Stroud Care Services Limited

Stinchcombe Manor

Inspection report

Echo Lane
Stinchcombe
Dursley
Gloucestershire
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Stinchcombe Manor is a care home that provides accommodation, nursing and personal care for a maximum of 36 people. At the time of our inspection 28 people were using the service.

This inspection was unannounced and took place on Saturday 25 June and Friday 1 July 2016. We last inspected the service on 1 and 2 December 2015. At that inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to ensuring people were cared for by suitably qualified staff and, the provider failing to submit notifications to the Care Quality Commission (CQC) as required by law. The provider sent us an action plan saying what they were going to do to make the necessary improvements. At this comprehensive inspection we checked if improvements had been made. CQC had also received information of concern from a number of sources. These concerns were followed up at this inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are registered persons. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were not always kept safe. This was because there was not always enough staff and medicines were not always managed safely. Fire extinguishers were not always secured properly or accessible, fire exits were not always clear, fire doors were being propped open and there was no evidence of fire drills being carried out.

The service provided was not always effective. Where people were assessed as not having the capacity to make choices and decisions and, there were restrictions upon their freedom, the provider had not always sought authorisation from the appropriate authorities. People's intake of food and drink and their weight was not closely monitored. The provider had carried out improvements to the home to make it easier for people living with dementia. Staff had received the training required to meet people's needs.

People did not always receive a service that was caring. Staff treated people in a caring manner. People's independence was promoted. Staff tried to ensure people's privacy and dignity was maintained. However, some people shared rooms and their privacy was compromised.

The service was not always responsive to people's needs. The provider had not maintained a clear record of complaints or monitored these over time to identify any themes or areas requiring action. People had access to a variety of activities that were planned taking into account their needs and interests.

The service was not well-led. The leadership and management of the service had not been consistent, resulting in people, relatives and staff lacking confidence in it. The provider did not operate effective systems to monitor and improve the quality of service people received. The provider had not operated audit

and governance systems effectively to identify where improvements were required and take action. The provider had not ensured accurate records of people's care were maintained. The provider had not published their ratings on their website.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of this report.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The provider had not always ensured there were sufficient numbers of suitably qualified staff to care for people safely.

Medicines were not well managed and people did not always receive their medicines as prescribed.

Fire extinguishers were not always secured properly or accessible, fire exits were not always clear, fire doors were being propped open and there was no evidence of fire drills being carried out.

Is the service effective?

Requires Improvement

The service was not always effective.

A system was not in place to ensure the service met the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Staff had received the training required to meet people's needs.

Staff worked with health and social care professionals to access relevant services.

The provider had continued to make alterations to the home to make it more appropriate for people living with dementia.

Is the service caring?

Requires Improvement

The service people received was not always caring.

Some people shared rooms and their privacy was compromised.

Staff treated people in a caring manner.

People's independence was promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

The provider had not maintained a clear record of complaints or monitored these over time to identify any themes or areas requiring action.

People had access to a variety of activities that were planned taking into account their needs and interests.

Is the service well-led?

Inadequate

The service was not well-led.

The leadership and management of the service had been inconsistent. People, relatives and staff told us they had lacked confidence in the leadership and management of the service but felt things were beginning to improve.

The provider had not published their ratings on their website.

The registered manager and provider had not operated audit and governance systems effectively to identify where improvements were required.

Stinchcombe Manor

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 25 June and 1 July 2016 and was unannounced. The inspection was carried out by two adult social care inspectors.

Prior to the inspection we looked at the information we had about the service. This information included the action plan the provider had sent to us following our inspection of the service on 1 and 2 December 2015. We reviewed the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We also looked at quality monitoring information provided by Gloucestershire County Council and information shared with us by other individuals and agencies.

We contacted a range of health and social care professionals including, a community nurse who visited regularly and the commissioners of the service. We asked them for some feedback about the service. We were provided with a range of feedback to assist with our inspection.

Some people were able to talk with us about the service they received. We spoke to ten people. We carried out two Short Observational Framework for Inspection (SOFI 2) assessments, one on the 25 June and one on the 1 July 2016. SOFI 2 provides a framework for directly observing and reporting on the quality of care experienced by people who cannot describe this for themselves

We spoke with nine staff, including the registered manager, clinical lead, nursing staff, a senior care worker, care staff, catering staff and housekeeping staff. We also spoke with five relatives.

We looked at the care records of seven people using the service, four staff personnel files, training records for all staff, staff duty rotas and other records relating to the management of the service. We looked at a range of policies and procedures including, safeguarding, whistleblowing, complaints, mental capacity and

deprivation of liberty safeguards, recruitment, accidents and incidents and equality and diversity.

Inadequate

Is the service safe?

Our findings

People, relatives and staff told us there was not enough staff at certain times of the day. One relative told us, "I'm not sure how they can keep people safe, we hardly see staff". Staff rotas showed there were usually six or seven care staff and a qualified nurse caring for people in the mornings, with four and, occasionally three, care staff and a qualified nurse during the afternoons and evenings. Staff said, "There's not enough staff in the afternoons" and, "When we have four staff and a nurse in the afternoon it's not enough, and sometimes we only have three".

We carried out structured observations in the afternoon on both days of our inspection. The impression we gained was of staff being rushed, concentrating more on completing tasks than spending time with people. We saw people sitting for long periods of time with little or no interaction from staff. We saw people calling out for staff and them not being attended to and, on several occasions we had to find staff on behalf of people.

The registered manager said they used a staff dependency tool to calculate safe staffing levels. They said they were in the process of reviewing staffing levels and intended to implement a revised rota to provide more staff at key times.

Prior to our inspection we had received information that a qualified nurse had not been at the service on the nights of the 27, 28 and 30 May 2016. We looked at staff rotas and saw the nurse was scheduled to work a sleep in shift rather than being awake all night. The registered manager confirmed this arrangement. At our inspection on 1 and 2 December 2015 we identified one night where no qualified nurse had been on the premises. Following this the provider had put in place an arrangement with a nursing agency to have nurses live in at the premises. The provider had put this in place to manage the risk of there being no nurse at the service. The registered manager said on the three nights in May 2016 steps had been taken to ensure staff could easily wake the nurse if required. Staff confirmed they had been instructed to do this. No harm had come to people on these nights and we saw people's needs had been met. However, we were concerned this arrangement did not provide the oversight required from a qualified nurse to ensure people were kept safe and their nursing needs met.

People were not always cared for by sufficient staff. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were not always stored in accordance with manufacturer guidelines. People's prescribed medicines were stored in locked cabinets within their own rooms. The provider had no way of ensuring medicines were kept at a safe temperature in accordance with manufacturer guidance. Additionally, the service had no 'master' key for all medicine storage cabinets. Nurses needed to carry around keys to each storage cabinet. As a time saving measure an agency nurse informed and showed us that nurses now pre-prepared people's medicine in dossette boxes before a medicine round. This dossette box had leaflets which documented people's names and a colour which referred to the specific medicine round. The nurse told us this saved them time. There was however a risk that people's medicines could be

prepared wrongly and may not be being stored effectively.

People's medicines were not always administered in a safe way. We observed an agency nurse supporting people with their prescribed medicines. For one person they left their prescribed medicines with them, whilst the person ate their lunch. The nurse told us, "They're compliant; they just don't like being interrupted". In doing this the nurse could not be sure the person had taken their medicines.

The storage and administration of medicines was not always safe. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Fire extinguishers were not always secured properly and not always accessible. Two that were adjacent to the dining room were obscured by a food crate and loose on the floor. Fire exit signage was in place; however some fire exits were obstructed by equipment and fire doors were being propped open. Additionally there was no evidence of fire drills being carried out on a planned basis.

The premises and equipment were not safe. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment records for staff employed at the service contained the relevant checks. Records included a Disclosure and Barring Service (DBS) check. A DBS check allows employers to check whether the applicant has any past convictions that may prevent them from working with vulnerable people. References were also obtained from previous employers prior to staff working with people. There was a record of checks to ensure qualified nurses were registered to practice with the Nursing and Midwifery Council (NMC).

Staff knew about the different types of abuse to look for and what action to take when abuse was suspected. Staff were able to describe the action they would take if they thought people were at risk of abuse, or being abused. They were also able to give us examples of the sort of things that may give rise to a concern of abuse. There was a safeguarding procedure for staff to follow with contact information for the local authority safeguarding team. Staff we spoke with told us they had completed training in keeping people safe. Staff knew about 'whistle blowing' to alert management of poor practice.

Risk assessments were in place and had been regularly reviewed. These assessments included personal care, moving and handling, skin care and fluid and nutritional intake. The assessments identified the risk to the person, how the risk would be minimised and any training required by staff. Staff were knowledgeable concerning these risk assessments and ensured they were followed.

Some people needed assistance with moving and handling. Where this required the use of a hoist and sling, the provider had ensured people had their own slings. Slings are individual lifting aids that fit to hoists to allow people to be moved safely and comfortably. We were told these slings were laundered separately and not used by other people. This meant the risk of cross infection was minimised. Staff were able to describe to us how people were assisted with moving and handling. This included the use of equipment as identified in people's care records.

The provider had a policy in place to prevent and control the risk of infection. Staff had received training on infection control. Staff said they were provided with personal protective equipment such as, gloves and aprons. The home was clean and free from odour. Housekeeping staff were employed to assist with the cleaning of the home and to complete the laundry.

Requires Improvement

Is the service effective?

Our findings

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 were being met. When we visited in May 2015 we found people were not protected from the risk of deprivation of their liberty without the correct authorisation being in place. The provider had told us how they would improve this in their action plan.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The provider had policies and procedures on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff told us they had received Mental Capacity Act 2005 (MCA) training and were aware of how this impacted on the support given to people. People's support plans did not always contain an assessment of capacity to make decisions. DoLS applications had been completed for some people and submitted to the appropriate authorities. The provider did not have a system in place to monitor these applications. This had resulted in one person's authorisation lapsing. This had not been identified. This meant this person's was being deprived of their liberty without authorisation.

The provider had not ensured a system was in place to monitor DoLS applications and ensure compliance with the Mental Capacity Act (MCA) 2005. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by staff who had access to a range of training to develop the skills and knowledge they needed to meet people's needs. Staff said they had access to training relating to people's specific needs. We viewed the training records for the staff team and records confirmed staff received training on a range of subjects. Training completed by staff included nutrition, safeguarding vulnerable adults, dementia awareness, medication, first aid, infection control, fire awareness, food hygiene and moving and handling. A programme of training was in place to ensure qualified nursing staff were able to update their clinical skills regarding wound care management and catheter care.

New staff were supported to complete an induction programme before working on their own. The provider ensured new staff completed the new care certificate as part of their induction. The care certificate aims to equip health and social care support workers with the knowledge and skills which they need to provide safe, compassionate care.

The service had a programme of staff supervision in place, these are one to one meetings a staff member has with their manager. Staff supervision was delegated appropriately to each staff member's immediate supervisor. Staff members told us they received regular supervision. Staff records showed these were held regularly. Supervision records contained details of conversations with staff on how they could improve their performance in providing care and support. Staff said they found their individual meetings helpful.

People had access to drinks in the dining area including squash, water, tea and coffee. Fresh and dried fruit and cakes were also available throughout the day. People told us the food was good. Menus were available and included photographs of the food. Relatives gave mixed feedback regarding the food. Some told us they thought the food was well presented and looked appetising. Three relatives said, "They need a chef. The food's not great". Another relative said, "We've asked for meat to be cut up so they can manage independently but it still gets served as slices".

We observed people at lunchtime. The food was hot and well presented. Meals were served from a heated trolley. People seemed to enjoy the mealtime experience. Some people chose to eat their lunch in their rooms. Staff provided the assistance people required.

People told us they had access to other health professionals and staff would organise health appointments if they were unwell. People were registered with a GP. The provider had an 'enhanced contract' in place with the GP surgery. This meant the GP regularly visited the service. We received feedback from the surgery. They said they had been concerned over the number of calls made to them for advice and assistance on things they felt the qualified nurses themselves should have been able to manage. However, they said this had recently improved and they know felt calls made to them were more appropriate.

Following our inspection in December 2015 we commented on the improvements to the environment carried out by the provider. We noted the home was cleaner, brighter, less cluttered and easier for people living with dementia to find their way around. At this inspection we saw improvements had continued to be made. A new patio area had been created and we saw people making use of this outdoor space both on their own and, with family and friends. A new larger, lift had recently been installed to make it easier for people to move between floors.

Requires Improvement

Is the service caring?

Our findings

Some people shared bedrooms. The provider said they were reviewing the provision of double rooms and considering a long term plan to move to single bedrooms all with en-suite facilities. Privacy screens were available and used in shared rooms. These screens did not always provide people with privacy. For example, the screens were 'concertina' style, resulting in the possibility of seeing through where they were jointed. The screens would also not prevent people overhearing any discussions with the person regarding their care and treatment whilst they were in bed. Health care professionals shared with us concerns regarding this. We were told how one person's wound care dressing was changed whilst the other person occupying the room was in bed. One person told us they did not like sharing a bedroom with another person.

People's privacy was not always maintained. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff knocked on people's doors and either waited to be invited in, or if the person was not able to answer, paused for a few moments before entering. We saw people's bedroom doors and doors to bathrooms and toilets were closed when people were receiving care.

People and relatives gave mixed feedback on whether the service was caring. One person said, "The staff are lovely to me" and another one told us, "They haven't always got time for you". One relative commented, "There is not enough staff and some aren't caring" and another told us, "Most of them are very nice and caring".

Staff we spoke with said they would be happy for a relative of theirs to be cared for at Stinchcombe Manor. They said, "Up until a few weeks ago I wouldn't have been so sure, but now yes I'd be happy for a relative of mine to be here" and, "I'd be happy with a relative of mine living here, the staff are really caring".

Staff spoke to people in a calm and sensitive manner and used appropriate body language and gestures. We saw some positive interactions and saw how these contributed towards people's wellbeing. We did not see many examples of staff sitting with people and spending time talking with them. Staff often appeared rushed and focussed on the task in hand rather than the people themselves.

The provider operated a keyworker system, where a staff member was identified as having key responsibility for ensuring a person's needs were met. Staff told us this system had allowed them to get to know the person they were keyworker for well and ensure their needs were met. Relatives commented that they'd like more contact and information from keyworkers.

People's independence was promoted. Changes to the lay out of the building meant people were now able to move around the home more freely. People's care records contained plans and risk assessments aimed at encouraging people to develop or maintain their independence.

There was an open visiting arrangement. People confirmed they could entertain their visitors in the lounge

areas or in their bedrooms. We observed some visitors sitting in the lounge area enjoying spending time with people.

People were encouraged and supported to develop and maintain relationships with people that mattered to them and avoid social isolation. People's care records identified people important to them and how they wished them to be involved in their lives. Relatives we spoke with said staff helped maintain relationships between the person and them. However, some relatives felt they needed more communication with senior staff.

People's wishes were respected about their end of life care. Care files showed people were asked about their end of life care. These included information on whether the person wished to remain at the home or be admitted to hospital if they became unwell. Contact details for family and friends and when they should be contacted was also in plans. Staff told us they would liaise with the district nursing team and GP to ensure all equipment and medicines were in place to ensure people were pain free when they required palliative care.

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive to people's individual needs. The overall impression of the service was that it was led by routines and tasks rather than being person centred.

Care records were stored on computer, with two terminals for staff to access in order to make entries. Some daily records were kept in people's rooms. The clinical lead told us care plans were going to be printed off and placed in people's rooms to ensure staff had better access to them. People's care records included information about their personal circumstances and how they wished to be supported. The records we looked at contained relevant information for staff to provide care and support in a personalised manner.

The provider had a complaints policy in place. Information on how to make a complaint was on display in the lobby area of the home. Relatives told us they did not have confidence complaints made would be looked into. One relative said they had felt their complaint had not been taken seriously. Another said, "I don't know who to go to with concerns". Health and social care professionals said they had not found the registered manager and provider to be receptive to comments and complaints. During the previous 12 months eight complaints had been made. Records of complaints held in the file at the service were disorganised and did not clearly identify the outcome and any actions taken in response. As a result the provider would not be able to monitor these over time and identify trends or areas of risk that needed to be addressed.

The provider did not have a system in place to analyse and respond to issues raised. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Call bells to summon staff were available to people and within their reach. Throughout our visit we saw staff responded to call bells promptly.

People had a range of activities they could be involved in. People were able to choose what they took part in and suggest other activities they would like to complete. In addition to group activities people were able to maintain hobbies and interests, staff provided support as required. People said they enjoyed the activities. A weekly plan of activities was displayed in the lobby area of the home. Activities suitable for people living with dementia were organised. These included tactile craft and age appropriate music and events. During our visit we saw the activities organiser engaging people in a range of different activities. One person told us they had arranged flowers with the organiser and enjoyed this. The organisers said activities were planned for weekends as well as in the week. They also told us how they planned individual activities for people in their own rooms, including reading poetry to one person receiving end of life care.

Inadequate

Is the service well-led?

Our findings

At our inspection in December 2015 we identified the registered manager had not always notified CQC of events as required by law and, when notifications were submitted they did not contain sufficient detail. The provider's action plan following our inspection said they would send all such notifications with the required information. Since then CQC had received notifications from the service. However, they have continued to lack the detail required for us to make an assessment regarding the information.

The website for Stinchcombe Manor had not been updated since Stroud Care Services took responsibility for the service in early 2015. Stroud Care Services' website did not give any information on Stinchcombe Manor. This meant any member of the public trying to find information on the service would not be able to do so through websites operated by or on behalf of the provider.

The provider had not published ratings on their website as required by CQC. This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not operate effective systems to monitor and improve the quality of service people received. Audits had been carried out on Wednesday 1 June 2016 in relation to maintenance and grounds, care overview, health & safety and infection control. Where shortfalls or concerns had been identified there was no record of the action taken to improve this. For example, the maintenance audit identified people's mobility equipment was not routinely checked to ensure it was in working order, no action had been taken in relation to this concern. There were no subsequent audits and no evidence of how the provider used these audits to drive improvement within the service.

The provider did not have effective systems to seek the views of people or their relatives. There was no record of current meetings with people and their relatives, quality assurance surveys were not distributed and complaints were not managed effectively.

The provider did not have effective systems to learn from incidents and accidents. Incident and accident records were not audited to ensure any trends or concerns could be identified. While the provider had a system to monitor incidents and accidents these had not been used.

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

People's care records contained food and fluid charts to monitor their intake. However, these had not been completed thoroughly. Some people had been assessed at being at risk of not eating or drinking enough. Their food and fluid intake charts contained many gaps and had not been totalled for the day. This meant people's food and fluid intake was not being monitored. Records of the weight of people identified as being at risk of malnutrition were also not consistently kept.

The provider had not ensured accurate records of people's care was maintained. This was a breach of

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

The management structure of the service had undergone significant change since our last inspection. A new clinical lead nurse had been appointed. The deputy manager and care co-ordinator had left the service. The structure now consisted of the registered manager, a clinical lead nurse, two team leaders and care staff. People, relatives and staff told us they had lacked confidence in the leadership and management of the service. However, many did say they felt recent changes had resulted in a better atmosphere in the service and increased professionalism. Staff told us the management structure was now clearer and they felt more positive. They said, "The new clinical lead is great" and, "Things are much calmer now, there's a better atmosphere and morale amongst staff".

Staff said they did not always feel supported by the provider, and did not feel their views were listened to. One member of staff told us, "They need to listen more, we're on the same side after all". This has been a common theme. At previous inspections staff have told us they did not feel valued or listened to by the registered manager and provider.

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 Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's privacy was not always maintained. Regulation 10 (2) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider had not ensured the most recent assessment of the overall performance of the service was displayed or, accessible through, websites maintained by or on behalf of the provider. Regulation 20A (2) (b) (c).

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from the risks associated with medicines because the provider had not ensured the proper and sage management of medicines. Regulation 12 (2) (g). Fire extinguishers were not always secured properly and not always accessible, fire exits were not always clear, fire doors were being propped open and there was no evidence of regular fire drills. Regulation 12 (2) (d) (e).

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not operate effective systems to monitor and improve the quality of service people received, effective systems to seek people or their relative's views were not in place and, the provider did not have effective systems to learn from incident and accidents and, accurate and complete records of care and treatment were not maintained. Regulation 17 (2) (a) (b) (c) (e) (f).

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing People who use services were not always cared for by sufficient staff numbers of suitably qualified staff. Regulation 18 (1).

The enforcement action we took:

Warning notice