Heathcotes Care Limited

Heathcotes (Erdington)

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?	**Inadequate**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Heathcotes (Erdington) is a residential care home providing personal care to five people under the age of 65 years, at the time of the inspection. The service can support up to eight people.

The service was registered with us prior to Registering the Right Support and other best practice guidance being introduced regarding the design of care homes for people with a learning disability. The principles and values that underpin this guidance reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes.

The service did not consistently apply the principles and values of Registering the Right Support and other best practice guidance. People using the service did not always receive person-centred support that was appropriate and inclusive for them.

People's experience of using this service and what we found
People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests. The provider had policies and systems in place, but the staff did not always support this practice.

The service did not always apply the principles and values of Registering the Right Support and other best practice guidance. These ensure people who use the service can live as full a life as possible and achieve the best possible outcomes which include control, choice and independence.

People had been put at risk by the poor culture at the home. The providers' governance systems had not ensured people's safety, health and wellbeing were always protected. Poor record keeping meant not all incidents had been reviewed and monitored.

People had not been kept safe from harm and abuse. Staff had failed to ensure risks to people were always minimised. People required one to one and two to one staff support and there were not enough staff to ensure this happened.

Staff deployment did not facilitate safe support, as some staff did not have the skills to support people's specific needs. Not all people got their medicines as prescribed because they were not managed safely. The use of restraint was not always recorded and monitored to ensure it was appropriate.

Staff did not always treat people with respect. Some staffs attitude towards the people they cared for did not show they treated them as equals or involved them in their own care. People did not always receive person-centred care.

People were not supported to maintain a healthy diet and menu planning was not structured to ensure this happened. People's needs were assessed and holistic care plans put into place. However, people's compatibility with others already living at the home had not been fully considered. People's healthcare needs were not fully met because best practice for people with learning disabilities and autism were not always followed.

People's communication needs were assessed and staff knew how best to communicate with each person. The provider had complaints processes in place and most were dealt with at a local level. People's wishes for end of life care had started to be looked at and discussed with people and their immediate family.

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 good (published 9 August 2019).

Why we inspected
The inspection was prompted in part due to concerns we received about inadequate staffing, people not being protected from abuse, inappropriate restraint being used and people not receiving care which was centred on them and their needs. A decision was made for us to inspect and examine those risks.

We found evidence the provider needs to make significant improvements.

Following our inspection and at our request, the provider took action to reduce the immediate risks we found.

Enforcement
We have identified breaches in relation to the management of risk and medicines, staff not treating people with respect or dignity and not providing person-centred care, inadequate staffing and staff skills and poor governance at this inspection.

You can see the enforcement action we took at the end of this report.

Follow up
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 effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not caring.

Details are in our caring findings below.

Inadequate

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Heathcotes (Erdington)

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.

Inspection team
This inspection was carried out by three inspectors and one assistant inspector

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

Heathcotes (Erdington) can provide accommodation with personal care to children aged 13-18 years, younger adults aged 18-65 years who may have dementia, learning disabilities or autistic spectrum disorder, mental health, physical disability or sensory impairment.

The service did not have a manager registered with the Care Quality Commission. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced on 25 and 28 October 2019 and announced on 29 October 2019.

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 since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

During the inspection
We interacted with three people, however they all had limited communication abilities and understanding. We spoke with three relatives about their experience of the care provided. We spoke with 12 members of staff including care staff, manager, regional managers and the director of operations. We spoke with two visiting professionals.

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

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with professionals from local authorities to discuss the service and obtain their feedback.

Inadequate

Is the service safe?

Our findings

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

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

Systems and processes to safeguard people from the risk of abuse

- Prior to our inspection we received concerns about the care and treatment of people who lived in the home. At the time of our inspection these concerns were subject to police, local authority and provider investigations.
- Despite the provider having safeguarding systems in place these had failed to protect people from actual and potential abuse.
- One person was subjected to a potentially unnecessary restraint. This was because of staff failure to follow guidance in the person's care record and understand their behaviour.
- During our inspection we received information about one person having improper restrictions on their liberty of movement. We shared this with the provider, who was unaware of this incident. We made a safeguarding referral to the local authority for them to investigate.

The provider failed to protect people from harm and abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- People's medicines were not managed safely. One person did not receive their medicine for a period of eight days because it had run out and not been re-ordered in time.
- People were poorly monitored by staff to determine if they required their 'as needed' medicine. As needed medicine is medicine which is only given when required, such as pain relief or to relieve constipation. One person required medicine if they had not had their bowels open, yet staff did not monitor this to establish if the person needed their medicine.
- When people refused their medicines, there was no follow up to say why they had refused it. Staff did not encourage or try to administer the medicine at another time. If medicines are not taken as prescribed they can become ineffective. This places people at risk of harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Information was available to staff on risks associated with people's care and support. However, staff did not always follow the guidance provided to reduce risks. For people's safety, the kitchen doors were meant to be kept locked. However, throughout our inspection we found the kitchen doors unlocked. Even when managers had asked staff to keep the kitchen doors locked we found them unlocked. This places people at an increased risk of harm if they gained access to the kitchen.
- The use of restraint was not always reviewed to ensure it was appropriate. Where staff used restraint techniques on people, records were not always completed or completed fully. We saw restraint records with

no follow up, debrief or management review. This prevents the root cause of restraint being analysed to identify what steps could be taken to prevent the same thing happening again.
● Staff did not always record incidents or complete incident reports in a consistent way. One person had experienced several incidents prior to our inspection. Staff could not find incident reports or restraint records for most of these incidents, despite the local authority and us being notified. This lack of internal records does not allow staff and managers to review incidents, learn lessons or ensure actions taken by staff were appropriate or legal.

People were placed at risk of harm due to ineffective systems to keep them safe. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● The provider had failed to ensure there were enough staff to safely meet people's needs. People were supported by staff on a ratio of one to one or two to one. The staff rotas showed there were not enough staff to provide this level of support at all times.
● There were not enough staff to ensure they were effectively deployed. Staff were allocated to work with specific people on a one to one or two to one basis. Despite people needing this level of support, staff were allocated other jobs to complete, such as laundry or the kitchen. Therefore, staff were not able to provide a safe level of care to ensure the risks to people were mitigated.
● The skills mix of staff were not always as required. One person's care record stated they needed staff who had emergency first aid training to support them. This did not always happen which placed the person at risk of harm.

There was not sufficient, suitably trained staff deployed to ensure people's needs were safely met. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● Staff were responsible for the cleanliness of the home. Prior to our inspection we had received concerns about the cleanliness of the home. However, on the days of our inspection the home was clean.
● Staff understood the principles of good infection control. However, managers told us they had identified there was an issue with standards of cleanliness at the home, on occasion and were taking actions to address this.

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

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

- People's care needs were assessed prior to moving in to the home and a care plan put in place to guide staff on how to support them. However, people's personalities and compatibility with people already living at the home were not fully taken into account. Staff told us how one person's behaviour had changed because a new person had moved into the home.
- People's care plans were holistic and considered people's protected characteristics and diversity. Staff found out about people's culture and religious beliefs but did not always discuss how gender or sexual orientation may affect how they want to be supported.

Staff support: induction, training, skills and experience

- The provider had not ensured staff had received the training they needed to complete their roles effectively. Records showed staff who had not received training in medicines were administering them. Staff had also not received enough training to help them understand one person's specific needs.
- Despite staff receiving training on autism, safeguarding and mental health, they did not always show they had retained learning or were able to put their learning into practice.

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

- Prior to our inspection, we had received concerns there was a reliance on take away food. We found there was no structure to menu planning or food shopping and staff needed to complete 'top up' shops to ensure there was enough food to make meals.
- Staff did not always follow guidance to reduce the risk of choking. One person's care records stated they should not be left alone with food. We saw the person was left alone with a plate of snacks.

Supporting people to live healthier lives, access healthcare services and support

- People did not always benefit from the use of evidence-based guidance in the delivery of their care. Some people's yearly health checks were not recorded or booked. Staff had failed to follow up on one person's blood test which was done several months before.
- However, we saw people had access, when they needed it, to local healthcare services such as their GP. People were supported to attend hospital appointments with their consultants.

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.

● The provider had systems in place to ensure MCA and DoLS were followed so people's human rights were upheld. At inspection we saw staff promoted people's rights with regards to gaining their consent. However, despite receiving training, not all staff's practice had demonstrated they put their learning into practice.

● The provider had ensured applications to lawfully deprive people were completed and authorised. Managers worked with the local authorities to ensure these were in people's best interests. We did find improvement was needed to ensure the records of capacity assessments and decision-making were available. These are important records as they provide evidence of why a DoLS is in a person's best interest.

Staff working with other agencies to provide consistent, effective, timely care

● Staff did not always work together to ensure people received consistent, coordinated, person-centred support when moving into the home from a different service. One person had come to the home with key information about their support needs, but this had not been incorporated into their care plan at Heathcotes (Erdington).

● People had 'Hospital Passports' in place, which are considered good practice for people with learning disabilities and autism. These contain key information about the person and will go with them if they are admitted to hospital. They contain other useful information, such as interests, likes, dislikes and preferred method of communication.

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

● The home was generally clean. Communal rooms were sparsely furnished due to people's medical conditions and behaviour, which could be directed at furnishings. However, people's own rooms were personalised how they wanted them.

● The home was a large domestic style property, within a residential area and gave no indication of being a care home. There were several communal areas which people and relatives could use, but we noted these were mostly occupied by staff or one particular person.

Inadequate

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 good. At this inspection this key question has deteriorated to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff attitudes had significant shortfalls.

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

- Staff did not always show respect towards people. We saw some staff who spoke to people in an infantile manner and used bargaining techniques to achieve the outcome they wanted.
- Some staff placed unnecessary anxiety on people. One person became anxious because they were eager to go out. We saw two staff members kept their coats on whilst in the home and supporting people. This contributed to the person's heightened anxiety because they saw staff with their coat on and equated this to going out.
- Staff demonstrated a lack of respect to the environment people lived in. Throughout the home we saw holes in the walls where, we were told, people had either punched or kicked the walls. Staff proudly told us which person had created which hole but could not tell us if these had been reported for maintenance or when the holes were likely to be repaired. Staff also smoked in the home's garden where people could see them. Staff left cigarettes burning in the ashtray and scattered around the garden.

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

- Staff did not always engage with people effectively or in a meaningful way. Some staff failed to communicate with people, ignored service users and failed to treat them as equals.
- Staff were not always seen to consult or involve people in making decisions. People's care reviews did not show how staff had involved them to give their views about their own care and treatment.

Respecting and promoting people's privacy, dignity and independence

- People's privacy was protected, and they were free to spend time in their own rooms when they wanted to. However, despite one person being at risk of seizures and harm due to their medical condition, staff shut their door when they were in there. This person required one to one staff support but the staff member sat outside the person's room. Staff failed to balance potential risk against promoting privacy and independence.

People were not treated as equals or treated with the respect they deserved. This is a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection, the provider investigated the behaviour of some staff members and kept us informed of the outcomes. The provider took disciplinary action against staff where necessary.

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People's care plans were not always kept under review and updated. Staff told us this should be completed every month but was generally not done. We saw one person who was routine driven had a strict food routine in their care plan. When we spoke with staff about this, they told us they no longer did this. Staff did not know why this had stopped or why the person's care plan had not been updated.
- People did not always have up to date records of their health reviews and outcomes. Staff, therefore could not tell us when the person was due their next health appointments. This demonstrates a lack of person-centred care, as health care and outcomes were not monitored to ensure they met their needs.
- People did not receive care that ensured they had choice and control to meet their needs and preferences. Staff did not fully understand people's specific needs or follow risk and care plans. Therefore, staff could not deliver care which was personalised for each person.
- Because some staff did not treat people as individuals, they were unable to provide care which was centred around the person.

People did not receive care which was wholly person-centred. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection, the provider's quality assurance team reviewed and updated people's care plans and risk assessment. The provider told us all staff must read these and sign to evidence they have read and understood the risks to people.

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.

- The provider was meeting the AIS. People's communication needs were assessed and their care plans gave staff information on how best to support their communication.
- The manager told us information was able to be provided to people in alternative formats when they required it.

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 supported to maintain relationships which were important to them. People were visited by

their families and spent days out and weekends with them.
● People took part in activities with staff, which included walks, picnics and trips out in the local community. However, staff told us these were not always possible due to the recent lack of staff.

Improving care quality in response to complaints or concerns
● The provider had systems in place to record and investigate and to respond to any complaints raised with them.

End of life care and support
● Managers told us they had not fully explored people's preferences and choices in relation to end of life care and wishes. They told us this was mainly due to most people being younger adults. People's relatives had contributed some information and managers acknowledged obtaining this information was ongoing.

Inadequate

Is the service well-led?

Our findings

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

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

This is the third consecutive inspection where a rating of good has not been achieved in well-led.

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

- People were placed at risk due to the staff culture at the service. We witnessed staff being derogatory about other staff when people were around. Staff did not always follow care plans or risk assessments, staff were not always open and care was not always centred on each person.
- The provider had not ensured the culture of the service fully supported the aims of national guidance for supporting people in care homes and with learning disabilities, such as Registering the Right Support. Some staff were in control of people, rather than treating them as equals and partners in their own care.
- Staff behaviour did not demonstrate respect towards people, managers and visitors. We observed staff being argumentative, disrespectful and verbally aggressive to each other, managers and to ourselves. Staff told us they did not feel supported by managers, yet they challenged managers when improvements needed to be made.

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

- No registered manager had been in post at the home since May 2018. A manager had been working at the home since September 2019. They were in the process of registering with us for the role of registered manager.
- People were not safe from a range of risks to their health, safety and well-being and people were not being safeguarded from abuse. People had experienced abuse and incidents when staff did not provide the one to one or two to one support people needed.
- People's safety, health and wellbeing had been compromised due to staff not receiving the knowledge they needed to support people. One staff member said, "We have supported (people) as best we can but we know we're failing."
- The provider's quality systems had not identified people's records were not up to date or complete. We saw care records with no dates on, no names on and initials used rather than the person's full name. One person's care record contained information which was out of date and not known to staff.
- In order for these failings to occur, the provider had not ensured effective oversight and governance of the service's safety and quality, to ensure all regulatory requirements were met. This had increased the likelihood of risk and harm.

Continuous learning and improving care

● The providers' auditing processes were not effective in monitoring the safe management of medicines. Staff had failed to order a new supply of medicines in a timely manner. When one person took their medicines out of the home, staff neglected to book these back in. This placed people at risk of having their health and wellbeing impacted as staff did not ensure they had their medicines as prescribed.

● The providers' governance systems had failed to ensure people's health, safety and wellbeing. When one person did not receive their prescribed medicine for six days, their records showed their anxiety levels had increased and they experienced changes in their personality and behaviour. Staff had not identified this as a reason for the change in their behaviour.

● The provider's incident reporting and safeguarding systems were not operated effectively to ensure risk to people was safely investigated, managed and escalated.

Due to poor governance of the service people were placed at risk of harm. This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had already identified a poor staff culture at the home and planned for senior managers to visit and monitor the home. Following our inspection, we took action which required the provider to put immediate plans in place to assure us of people's safety. The provider acted quickly to reduce the immediate risks to people at the home.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The duty of candour requires registered persons to act in an open and transparent way with people in relation to the care and treatment they receive. Relatives gave mixed opinions of how open managers and staff were. During and after our inspection we found the provider to be open and transparent about the failings at the home.

● The provider had displayed their rating from our last inspection at the home and on their website, as required by law.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● There was little evidence people were involved in the day to day running of the home. Despite people having limited verbal communication, staff had not explored other options to get their feedback.

● The provider had links with the local community and people were able to access local facilities with staff support.

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 9 HSCA RA Regulations 2014 Person-centred care People did not receive care which was wholly person-centred.

The enforcement action we took:

We imposed conditions onto the provider's registration in respect of the regulated activity, accommodation for persons who require nursing or personal care, at Heathcotes (Erdington).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated as equals or treated with the respect they deserved.

The enforcement action we took:

We imposed conditions onto the provider's registration in respect of the regulated activity accommodation for persons who require nursing or personal care at Heathcotes (Erdington).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were placed at risk of harm due to ineffective systems to keep them safe.

The enforcement action we took:

We imposed conditions onto the provider's registration in respect of the regulated activity, accommodation for persons who require nursing or personal care, at Heathcotes (Erdington).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to protect people from harm and abuse.

The enforcement action we took:

We imposed conditions onto the provider's registration in respect of the regulated activity,

accommodation for persons who require nursing or personal care, at Heathcotes (Erdington).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Due to poor governance of the service people were placed at risk of harm.

The enforcement action we took:

We imposed conditions onto the provider's registration in respect of the regulated activity, accommodation for persons who require nursing or personal care, at Heathcotes (Erdington).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was not sufficient, suitably trained staff deployed to ensure people's needs were safely met.

The enforcement action we took:

We imposed conditions onto the provider's registration in respect of the regulated activity, accommodation for persons who require nursing or personal care, at Heathcotes (Erdington).