforcement action we took:**

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance  Systems to assess and monitor the quality and safety of the service were ineffective. The governance arrangements had failed to identify the compromised quality and safety of the service.

**The enforcement action we took:**

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing  Systems to assess numbers of suitably qualified, competent, skilled and experienced staff have not ensured there are sufficient staff deployed to meet people's needs

**The enforcement action we took:**

Warning Notice