Rushcliffe Care Limited

Oakford Manor Nursing Home

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

Summary of findings

Overall summary

About the service
Oakford Manor Nursing Home is a care home providing personal and nursing care to 23 people aged 65 and over at the time of the inspection. The service is registered to support up to 50 people, however this includes eight 'companion rooms' which were not used. Each person living at the service has their own bedroom. The building is set over two floors, during inspection the ground floor was used for people receiving nursing and personal care and the first floor was used for people who received personal care.

People's experience of using this service and what we found
There were widespread and significant shortfalls in the way the service was led by the provider. The delivery of high-quality care was not assured by the leadership or governance in the home. Audit systems failed to highlight the concerns we found during the inspection. There continued to be a lack of stable management in the home. Staff told us they felt managers were unsupported in their role by the provider.

National guidance in relation to new admissions during COVID-19 was not followed. This placed people and staff at increased risk. Risk assessments were in place but did not always cover all relevant risks to people's health and safety. Accidents and incidents were reported to the relevant agencies; however, little action was taken by the provider to learn from these. The provider did not ensure there were always enough suitably qualified staff to give people the support they needed.

Records did not always show that care was delivered in a way that responded to people's needs. There was a complaints policy and procedure in place which people and their relatives had access to. Some language used in care plans was not respectful. The provider responded immediately and assured us action would be taken to address this.

Staff were observed to be kind and caring with close bonds with people. People were involved in care planning.

Most people were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service generally supported this practice. The provider did not always recognise their responsibility in ensuring people were protected under the Mental Capacity Act (MCA), this was addressed after our inspection.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was inadequate (published 23 September 2020) and there were multiple breaches of regulation. This resulted in a warning notice for the service. We returned to the service to follow up the breaches of regulation and see if sufficient improvement had been made. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

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

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

You can see what action we have asked the provider to take at the end of this full report. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Oakford Manor Nursing Home on our website at www.cqc.org.uk.

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

We have identified breaches in relation to safety, governance, staffing levels, staff training, safeguarding people from abuse and meeting legal requirements.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

Special Measures
The overall rating for this service is 'Inadequate' and the service remains 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 of 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Oakford Manor Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Inspection team
This inspection was carried out by two inspectors.

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

The service did not have a manager registered with the Care Quality Commission. The previous manager had not registered with CQC. The service has been without a registered manager since January 2020. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was announced to the provider by email, the inspection team arrived at the home simultaneously as the email arrived. The announcing email was sent to reassure the provider of the COVID-

19 testing completed that day by the inspection team and that inspectors would wear PPE throughout the inspection visit.

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

During the inspection
We spoke with three people who used the service and five relatives about their experience of the care provided. We spoke with 12 members of staff including the compliance manager, area manager, manager, administrator, and support workers.

We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at four 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 looked at training data, rota's and quality assurance records. We spoke with professionals who regularly visit the service.

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 inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had failed to assess the risks relating to the health safety of people, actions had not been taken to do all that was reasonably practicable to mitigate risks to service users, including in the prevention, detection and control of the spread of infections that were health care related. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

Preventing and controlling infection

● We were not assured that the provider was admitting people safely to the service. At the time of inspection, the local area was undergoing surge testing in relation to high numbers of the Delta variant of COVID-19. A person was admitted to the service during our inspection and not isolated as required in COVID-19 government guidance. The provider had not received the result of the person's COVID-19 PCR test and staff were unclear on the admission process. Their bedroom was in a crowded corridor and no signage was visible to indicate their COVID-19 status. Pre-admission paperwork did not cover COVID-19 and related risks were not assessed. This increased the risk of transmission to people and staff.

● This was the first time a person had moved into the home in 11 months and staff were not supported by the managers to ensure this was done safely. Managers had not identified these issues until we raised them during inspection (24 hours after the person had moved in).

● Artificial flowers were not covered in the cleaning schedule which was not in line with government COVID-19 guidance. This increased the risk of transmission of the virus.

Assessing risk, safety monitoring and management

● Risk assessments were not always completed for all identified risks. For example, one person who needed their fluids thickened in order to drink safely did not have a choking risk assessment in place. Another person needed to be fed through a tube directly into their stomach and was known to find this difficult at times, there was no clear guidance for staff about how to support this person safely when this happened. Lack of guidance for staff on how to support people with these risks placed them at risk of harm.

● Pre-admission documentation for a new admission was not comprehensive. Information provided was vague, for example it stated "needs assistance" in the shower but did not clarify what assistance was required or by how many staff. It also referred to a previous assessment that was completed in 2018. The documentation did not provide enough up to date information on the person's current needs for staff to support them safely.

● Food records for one person who required a modified diet showed they sometimes had food that was not

made to the recommended consistency. The provider had not identified this concern until raised on inspection. Lack of oversight by the provider meant that emerging risks were not picked up on and no action was taken to prevent avoidable harm.
● Personal Emergency Evacuation Plan's (PEEP's) had not been updated. We found a PEEP for a person no longer living at the service and another with the wrong room number for a person. In case of emergency, this increased risk of confusion and delayed evacuation for people.

The provider had not done all that was reasonably practicable to mitigate risk. Systems were not operated effectively to ensure people always received safe care. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The provider responded to the concerns noted above during and after the inspection. The person who had recently moved in moved to a more suitable bedroom and was supported to self-isolate. The provider confirmed all the artificial flowers had been removed from the service until they were added to the cleaning schedules.
● Many improvements in relation to infection prevention and control were seen since the last inspection. The service was clean, and staff were observed to be wearing correct PPE. Visitors adhered to COVID-19 visiting guidance and were able to use a visitor's pod and outdoor areas.
● The provider immediately rectified PEEP's during inspection and we were satisfied they held clear information for an emergency evacuation.

Staffing and recruitment
At our last inspection the provider had failed to ensure the deployment of suitably qualified, skilled and experienced staff, placing people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● A relative told us "There is sometimes a shortage of staff, that has been the biggest problem". One staff member said, "Staff leave because it's too much for us managing on short staff, it's a constant issue." A different staff member said, "It's hectic, they've (the provider) dropped staffing levels again… it's not safe."
● Staff consistently raised the concern of not feeling able to meet the needs of the people at the home. Staff told us that they were exhausted and as a result this had increased their sickness levels. During our observations, staff appeared rushed.
● Staff rotas showed that there had been occasions where not enough staff were on duty. We identified seven occasions where three or less staff (one nurse, two care staff) had been on night shifts. It was not clear how this staffing level was sufficient to meet people's needs.
● The normal staffing level on night shifts was two care staff downstairs and one nurse and one care staff upstairs, this was calculated using the providers 'dependency tool'. Many people on both floors needed support from two staff at a time, as the nurse on duty was not always available to assist care staff (due to completing medicine rounds and other nursing duties). This meant there was regularly only one member of staff available on each floor. This placed people at risk of not having their needs met safely or in a timely way.

We found no evidence that people had been harmed however it was not clear how staffing levels were sufficient to meet people's needs. This placed people at risk of harm. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We reviewed staff recruitment files and saw that pre-employment checks were not always comprehensive. For example, the provider did not always explore gaps in employment histories, some applications had no qualifications listed and dates were not always clear.
● Criminal record checks were completed before staff started working at the service.

Systems and processes to safeguard people from the risk of abuse
● Safeguarding referrals were made when required, but investigations were not always completed, and outcomes were not recorded. The provider had not initiated any learning from safeguarding incidents, placing people at risk of re-occurrence.

Learning lessons when things go wrong
● Behaviour charts were completed by staff, but they were not reviewed by the provider to identify themes and trends. For example, we saw that a person would regularly refuse medication but reasons for this behaviour had not been considered. This placed people at risk of not having their care needs fully met.

Using medicines safely
● People's medication was stored, administered and disposed of safely. Some improvements were required in recording of medicines as staff did not always record quantities of tablets. This meant it was not always clear how much medication someone had taken.

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 not looked at. In March 2018 this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

At the last inspection, staff training was looked at in the Safe domain. At this inspection we have reviewed staff training under the Effective domain.

Staff support: induction, training, skills and experience

- Not all staff had completed mandatory training. The mandatory training policy was not clear about what training should be completed or by when. The provider told us that if staff had not completed their mandatory training, they were given a further timeline to complete it but were still allowed to work independently. This placed people at risk of being supported by staff who were not adequately trained.
- Staff were not always up to date with safety related training. We reviewed the provider's training matrix and found some staff had been working without safeguarding or infection prevention and control training. This put people at risk of being supported by unqualified staff.
- Not all staff had completed COVID-19 training. PPE training that was given during induction did not cover routine use of PPE during COVID-19. This increased the risk of unsafe PPE practice, putting people and staff at risk.
- Staff completed an induction when they first started. We were told by the provider that new starters would work alongside experienced staff until training is completed, however during inspection we reviewed staff rotas which showed new starters were counted in normal staff numbers for all but their first three shifts, even if their mandatory training was not complete.

Systems in place to ensure staff were supported to complete mandatory training were not robust. This was a continued breach of regulation 18 (2) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 did not recognise their responsibility in ensuring DoLS applications were made for everyone who required one. We read information within a person's care plan which indicated they were being unlawfully deprived of their liberty. Staff were guided to stop the person from leaving the building and to hide key codes for doors from them. The provider had sought advice from a social worker; however, this is not in line with the MCA which states it is the responsibility of the managing authority (the provider) to make a DoLS application.

The provider's procedures and processes to prevent inappropriate deprivations of liberty were not always operated effectively. 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.

● Following the inspection, the provider submitted a DoLS application for this person.
● Mental capacity assessments were in place and best interest decisions were made for people who lacked capacity to make specific decisions. People's relatives and representatives were consulted with.
● Staff asked people for consent before carrying out care

Supporting people to eat and drink enough to maintain a balanced diet
● People's food intake charts were not always accurate. We found records that showed two people who required a modified diet had been given food of a normal consistency. We were assured that no one had been harmed, however this recording issue had not been identified by the provider before our inspection.
● Staff ensured people had plenty to drink. We observed staff to regularly ask people if they would like a drink and drinks were placed within reach for people with limited mobility.
● Staff were responsive to people's food and drink requests. People told us that they liked the food.

Assessing people's needs and choices; delivering care in line with standards, guidance, and the law; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
●Care plans were reviewed regularly and updated when people's needs changed. Care plans were person-centred and showed holistic assessment of needs and choices.
● Staff communicated with a range of professionals. We saw that the GP was consulted with weekly and people had prompt access to healthcare services when required.
● There was information in people's records demonstrating that people's oral care needs were assessed and met.

Adapting service, design, decoration to meet people's needs
● The building was light, airy and spacious with a choice of inside and outside space for people to spend their time. Visiting areas were decorated in a pleasant way and the environment felt homely and comfortable.
● People's bedrooms were personalised to meet their preferences.

Requires Improvement

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 not looked at. In March 2018 this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

- Language used in people's care plans did not always promote people's dignity. We reviewed a person's documentation and saw their behaviour had been described in a derogatory way. The provider had not identified this before our inspection. The provider responded and assured us this was due to a language barrier that additional training would be put in place to address this issue.
- Staff told us they tried their best to be caring but found this difficult due to staffing levels, especially at night-time. One staff member said, "It's so hard trying to give people the care they need, especially at night, to get quality care we need an extra staff member."

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

- We received mixed feedback from relatives about being involved in people's care. After the inspection a relative contacted us to raise a concern, they had not been informed of the latest changes regarding their relation's care. Another relative told us they often found out things about their relation's care from other relatives rather than the provider or manager and they had suggested improvements to aid good communication. They told us the staff took their recommendations on board and did implement changes.
- Advocacy services were available and used for people who required an independent advocate to support them to express their views.

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

- Relatives told us staff were kind. During inspection, staff were observed to be caring and patient. People had positive relationships with staff. One relative said, "The staff are lovely, they really are kind to [Name]." Another relative said, "Staff are very nice and often go the extra mile."
- People's care plans were personalised and considered individual preferences. Staff knew the people they were supporting well.

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 not looked at. In March 2018 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

- Care records did not always demonstrate that care was delivered in a way that responded to people's needs. For example, re-positioning charts for people who required regular re-positioning in order to maintain skin integrity were not always completed. We identified gaps in two people's charts that showed they had not been re-positioned every four hours as required, with one gap noted as 12 hours. The provider assured us this was a recording error. After the inspection the provider informed us they had been aware that records were not completed effectively two months before this inspection but had failed to implement improvements during the inspection.
- When people displayed behaviours that could challenge others, there was not always clear guidance or advice to staff to identify potential causes of the behaviours, such as pain or discomfort.
- We observed staff did respond to people in the way directed in care plan guidance and people told us they enjoyed the company of the staff.

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 AIS was considered in people's care planning. Some information around the service was displayed in accessible formats, such as the menu, which was in a large font with accompanying photographs.

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. Visiting procedures were in line with government COVID-19 guidance and technology was also utilised to support contact with relatives.
- An activities co-ordinator started with the service on day one of our inspection, on day two we observed activities taking place.

Improving care quality in response to complaints or concerns

- There was a complaints policy and procedure in place. All complaints reviewed had been dealt with appropriately and relatives were satisfied with how their complaints had been handled.

End of life care and support

● During our inspection, no one using the service was in receipt of end of life care. Discussions were had with people and their relatives about how they would like to be cared for at the end of their lives and where appropriate, people had Do Not Attempt Resuscitation (DNACPR) or Respect forms in place. These are documets that set out of a person would choose to be resuscitated or if they would choose to be admitted to hospital if they were to become seriously unwell.

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 inadequate. At this inspection this key question has remained the same. 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.

Managers and staff being clear about their roles, and understanding quality performance, risks, and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive, and empowering, which achieves good outcomes for people

At our last inspection the provider had not implemented effective systems to assess and monitor the quality of care, this included a lack of overall scrutiny at board level. This was a breach of regulation 17 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● The service still did not have a manager that was registered with CQC. Since our last inspection, there had been two different managers at the home. The provider had not considered how they could address the issue of unstable management. Staff told us they felt senior managers did not allow managers autonomy to manage the home. One staff member said, "It's the senior managers that put these deadlines on us, they don't see the bigger picture." A different staff member said, "Rushcliffe don't let managers manage, that's why managers always leave." The manager in post did tell us they felt they had been supported by the provider.
● Management oversight was not effective. Quality assurance systems and audits did not review daily care notes, people's weights records, skin integrity charts or behaviour charts. This meant the issues in these records we identified during this inspection had not been picked up at management or provider level. This placed people at risk of harm as risks were not identified and addressed.
● There were three managers at the home during this inspection. None had recognised that the person who moved in on the first day of the inspection was not admitted safely until raised by inspectors. Immediate risks were not identified, and this placed people and staff at risk of harm.

The provider did not operate systems effectively to assess and monitor the quality of care. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care; Working in partnership with others

● Although some improvements had been implemented since the last inspection, such as electronic care plans and new staff training procedures, these were not always operated effectively. For example, the electronic care plans could generate audits and analyses for review, but this was not completed.

● Commissioners at the local authority told us they had given a lot of support to this home to improve but had not referred new people to move into the home for 11 months due to on-going concerns.

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

● Staff did not feel they were actively involved in the running of the home. Whilst staff felt supported by the manager, many staff were critical of the way the provider engaged with them and the pressures they felt were placed on them. One staff member told us "They [the provider] don't know how it feels to work on the floor, they don't think of person-centred care, they think of money and try rush us."

● Records did demonstrate people were actively involved in their care and some relatives were positive about communication with the service.

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 provider was meeting the duty of candour. When things had happened to people, such as accidents, they did ensure people and relatives were informed.

● The provider is legally required to submit statutory notifications to us when certain incidents occur, such as when a person dies, or if a person sustains a significant injury. We reviewed records against the notifications we had received and saw this was done.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The providers procedures and processes to prevent inappropriate deprivations of liberty were not always operated effectively.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Systems in place to ensure staff were supported to complete mandatory training were not robust. We found no evidence that people had been harmed however it was not clear how staffing levels were sufficient to meet people's needs