

The Salvation Army Social Work Trust

Smallcombe House

Inspection report

Oakwood Gardens
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Bath
Somerset
BA2 6EJ

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

We undertook an unannounced inspection of Smallcombe House on 20 September 2016. When the service was last inspected in November 2014 there were two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identified. We found that people had been placed at risk as Medication Administration Records (MAR) were not accurately completed. Also, that people had been placed at risk of unsafe or inappropriate care and treatment as records had not been accurately maintained. These breaches were followed up as part of our inspection.

Smallcombe House provides accommodation and personal care for up to 32 older people. At the time of our inspection there were 26 people living at the home.

A registered manager was in post at the time of our inspection. 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 home is run.

The home was not always safe as medicines were not always given as prescribed and records relating to people's medicines were not always accurate. Accident and incidents were reported but did not show clear actions taken to prevent future occurrences. Risk assessments were in place and had guidance in place for staff on how to support people in a way that minimised risks.

Staffing levels were safe. Staff were supported through an induction process and regular supervision. Staff had regular training although we found there was no training for staff in the Mental Capacity Act 2005, the Deprivation of Liberty Safeguards (DoLS) or diabetes.

The home was not always effective as people's healthcare needs were not always met. People were at risk of not receiving appropriate care in relation to their nutrition and hydration needs.

The registered manager was aware of their responsibilities in regards to (DoLS). DoLS is a framework to assess if the deprivation of liberty for a person when they lack the capacity to consent to care or treatment or need protecting from harm is required. The registered manager kept clear records of the steps taken in the DoLS process. Staff were not always knowledgeable in how the Mental Capacity Act 2005 and DoLS was relevant to their role.

The home was caring and responsive. People and relatives told us that staff were kind and caring. We observed positive interactions and relationships between staff and people living at the home. Staff knew people well and their personal preferences. Care records were person centred and gave details of how people wished for their care to be delivered.

The home was not always well-led. Notifications had not always been sent to the Commission, which is a

legal requirement. Audits were in place to assess and monitor the quality of care. However, these were not always effective in identifying areas that required improvement or instigating the necessary changes. People and staff could contribute their feedback and ideas through meetings and surveys.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In addition, a breach of the Care Quality Commission (Registration) Regulations 2009 was also identified. You can see what action we told the provider to take at the back of this report.

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 home was not always safe. Medicines were not always administered as prescribed and medicine records were not always accurate.

Incidents and accidents were recorded. However, actions taken to minimise risks were not always recorded.

Risk assessments were in place and gave guidance to staff about how to manage risks.

Staff knew how to identify and report safeguarding concerns.

Staffing levels were safe.

Requires Improvement ●

Is the service effective?

The home was not always effective.

The home had not always ensured people's healthcare needs were met.

The home was meeting the requirements of the Deprivation of Liberty Safeguards.

Staff did not always have the appropriate knowledge and understanding of the Mental Capacity Act 2005 or the Deprivation of Liberty Safeguards.

Staff were supported through effective induction and supervision.

Requires Improvement ●

Is the service caring?

The home was caring.

We observed positive relationships with people living at the home.

Staff spoke to people with kindness and respect.

People's visitors were welcomed at the home.

Good ●

Is the service responsive?

The home was responsive.

People were involved in deciding the activities on offer.

Meetings were held to gain people's views and opinions.

People and relatives had access to the home's complaint procedure and knew how to raise a complaint if necessary.

Good 

Is the service well-led?

The home was not consistently well-led.

Notifications had not always been submitted to the Commission as required.

Systems were in place to monitor the quality of care and support but these were not always effective.

Surveys gained feedback from people. However, further actions were not always completed.

Polices, assessments and documentation was not always up to date or accurate.

Communication systems were in place for staff through meetings and handovers.

Requires Improvement 

Smallcombe House

Detailed findings

Background to this inspection

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

The inspection was carried out by one inspector 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.

Before the inspection we reviewed previous inspection reports and other information we had received about the home, including notifications. Notifications are information about specific important events the home is legally required to send to us.

Some people at the home were not always able to tell us about their experiences. We used a number of different methods such as undertaking observations to help us understand people's experiences of the home. As part of our observations we used the Short Observational Tool for Inspection (SOFI). SOFI is a way of observing care to help us understand the needs of people who could not talk with us.

During the inspection we spoke with 11 people living at the home and six staff members. After the inspection we spoke with two relatives of people that lived at the home. We looked at five people's care and support records and five staff files. We also looked at records relating to the management of the service such as incident and accident records, meeting minutes, recruitment and training records, policies, audits and complaints.

Is the service safe?

Our findings

People were not always kept safe as medicines were not always given as intended by the prescriber and Medicines Administration Records (MARs) were not consistently completed accurately. We found instances when people's MARs had not been signed or a reason for not giving a medicine recorded. For example, one person's MAR had not been signed on 7 September 2016 for one medicine and on 10 September 2016 for four medicines. Another person had two medicines that were not signed for on 7 September 2016.

The home was currently using two different MAR systems. Both had different codes stated on them for why medicines had not been taken. As staff were using the codes from one MAR on both MAR records it meant that it did not correspond to the correct reason why a person had not taken their medicines. For example, on one MAR the code 'N' was used for when a 'when required' medicine was offered but declined. However, on another MAR the code for 'N' related to a person having not taken their medicine due to nausea. This meant that records for medicines administration were inaccurate. It was also misleading as the MAR for one person looked as if they had been nauseous for several days, when this was not the case. A senior member of staff said this would be addressed by using one type of MAR.

We noted that when a medicine to be given 'when required' had been prescribed there was no guidance available for staff on factors or triggers that may lead to a person requiring an additional medicine, such as pain relief. This meant that staff could not be sure when this medicine should have been given and what the intended outcome should have been. This had been highlighted to the home at the previous inspection in November 2014.

We also found that three people did not have any of their prescribed medicines in stock at the home on the day of our inspection. Therefore they were not being administered their prescribed medicines. One person had not had their prescribed medicines since the evening of 19 September 2016. Another person had not had any of their six prescribed medicines for the previous 14 days. Another person had not had their two prescribed medicines for 15 days. For one person, a senior staff member had records to show that the person's GP surgery had been contacted to re-order more medicines on 2 September 2016. Despite this, the medicines were still not available.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff reported and recorded any accidents or incidents. This detailed what had happened and immediate actions taken. There was a section on the form which asked, 'What has been done to minimise the risk?' Whilst we saw that this had been completed on some occasions this was not consistent. For example, we found three accident reports on 6 September 2016, 15 September 2016 and 17 September 2016 where this had not been filled out. This meant it was not always clear what actions had been taken to reduce future reoccurrence.

Safe recruitment processes were in place, but we found one instance where this had not been fully

completed. Staff had completed an application form prior to their employment and provided information about their employment history. References had been obtained by the home together with proof of the person's identity and an enhanced Disclosure and Barring Service (DBS) check was completed. A DBS check helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with certain groups of people. We saw that when a DBS check had identified areas needing further investigation a full risk assessment had been undertaken. However, we did find that for one person two references had been obtained that would both have required further enquiries in relation to the home's policy and legal requirements, these had not been completed.

Individual risk assessments identified potential risks to people for example in falls, mobility and finances. Guidance was in place to inform staff how to support people safely. For example one person's risk assessment guided staff in relation to a person safely moving around the home. The risk assessment said, 'Better to use the lift to prevent falls.'

Staffing levels were safe. We reviewed the staffing rotas from the previous eight weeks and the number of staff was consistent with the planned staffing levels. The home currently had one vacancy and was recruiting for this position. The home was currently managing a period of some longer term staff absences. These were being covered by existing staff and agency staff. Relatives and staff said that staffing levels were generally good. One staff member said, "staffing levels are fine." Another staff member said, "We are well staffed." A relative said, "The staffing levels are pretty good."

The provider had policies and procedures in place for safeguarding adults. This contained guidance on what staff should do in response to any concerns identified. From the training records we reviewed we saw staff received regular training in safeguarding adults. This was confirmed with staff. Staff said they knew how to recognise signs of abuse and how to report any concerns they might have. One staff member said, "I would report to my team leader or the head of care." Staff said they were confident that matters were investigated thoroughly. One staff member said, "Things do get looked into." We saw that the registered manager knew when to refer concerns to the local safeguarding teams and kept records of this.

We reviewed records which showed that appropriate checking and testing of equipment and the environment had been conducted. This ensured equipment was maintained and safe for the intended purpose. This included safety testing of electrical equipment and the lift. There were also certificates to show testing of fire safety equipment and gas servicing had been completed. A weekly health and safety check was completed of the premises and areas identified that required maintenance. For example, a lightbulb not working or a door lock broken.

Staff had regular training in fire safety. Systems were in place to regularly test fire safety equipment such as emergency lighting, alarms and extinguishers. Regular practice fire drills had been undertaken and actions taken to any identified areas. For example, additional training for team leaders. An emergency and contingency plan was in place that had been reviewed in September 2016. This contained protocols to deal with unforeseen circumstances such as a flood or gas leak.

We did note that there was little outside area that was accessible to people. The patio area which was available off the lounge was not well maintained. A senior member of staff said there were plans in place to improve this area and make it safer and more attractive.

Is the service effective?

Our findings

People did not consistently receive effective care because information in regards to meeting people's nutritional and hydration needs was not always sufficient. People had a nutritional assessment in place which monitored if people were at risk. However, we found that people who were identified as being at risk were not then regularly monitored. For example one person, had been weighed in July 2016 and had not been weighed since. This meant that potential further weight loss would not be identified or acted upon. In one person's daily notes it commented on 1 September 2016 about the lack of food and fluids the person was consuming. For example, 'Been unwell, not eating and drinking.' Further concerns were noted on 14 September 'When she swallows she is finding it hard,' and on 16 September, 'Not really taking fluids.' The fluid chart being used did not give accurate measurements of how much fluid was being drunk per day. The care documentation did not give an indication to staff of how much the person should be drinking and what to do if this fell below a certain level. The 'resident records' in relation to contact with health professionals had not been kept up to date, so it was not clear what referrals had been made. However, it was ascertained that the person's GP had been contacted.

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

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager was aware of their responsibilities in regards to the Deprivation of Liberty Safeguards (DoLS). Applications had been made for five people. Documentation recorded the steps taken in the process.

Training records showed that staff had not completed training in the Mental Capacity Act (MCA) 2005 and DoLS. Some staff we spoke with told us they had not completed any training in the MCA or DoLS. Whilst some other staff members said they had undertaken training in the MCA some time ago. One member of staff said, "I have had training in MCA years ago." Staff we spoke with did not have a good understanding of the principles of the MCA nor DoLS and how this related to their role.

A section in people's care plans related to mental capacity assessments. There was clear documentation in place to work through the capacity assessment process. However, we found in the care files we reviewed that this documentation was not always completed when relevant or when it had been completed staff were

not always clear of the process. For example, in one file we reviewed when the question was asked on the form, 'Is there an impairment or disturbance in the functioning of the mind or brain and is this permanent or temporary.' The answer had been documented as "permanent resident." The best interest decision making process had also not been followed when identified. For example, for one person in regards to their medicines. We saw that these mental capacity assessments had not been regularly reviewed. For example, one person's assessment was from February 2014 which may mean it is no longer relevant.

Care documentation did show how people could make their choices. For example one care plan said, 'Able to choose own clothes.' We observed staff support people to make decisions. For example at a mealtime, staff showed people different food options or explained in their preferred method of communication what the choices were

We reviewed the staff training records and saw that staff received ongoing training in areas such as moving and handling, food hygiene and fire safety. Staff spoke positively about the training they received. One staff member said, "We have training all the time. It is very good." Staff told us they had training specific to the needs of people living at the home. For example in dementia and end of life care. We saw that senior members of staff had training specific to their roles for example in risk assessments and supervision and appraisals.

We found that staff had not received training in diabetes. We reviewed the care plan documentation in relation to two people with diabetes. We found there was limited information about how people's condition were managed. For example one care plan said, 'has type two diabetes, which is medically controlled.' However, there was no further information and no related risk assessment. We were told by a senior staff member, "That a member of night staff monitors the blood sugar levels." However, there was no information about how often this was done, by whom or any guidance around action that should be taken. We found not all staff we spoke with were aware of who was diabetic and how this was managed. However, the kitchen staff were very knowledgeable about people's dietary needs in relation to their diabetes management.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed two people's records in relation to bathing. We found that this information was recorded in three different places in the daily notes, a folder kept in the staff room and in individual care records. This meant that it was not clear to staff what care people had received and what care the person may require. We found that when care records said a person had 'refused' a bath it gave no further details of what had been offered instead or what care had been completed. One person's record said they had been offered a bath on 1 May 2016, 22 May 2016, 31 May 2016, 1 June 2016, 14 June 2016, 25 June 2016 and 1 July 2016 all at 19.00 hours and had declined. There was no explanation of why the person had declined, why they had not been offered one sooner or at a different time. The care records for August showed the person had bathed twice but information located within the office showed they had bathed on an additional three occasions. There was no record of what had been done to address this issue and how the person could be supported.

Staff said they received regular supervision and this was confirmed in the records we reviewed. Staff said they felt valued and supported in their roles. One staff member said, "We are well supported." We saw that supervisions gave positive feedback to staff and identified areas for improvement. We saw that keyworker's responsibilities, training and staff's well-being were also discussed. When matters had been brought to the attention of senior staff members these were appropriately addressed within supervisions or by the home's disciplinary procedures.

New staff completed an induction programme when they joined the organisation that was aligned with the Care Certificate. All the staff we spoke with confirmed they had received an induction. The induction consisted of mandatory training, orientation to the home and getting to know people and their support. All new staff shadowed a more experienced member of staff as part of the programme.

Is the service caring?

Our findings

People were supported by staff who were kind and caring. We saw positive interactions between staff and people living at the home. One person said, "They [staff] are very kind." A relative told us, "Staff are kind and thoughtful and enjoy their work."

We observed that staff had positive relationships with people and knew people well. When we spoke with staff, they were knowledgeable about people's personal preferences and how they liked their care and support delivered. We observed staff spending time with people, sat talking or assisting people to move safely around the home. One relative said, "The staff have good relationships with people there."

Staff told us that the home provided good care. One staff member said, "We give a good level of care to people." Staff told us they had time to spend with people and were not rushed in their duties.

We observed a mealtime at the home. We saw that staff came down to people's level to speak and make eye contact. We observed staff being friendly and attentive to people. People were offered choices and specific requests were responded to.

Relatives told us that people always looked well cared for. One relative said, "They are well looked after, well cared for and very happy." Relatives told us that staff had time with people and enhanced their well-being. One relative described the changes in their relative since being at the home, "She has improved enormously. She is much happier in herself." Another relative told us there was always staff around, "Staff are friendly and willing to talk."

Staff were knowledgeable about maintaining confidentiality within their role. One member of staff described this as, "Keeping information to myself, unless I need to report to a team leader." Staff respected people's privacy. Staff told us they always knocked on people's doors before entering and we observed this take place.

The home had received several compliments of the staff and home. One compliment read, "All your kindness and support is much appreciated." Another compliment said, "Thank-you for looking after me so well." However we were unable to tell how recent this information was as the date had not always been recorded. A senior staff member told us they would review how this information was kept.

Family and friends could visit whenever they wished. One staff member said, "Visitors can come when they want. They can just turn up." Relatives we spoke with said they visited regularly and were always warmly welcomed by staff. One relative said, "I can visit when I want."

Is the service responsive?

Our findings

People told us the home was responsive to their needs. We observed staff being attentive to people's needs. One person said, "The home is excellent." At our last inspection in November 2014 we found that people's care records had not been accurately maintained. At this inspection we found that care records and risk assessments had been improved to give sufficient detail on how to support people in their preferred way.

Care records contained a photograph of people, essential information and their life history. Care documentation gave staff an overview of people and the things that were important to them. A full assessment of people's needs was conducted before people came to the home to ensure the home could meet people's needs. Care records described people's personal preferences in relation to clothing, food and activities. For example, "I like reading, art and TV," and "My faith means a lot to me." Specific details were included for example particular foods people liked or disliked, favourite hymns to be sung and how people liked their hot drinks made. Care plans gave guidance to staff into the level of support people needed. For example, "I need assistance to dress myself." We saw that care plans were regularly reviewed and relatives told us they were involved in this process.

There was a designated co-ordinator for activities. A new appointment had recently been made and the new activity co-ordinator was completing their induction at the time of our inspection. We saw a timetable of recent activities at the home which included baking, games and a tea party. People told us they enjoyed the activities on offer and had enough to do. There were regular religious services which followed the ethos of the home and people could choose if they wished to attend. The home supported people to maintain their interests, this was reflected in people's care plans. For example, one person liked gardening. They had their own watering can and with staff support tended to the flower pots on the patio area.

The home had recently redecorated the corridors which led to people's rooms' in two different themes. They were clean and bright with different ornaments and pictures for people to explore. A staff member said the changes had made a difference as they were, "Interesting for people."

The home held regular residents meetings. People told us that these meetings asked for feedback about the home. We reviewed the minutes from the previous meeting held and saw areas such as meals, activities, people's rooms and laundry were discussed. We saw that people had suggested places they would like to visit for future activities.

We saw a meeting in May 2016 where people had been involved in giving particular feedback about the meals on offer. People had taste tested the meals and given their opinions on what the food was like. This assisted in shaping the menu for the forthcoming months. We saw that people's cultural beliefs were supported through the meal choices offered. For example, one person had particular ethnic food supplied.

The home had not received any complaints in the last 12 months. There was an accessible complaints form in place for people. Relatives we spoke with said they would be happy to raise any concerns if needed. One relative said, "I have no complaints. I know they have a procedure at the home."

Is the service well-led?

Our findings

The home was not always well-led as notifications had not always been submitted as required. We found that two notifications in relation to people's DoLS authorisations from August 2016 had not been sent to the Commission as required. A notification is information about important events which affect people or the home which the home is legally obliged to submit.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

Due to unforeseen circumstances at the home for a short period of time usual management operations were not in place. During this time the provider had not always ensured there was sufficient oversight in place for effective management.

A survey had been conducted in January 2016 for people, Overall the results were positive. With comments such as, "A very friendly atmosphere." An analysis of the results was completed and we saw that actions were taken. For example, a meeting was held to address the issues around people's laundry. However, where comments had required further investigation or people had ticked an answer that required further thought; how this could be facilitated had not always been completed. For example, one person had ticked that they were not enabled to vote, another person had ticked that they did not have enough privacy and another person had ticked they did not have a choice of what to eat.

Staff had completed a survey in 2016. The survey had produced some useful feedback about what worked well and what could be improved within the home. Communication was a key area that had been identified by staff as an area that needed improving.

We found grammatical errors within four of the five people's care documentation we reviewed, which could be misleading to staff or give inaccurate information. For example in one care record, 'he' instead of 'she' was used. In another care record 'male' instead of 'make' was used. Also, whilst we found that staff were knowledgeable about people's needs, staff told us they had not always read or regularly looked at the content of people's care plans. One staff member said, "I have been shown the care plans, but I have not read them."

We found that policies and assessments available to staff were not always up to date. For example, the safeguarding policy in the folder was from 2012, the fire risk assessments was due for review in June 2016 and the incident and accident policy in the relevant folder was dated 3 January 2012 and due for review in January 2015. This could be misleading for staff if information is not kept up to date and accurate.

The registered manager had systems in place to regularly monitor the quality of the home. This included audits of care records, medicines and accidents and incidents. Whilst some of the audits were detailed and effective for example the care records audits, which identified areas for action and communicated this to the person's keyworker. Other audits we reviewed were not so effective in identifying areas that required attention or ensuring improvements were achieved. For example, the medicines audit had identified some

gaps in recording and was discussed at a seniors meeting in July 2016. However, this had not been effective as the same issue was still occurring. The audit also had not highlighted other areas we identified during this inspection for example, with the coding on MAR records. Some audits we reviewed, for example the monthly accident and incident audit was very brief and did not give enough detail to be effective. For example, 'Had fall, treatment received' or 'Five falls, referred to fall clinic.' Details or actions taken or changes made were not recorded. We noted these audits had also not been completed since June 2016.

People, relatives and staff all spoke highly of the registered manager. One relative said, "She is a lovely lady, she knows the job, speaks to people and is visible in the home." Another relative said, "She is kind and understanding." One staff member said, "The manager is friendly and efficient."

Relatives said they could speak with the registered manager or any senior staff members if they had any concerns. One relative said, "Yes, I could raise a concern." Relatives said they were kept well informed. One relative said, "We receive letters about events. We have been phoned if there is anything wrong, they always let us know. There is always staff around to speak to when we visit."

Staff said they were well supported in their roles and there was a positive atmosphere within the home. One staff member said, "It is a good team, we work well together, we all support each other." We saw that the home had an employee recognition scheme. Staff members could be nominated to receive a reward for their contribution to the home.

Information was communicated effectively to staff. Messages and important information were conveyed to team leaders through a communication record. A weekly list of important information relating to each person was displayed in the staff office. For example, birthday's, health appointments and changes in care needs. A written and verbal handover took place at the start of each shift so staff were kept informed of people's current support needs.

The registered manager organised regular team meetings. Different meetings were held for different roles. For example, care staff, kitchen staff and team leaders. We reviewed the minutes of recent meetings and saw areas such as health and safety, working practices and staffing were discussed. Staff told us they were able to raise any issues at staff meetings. One staff member said team meetings were, "Useful." We saw from meetings that when areas had been identified that were not at the expected standard these were discussed in order to make improvements. For example, with communication or documentation.

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 18 Registration Regulations 2009 Notifications of other incidents Regulation 18(2) (c) The provider had failed to notify the Commission, as required, of two authorisations to deprive people of their liberty.
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (2) (b) The provider had not always ensured that medicines were available as prescribed or recorded accurately.
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (2) (c) The provider had not always ensured that records were complete and accurate in relation to people's food, fluid and healthcare needs.
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 (2) (a) The provider had not always ensured that staff

had appropriate training and learning to undertake their role.