Prime Life Limited

Phoenix Park Care Village

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

Phoenix Park Care Village is a purpose build home situated on the outskirts of Scunthorpe. It is registered to provide accommodation for people who require nursing or personal care for a maximum of 111 people.

The service is separated into two units Hilltop and Overfields. Hilltop offers 77 single en-suite rooms for older people some of whom may be living with dementia, complex medical conditions and behaviours that may challenge the service and others. Overfields provides 34 single en-suite rooms for younger adults with complex needs, disabilities and mental health conditions. At the time of our inspection there were 109 people living at the service. The service offers a number of communal lounges, conservatory, kitchens, a mixture of dining and bistro areas, games rooms, hairdressing and beauty salon, landscaped gardens and outdoor seating areas.

The inspection took place over three days on 17, 25 and 28 September 2015. This was an unannounced inspection which meant that staff and the registered provider did not know that we would be visiting. At the last inspection in June 2014 we found the registered provider was compliant with all the standards we assessed.

Summary of findings

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission [CQC] 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.

We brought the inspection forward due to the number of incident notifications we had received from the service. We also had a number of concerns raised by relatives of people living at the service, which included concerns regarding the cleaning standards and poor standards of care. A local Member of Parliament [MP] and two of their constituents had also raised concerns about the care practices taking place at the service. There was also one on-going investigation into allegations of abuse which relates to an ex-employee at the service. This continues to be investigated by Humberside police.

We found the information submitted to the CQC and local safeguarding teams was not always accurate and lacked the detail needed to understand fully what the concern had been. Therefore, we found it difficult to determine if further investigations were required; if the concerns should be escalated to other agencies or if the registered provider had taken the appropriate steps to mitigate any risks. Other agencies also reported to us that they had experienced difficulties accessing information from the registered manager when requested. Although staff told us they felt well supported we found that the governance systems in place at the service were not as effective as they could have been and we struggled to obtain information from the registered manager during our inspection.

We found that a number of people regularly displayed behaviours which challenged the service and others, which had led to physical interventions such as hand holds being used by staff. We found not all staff involved in these types of incidents had received appropriate physical intervention training.

For those who had received physical intervention training we found this was not accredited as recommended by the department of health and it did not assist staff to safely support someone using physical interventions; record what actions staff needed to take; the holds to be used for each person; or inform them that they needed to maintain very detailed information about how they had dealt with incidents.

We saw safety gates were widely used throughout the service. Staff explained that these were in place to prevent some people with behaviours that challenged accessing the individual bedrooms of people who lived in the home. We requested evidence to ensure this risk had been assessed, but the registered manager could not produce any risk assessment documentation to support these actions. We found no evidence to show that staff had taken any action to determine if alternative, less restrictive methods had been explored.

We found the home admitted people with a wide range of complex needs and conditions; many of which were related to a mental disorder. However, staff had not received training in supporting people with specialist conditions such as mental health disorders and Asperger. We also found that there were 58 people who had been assessed as requiring nursing care at the location. Of the qualified nurses employed at the service only one was a registered mental health nurse and none of the nurses were based in the Overfields unit. Thus we found that there was an over-reliance on care staff to provide the care and that these staff had not received the training needed to deliver these expectations.

Safe staff recruitment processes were not always followed. We saw one person had been employed even though they had received a serious warning from the police authorities on their Disclosure and barring service [DBS] check and one of the references stated they would not employ this person. We found that the registered provider had not completed a risk assessment for this person around the disclosure and had not taken any additional steps to ensure the person was fit to work at the home and with vulnerable people.

The Mental Capacity Act [MCA] 2005 was not fully understood by all staff members and there was also a limited understanding of the MCA Deprivation of Liberty Safeguards [DoLS] and what restriction, if any could be implemented within practice. We saw that 11 safety gates were being widely used throughout the Hilltop unit but we did not see MCA documentation to evidence this as in the best interests of people and the least restrictive option that could be identified.

Summary of findings

People who used the service and their relatives told us there was a good range of food available which looked well-presented and appetising. We saw positive interactions between some people and staff and people told us the staff were caring. However, we also saw there was a lack of meaningful activities taking place in the Hilltop unit and many people appeared to be sleeping for most parts of the day. A number of people were supported by staff on a one to one basis but we saw very little communication and interactions between those people and staff members in these situations on the Hilltop unit.

People's dignity was not always respected on the Hilltop unit. We saw people being left in positions which compromised their dignity. Effective and safe standards of hygiene had not been maintained in all areas of the service.

The storage and administration of medicines were safe and well managed along with thorough maintenance checks that ensured equipment was safe and fit for purpose.

We found multiple breaches of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures. We are considering our enforcement actions in relation to the regulatory breaches identified. We will report further when any enforcement action is concluded. You can see what action we told the registered providers to take at the back of the full version of the report.

Summary of findings

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 registered provider failed to fully explore and address safeguarding concerns. The safeguarding alerts records submitted to the local safeguarding team and CQC did not contain the same information that was held at the service.

The registered provider failed to deploy sufficient staff with the skills and experience needed to meet each person's needs.

Safe recruitment processes had not always been followed. Physical intervention was used on a regular basis by staff who had not received training around how to do this safely. Mechanical restraints had been used throughout the service without exploring alternative less restrictive options.

Hygiene standards were not adequately maintained.

Is the service effective?

Inadequate

The service was not effective.

People were admitted to the home with no consideration to where their room would be and whether this would negatively impact other individuals in that area of the home. People did not have their needs assessed to determine if they were compatible with others who had complex needs. The registered provider did not consider how to use the space in the home to provide the most appropriate accommodation for people and did not look at whether people might need to move to a different part of the home when their needs changed.

Staff did not fully understand the Mental Capacity Act 2005. There was limited understanding of the Deprivation of Liberty Safeguards (DoLS) and what this meant in practice.

Staff lacked specialist training and knowledge to safely support people.

The environment was restrictive and people could not move freely around or access the outside or garden areas without support from staff.

Is the service caring?

Requires improvement

The service was not always caring.

People's dignity was not always protected within the service.

Promoting people's independence was not always a priority.

Staff had good interactions and communicated positively with people.

Summary of findings

Is the service responsive?

Requires improvement

The service was not always responsive.

There was a lack of stimulation and meaningful activities taking place within parts of the service.

A large proportion of the people who used the service had one-to-one support but this was used to guard people rather than to engage them in meaningful occupation.

Complaints and concerns were appropriately responded to and documented within the service.

There was positive involvement of partnership working with local commissioners.

Is the service well-led?

Inadequate

The service was not well led.

We found the registered manager failed to provide information to ourselves and others when requested. We found there was a lack of comprehensive oversight of the service and a lack of awareness of the risks this posed.

The evaluation of accidents and incidents within the service was difficult to understand and it was hard to determine who the information related to, what action had been taken and if there were any lessons learnt for the registered provider and the service.

Staff told us they felt well supported working at the service.

Phoenix Park Care Village

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 registered 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 unannounced inspection took place on 17, 25 and 28 September 2015. The inspection team consisted of five adult social care inspectors, one inspection manager and a specialist advisor who specialised in medication and dementia related conditions. We also used 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. In this inspection, the expert-by-experience was knowledgeable about the use of services for people living with dementia and age related conditions.

Before the inspection took place we reviewed the notifications of incidents that the registered provider had sent us since the last inspection. We also contacted the local authority's contracts monitoring team, adult safeguarding team and health and social care professionals to gain their views about the service. People from those agencies told us given the size of the service they felt people were generally well cared for.

We also spoke with 21 people who used the service, 15 relatives, 19 staff members who worked at the service, four professionals who visited the service and the registered manager. We spent time observing the interactions between people, relatives and staff in the communal areas and during mealtimes. We looked at all areas of the service including peoples' bedrooms, kitchen, dining area, bathrooms, laundry room, and the outdoor space on both Overfields and the Hilltop unit.

We spent time reviewing records at the service. This included 12 care records, six staff recruitment files, staff rotas, training records, accident and incident records, medicine administration records [MARs],and policies and procedures in place at the service. We also spoke with staff about their experience of working at the service, the induction training and on-going training. We used a number of different methods to help us understand the experiences of the people who used the service. We used the Short Observational Framework for Inspection [SOFI] in two communal areas. SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

Some people and relatives we spoke with told us they felt the service was safe. One person told us, "When you're in a home like this, you're no longer in a cruel world. They care for me and look after me." A relative also told us, "I can leave here quite happy knowing [my relative] is happy" another said, "Staff are very caring and respond when there's any problems; I think my [relative] is safe." However, one person who used the service told us, "I like my room, It's a lovely room, but [name] comes in and he pulled my curtains down. I'm very frightened you see." A relative also told us, "I'm not happy with some of the things that go on here but I don't want to rock the boat or make a fuss while my [relative] still has to live here."

Although the registered manager had notified the appropriate agencies and people about incidents during the inspection, we found incident records held within the service contained more details about the events than what had been submitted to CQC and the local safeguarding team. This meant that many of the alerts submitted to agencies had not been further investigated or had been deemed as low level incidents based on the detail and content provided. If more explicit content had been submitted alternative action and further investigations may have taken place. We also found that information about the registered provider's investigation and any steps taken to reduce the risk, were not available during the inspection.

One of the incidents we reviewed was from July 2015 and involved two people who used the service at Hilltop assaulting each other. In the documentation sent to the local authority safeguarding team the information stated both people were separated, checked by nurses and appropriate people informed. However, on the behaviour incident charts kept at the service the incident stated three staff members had to intervene to diffuse the situation and separate the two people involved.

On another incident that occurred on Hilltop in June 2015 involved two people who used the service assaulting one another. The details submitted to the local authority safeguarding team stated the individuals were separated. However, the notification does not provide detail of clarity into how the individuals were separated by staff, what techniques were used and how long the incident occurred for.

We looked at the behaviour monitoring chart for one person on Hilltop who had also been involved in an incident dated July 2015. The details documented in the record stated, "The carers safely restrained him." This wording was not included on the alerts made to the local safeguarding team or on the notification submitted into the CQC. There was no detail into what this restraint consisted of, how long the incident had occurred for and how staff knew this was safe when accredited physical interventions training had not been completed by all staff.

We were told the registered provider and registered manager had not actively supported the police to gather evidence. We were informed by the registered manager that they were initially unaware of the current police investigation albeit the incidents had occurred in the home. We were concerned about the lack of co-operation displayed to other bodies and also during the inspection process.

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

Since April 2015 the local authorities safeguarding team has received alerts for 43 incidents that have involved people using the service at Phoenix Park Care Village. Twenty one of these have been assessed as low level incidents and have been closed resulting in no further investigation. The local authority safeguarding team used the information submitted by the service to determine if any further investigations were required. Based on the information submitted, the safeguarding team did not progress the incidents described further.

However, if more accurate details of the incidents had been provided, the safeguarding team have since informed the Commission these would have been investigated by themselves. The local authority safeguarding team have been regularly visiting and monitoring the service in the last month due to the number of concerns raised by relatives of people living at the service and amount of alerts which have been submitted.

Most of the staff we spoke with in Overfield's and Hilltop could describe some signs of possible abuse and ways to report safeguarding concerns. However, we saw that when

concerns had been raised about staff behaviours and practice the registered manager was unaware of this and the registered manager was also unaware of why a recent police investigation was initiated at the service.

We spoke to some newly recruited staff on Hilltop who told us they had not completed safeguarding vulnerable adults training since commencing their role. The training matrix dated September 2015, provided by the registered manager, showed us that 55 out of the 157 staff working at the service had not completed safeguarding adults training. The new members of staff we spoke with were unsure if safeguarding training was part of their induction or a separate course offered by the service. One staff member told us that they were given a workbook after their two day induction which they had to work through within 12 weeks of starting at the service. The staff member told us they had only managed to complete a few pages of the book so far. This member of staff told us they commenced their role in June 2015. We asked the member of staff if they had a mentor to support them to which they told us, "No I don't have one."

This was a breach of Regulation 13 (2) and (3) (Safeguarding services users from abuse and improper care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The incident records we reviewed on Hilltop contained brief content with limited analysis of the incident and did not identified clear actions to be taken. The lack of information made it difficult to establish any triggers or patterns of behaviours which may be occurring. The physical interventions staff had used had not been comprehensively documented to ensure these were detailed, followed good practice and were not used unlawfully.

Staff and the registered manager told us they did not use physical interventions when supporting people who might be challenging. However, incidents records and behavioural management charts we looked at showed staff had documented they had 'separated people' and 'safely restrained people.' We looked at the staff training records for all staff working at the service, which was provided by the registered manager. The records did not confirm that staff had undertaken any accredited training regarding the use of physical interventions. The registered manager told us, "Most of the staff at Overfield's have completed the physical intervention training and a handful of staff at Hilltop have done this."

A staff member on the Overfields unit told us, "I completed break away & restraint training recently which was very helpful." Two staff members we spoke to on Hilltop told us they had not completed physical interventions training but said they were booked to do this in the next few months.

During the inspection we requested a copy of the physical interventions training and course content. We were given a leaflet but this did not detail the content or confirm the training was accredited as recommended by the Department of Health. When we spoke to the registered manager they could not confirm if the training being completed by staff was accredited as recommended.

This was a breach of Regulation 13 (4) (b) (Safeguarding services users from abuse and improper care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked the recruitment files for six of the staff working at the service. The files contained completed application forms, two references, and appropriate checks made with the disclosure and barring service [DBS]. A DBS check is completed during the staff recruitment stage to determine whether or not an individual is suitable to work with vulnerable adults. However, one staff file we checked showed that their DBS contained a warning from Humberside Police for an incident which had occurred involving a serious assault. We also saw that one of the references was negative and the referee would not recommend the person for employment as they had a poor ability to demonstrate a patient and caring nature. They were also rated as 'poor' in term of honesty and integrity.

When we asked the registered provider about the recruitment and how they had assessed this risk, they told us the person came highly recommended from a relative who already worked at the service and did not feel it was a risk to employ this person. The staff member has since been dismissed by the registered provider, this was not in relation to poor practice. We found there were no risk assessments in place for the staff member or protocols

available to support the registered manager to make decisions around whether to employ people with convictions. This showed us that safe recruitment practices were not always followed at the service.

This was a breach of Regulation 12 (1) (Safe care and treatment of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that 11 people within the Hilltop unit had safety gates fitted to their bedroom doors. The risk assessments in place to support the use of these gates were generic and not specific to each individual. The gates were of different styles and sizes. Although the risk assessment detailed how the gates were to be managed during a fire and this was documented in people's personal emergency evacuation plans [PEEPS], there was no other information provided such as consent to have the gate installed or the possible risks of falling over the gate.

The staff we spoke to told us the people who used the service or their relatives had requested the use of the safety gates, as it made them feel safe from others trying to get into their rooms. We looked at an incident record for one person from July 2015 which recorded a sexual incident involving two people who lived at the service. One of the outcomes documented from this was to purchase and install a safety gate, which was in the person's best interest. We asked staff if they had explored alternative methods such as alarms or pressure pads rather than this type of mechanical restraint. The registered manager and staff were unsure of what less restrictive alternatives were available and could not give a response.

We saw vulnerable people in Hilltop were living in bedrooms at the end of corridors, which were not readily observed by staff and adjacent to people who were not under supervision, but prone to displaying disinhibited behaviours. We saw that in Hilltop and Overfields there were specific enclosed units for vulnerable people with nursing needs and for people who experienced violent and disinhibited behaviours. However, people with similar needs and vulnerabilities were also placed randomly outside of these units. We could not establish why this had occurred or how staff had considered the presenting risks prior to offering a person a particular bedroom. We found that no action had been taken to see if an alternative location in the home would reduce the risks and allow individuals to feel safer when in their bedroom.

We found that cleanliness and hygiene standards were poor within some areas of the service. We saw in the Overfields unit there were some unpleasant odours on the first day of our inspection and the unit looked in need of a deep clean. We looked at the cleaning schedules for Overfields which did not demonstrate robust recording or documentation to confirm which rooms had been cleaned. On the schedules we looked at dated 21 September 2015 and 22 September 2015 staff had recorded they did not have time to 'deep clean'. A member of staff told us they did not have any cleaning records for August 2015 as the, "Folder got wet and damaged and we now don't know where they are." A member of the house keeping team for Overfields told us, "On my induction I was shown a cleaning schedule for every day, but since I've started I do not have any paperwork to fill in, I just know which rooms I've done." Another staff member told us "If I didn't have to cover the dining room it would help me keep the cleaning up to date more thoroughly by doing 'deep cleans'."

One the first day of our inspection we saw that the Overfields laundry room had a mesh type material covering the vent on the door. This material had worn away in places and we saw what appeared to be rodent droppings in this area. We spoke to staff about this who confirmed they would report this as a maintenance issue. When we returned on day two of the inspection we saw the maintenance request had been recorded but was still waiting to be actioned.

On the first day of our inspection we also saw that a mattress, bicycle and two chairs had been stored under the fire escape stairs in Overfields, which presented a fire risk. We pointed this out to staff and these items had been removed when we returned on the second day. On day two of our inspection we saw that three drain rods had been left in the garden area of Hilltop. We also noticed the wooden seat of the swing was broken, loose planks of wood had been left in the garden and a wooden garden chair was also broken and had no legs on it. These items could have been used as objects to attack people with or use as missiles if service users had found them.

A visiting professional told us, "My client's room is often dirty and I have had to help clean it up before their [relative] visits." A relative of someone living at Hilltop told us they had concerns about the standards of cleaning. They told us that every day they had to clean the bedrail protector of faeces for their loved one. When we went to

look at the room it had just been cleaned by the domestic staff and appeared clean and fresh. The bed had been made with clean linen, however on closer inspection the bed rail protector was smeared with faeces. We brought this to the attention of a nurse on duty who confirmed this was the job of the care staff and they would address this.

We saw that the bistro area in Hilltop had a radiator cover which was very dirty with old ingrained food on the grill. We also saw large amount of bread had been pushed through the grill and not been cleaned. A wall in this area was also badly marked with food spills. We also found one of the work surfaces in this area had a section that lifted up and contained a rubbish bin underneath. This area was extremely dirty with congealed and dried food waste which appeared to have been there for some time. The bare chipboard under the work surface was also covered in large amounts of food spillages, which could not be cleaned effectively. We brought this to the attention of the registered manager who immediately asked staff to clean this area.

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

We received a number of mixed comments regarding staffing levels at the service. These included, "Occasionally, they are so busy I get forgotten because my room is in a corner", "There's not enough staff, but there never is in any home", "There's not enough staff. They all seem very stressed out." A staff member told us, "Staffing levels are sometimes tight due to sickness or absence but on the whole it's ok." One professional who visits the service told us, "There is a lack of staff on duty; staff from Overfields are constantly covering at Hilltop."

On the second day of our inspection the first floor unit were running short of staff due to two people being taken to hospital and staff going with them to provide support. We observed a period of over one hour between 14.50pm to 16.00pm when a group of five people with complex needs were left unsupervised in a lounge area for the majority of time. We observed two occasions when staff came to briefly check the room and then left. We discussed this with the registered manager who told us the service did not use agency staff and relied on the current workforce, which included bank staff to cover and do extra shifts.

We saw on the Hilltop unit there was a lack of stimulation and interactions for people using the service. We saw that twenty four people using the service were supported by staff on a one to one basis, but we observed very little conversation or meaningful activities taking place between these people and staff. We saw from incident records that incidents were still occurring when people were supported on a one to one basis. For example, one incident we looked at dated August 2015 showed that a staff member was completing their one to one notes when the person they were supporting walked passed them and proceeded to attack another person who used the service.

Our observations of the Hilltop unit found people were watched by their one to one support member of staff whilst they were sleeping. Feedback from relatives told us that they would like to see more activities going on within the service. After day one of our inspection one relative told us, "I was extremely shocked when I entered the reception area of the home today. A carer was sitting and playing cards with some of the residents. I then witnessed the carer interacting with residents by reading a book to them." The relative went on to say that they felt the activities taking place were staged for the CQC inspectors as normally the people who live in the home receive no stimulation of this kind and they are normally left just to sit all day.

The only consistent stimulation we saw came from either the TV being on or music playing. We did observe dominos being played in Hilltop on two occasions with one staff member and three people who used the service, which was positive. The registered manager also confirmed that the service did not employ an activities co-ordinator as this role was for all the staff to undertake. However, one staff member told us, "We don't have time, personal care is the priority and activities are left for the afternoon staff." Some staff also told us that they felt activities training would be useful.

This was a breach of Regulation 18 (1) (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found medicines were ordered and stored appropriately. The service used the Bio dose system for administering medication and we found the system to be comprehensive. The recording of medicines were done in line with current guidance and only the registered nurses administered the medicines. We saw on the first day of our inspection that an amount of controlled medicines were

Inadequate

Is the service safe?

being stored at the service although the people they were prescribed for had died some months ago. When we spoke to the nurse and senior carer about this, they informed us that the service did not currently have a supply of destruction 'kits' that they used to safely destroy and dispose of the controlled medicines. When we inspected on day two we saw that these drugs had been safely disposed of and documented in the correct way.

We found the service had completed all the appropriate checks regarding the maintaining of equipment and health and safety checks within the service. We saw that checks were carried out and documented within the service for equipment including hoists and wheelchairs, fire doors, emergency lighting, water temperatures, window restrictors, fire doors and call bell system. We saw cleaning trolleys were locked and secured when they were not being used or supervised and we saw individual risk assessments were in place for people regarding falls, mobility, nutrition and pressure damage. However, we did see on day two of our inspection that one of the cleaning cupboards had been left unlocked whilst the housekeepers were cleaning peoples' rooms. This cupboard contained disposable gloves and cleaning equipment. We spoke to one of the housekeeping staff about this who confirmed the cupboard should be kept locked at all times and locked the door immediately.

The service introduced a policy regarding the storage of disposable gloves following a serious incident that occurred involved the death of someone who lived at the service. The policy stated that all disposable gloves should be kept out of peoples rooms and in a locked area. However, during our inspection we saw that a box of disposable gloves were located in a person's bedroom where the door was left open for anyone to access. A relative also told us "My [relative] always has gloves in their room. I know they're not supposed to but staff normally store them on the window ledge." This meant that the registered provider was not ensuring their own policies and procedures were implemented safely.

Inadequate

Is the service effective?

Our findings

A relative told us, "I don't think the nurses have the skills or knowledge to deal with [my relative], however, the care is good now and I have no intention of moving [relative] elsewhere."

Most of the staff we spoke with told us that they had completed training in the Mental Capacity Act [MCA] 2005. MCA is legislation to protect and empower people who may not be able to make their own decisions, particularly about their health care, welfare or finances. However, staff were very unclear about what action they needed to take to ensure the requirements of the MCA and guidance from the MCA Code of Practice were followed. The training records we looked at from September 2015 showed that 53 staff out of 157 had not completed MCA / Deprivation of Liberty DoLS training.

Staff and the registered manager told us they had completed capacity assessments but when we explored these we found staff lacked the skills and knowledge needed to complete them. The staff we spoke with in the Hilltop unit told us that some people had capacity to make decisions about the use of stair or safety gates across their bedroom doors.

However, when we discussed this with the people using the safety gates we found that they were either confused or unaware that the safety gates were in place; some people could not remember why they were being used; some people did not understand what the consequences would be for them if there was a fire; and some could not remember agreeing to them being used. Some people who used the service also had impairments of or disturbance in the functioning of the mind or brain, which would suggest that they did not have the capacity to make this decision. The MCA requires that a person must be able to understand, retain, use and weigh information to reach a specific decision. The staff we spoke with were unaware that these checks formed part of a capacity assessment.

Some staff we spoke with were unaware of the principles of the Mental Capacity Act 2005, among which are the presumption that people have capacity unless there is evidence that they cannot make a certain decision even with all possible help, and that people can make unwise choices unless there is evidence to show the individual lacks capacity. Some staff we spoke to were unaware of the overriding principle of the MCA, which is to ensure people who lack capacity are cared for in the least restrictive way. Some staff told us that even when people had capacity they prevented them from going out by themselves. They could not produce supporting evidence to show that people with capacity had agreed to this restriction. We saw limited evidence of best interest documentation within people's records and therefore requested further examples of 'best interests' decisions being made within a multi-disciplinary team framework. We asked on numerous occasions during the three day inspection, however did not receive any further documents or examples to support this.

We saw some relatives were consulted or made decisions for people who used the service but some care records did not to show whether relatives had become Court of Protection approved deputies, or if they had powers of attorney for care and welfare or finance, or if they were appointees for the person's finance. Relatives cannot make decisions about care and welfare unless they have the legal authority to do so and the person lacks the capacity to make these decisions for themselves. Staff were unaware that even when there are appointed deputies or attorneys they cannot make decisions around the withholding of treatment. The registered manager and senior support worker told us this was an area they were working on across the service and had requested information from relatives.

We saw that some of the care records we looked at for Hilltop and Overfields did not contain signed care plans and we found that photographs of people's pressure wounds had been taken without signed consent or consideration for best interest discussions. Two of the care records we looked at had Do Not Attempt Cardio-Pulmonary Resuscitation [DNACPR] in place, but the files did not contain capacity assessments, best interest meeting records or review documents to support this was still appropriate.

The recording of incidents within the service documented that staff were 'separating' and 'safely restraining' people from situations that had occurred. However, the records we reviewed did not detail the length of time the incidents and physical interventions had taken place, there was a lack of body maps detailing how people had been held or separated by staff. Staff were not clear on the decision making around when to use this support, how many staff needed to be involved and the detailed recording

necessary for such interventions. If restraint as defined in the MCA is used which includes restricting someone's freedom of movement whether they resist or not documents should detail this as defined in the code of practice. Records should clearly demonstrate that the least possible restraint for the shortest time possible had been used. It was also unclear if consent had been gained from people or best interest processes followed for such interventions to take place.

This was a breach of Regulation 11 (3) (Need for consent) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed the Deprivation of Liberty Safeguards [DoLS] authorisations that were in place at the service. DoLS are part of the MCA and ensure people in care homes and hospitals are looked after in a way that does not deprive them of their freedom unless it is in their best interests, and that, if they are deprived of their liberty, they can challenge this.

We found that staff had put DoLS application forms into 65 people's folders. However, on closer inspection we found that this information did not match with the applications that had been made to the local authority supervisory body and only 16 of these standard applications had been approved. Seven of these authorisations had lapsed. We found that the registered manager had followed up these lapsed authorisations and DoLS applications up with the supervisory body. However, we found that staff believed that the presence of an application allowed them to deprive people of their liberty. Staff did not understand the actions they needed to take to ensure people were cared for in the least restrictive environment. We found that most of the issues regarding incorrect understanding of DoLS applied to the Hilltop unit. We found that DoLS and guardianships within the Overfields unit were in place and had been maintained.

We saw that the registered manager had applied for DoLS authorisations for three people who used the service who had been assessed as having capacity. We found that staff and the registered manager had not considered this to be inappropriate or that it was illegal to detain people who have capacity. We found that some people did have difficulty making decisions; were under constant supervision; and prevented from going anywhere on their own. Staff did not know whether these people were subject to DoLS authorisations, but despite this had maintained the same level of restriction. We found that staff applied restrictions to virtually everyone who used the service regarding leaving the home unaccompanied. None of the staff we spoke with could tell us how they ensured the service took action to make sure people were subject to the least possible level of restrictions or show us evidence that those people with capacity had agreed to these restrictions.

This was a breach of Regulation 13 (5) (Safeguarding service users from abuse and improper treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff we spoke to and observed on the Overfields unit appeared to have a good knowledge and understanding of the needs of the people they were supporting. Staff told us, "There's always training on offer and it's really good."

We spoke to two newly recruited staff working on the Hilltop unit who had limited understanding of whistleblowing, MCA and DoLS. Both staff confirmed they had yet to complete training in these areas. We looked at the induction for newly recruited staff and spoke to the registered manager who told us, "New starters shadow experienced staff for two days and should not be part of the rota or undertake one to ones."

During our inspection we saw that one newly recruited member of staff was undertaking one- to- one duties. We saw this person was completing records of the one to one observations for the person they were supporting. We spoke with the member of staff who confirmed it was their first day of induction at the service. They explained they had undertaken two hours of induction which covered looking at the first floor facilities in the Hilltop unit and the fire procedures. The member of staff told us, "It's my first day and I am doing a one to one with [person name]." We asked them what a one to one involved and they explained, "I sit and observe and write down what [name] does." We asked them if they had read the care records of the person they were supporting to which they responded, "No I have not seen the care plan, but they have told me [person name] can be aggressive." We then asked the member of staff what they would do if an incident occurred. The member of staff said, "I would try and calm [person] down, but I'm not sure."

From speaking with staff it was evident that they had received limited training in supporting people with

Is the service effective?

specialist conditions including mental health and associate conditions such as Asperger's and Autism. The staff we spoke with said they would welcome more training on the different conditions the people they supported have. We found some staff working in Hilltop had not received accredited training in safely supporting people with physical intervention techniques. However, incident records documented that staff were 'separating' people and 'safely restraining' them without appropriate training or reference to the MCA code of practice. This showed us that some members of the staff team at the service had not received the appropriate training to support people safely and minimise the risks to themselves and others.

This was a breach of Regulation 12 (1) (Safe care and treatment) and 18 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the Hilltop unit we saw that limited therapeutic activities took place and lots of people were sat around the unit in areas that contained no windows or limited natural light or ventilation all of which promote good mental health. The environment was not stimulating and was neutral in colour and did not promote a dementia friendly environment. We found that most of the areas within the service were restricted by locked doors and key codes and even access to the outdoor secure garden was via key coded doors. Lots of people we observed were sat in chairs sleeping or without any means to entertain themselves.

Staff told us they received regular supervision approximately every two months and received an annual appraisal. Staff also felt they could discuss any issues they had. We checked the supervision records which confirmed when they had taken place, what was discussed and any further actions. The records also showed that 60 second learning was discussed during supervision which covered a range of subjects including whistle blowing, checking rooms, making beds and absconding.

Staff told us communication between staff and shift changes was good. The communication we observed between staff and people using the service appeared kind and caring. However, we saw that people being supported on a one to one basis were often not involved in conversations with staff and interactions between staff and people being supported on a one to one basis were very limited.

We observed that people were offered choices of hot or cold drinks over the lunchtime period. One person told us, "I don't see a menu but I enjoy the food". Another person said, "The food it's just like my mother cooks, honestly, the flavour and everything". A relative told us I've never seen anyone get asked what meal options are available. We spoke with a staff member who said "There is always choice and options offered. If someone doesn't like what is being served we will always offer an alternative."

The food offered appeared appetising and well presented. We saw that a range of hot and cold meals were offered and provided. One relative told us, "The food is excellent, first class; there is always plenty of choice." People had evidence within their care records that health professionals were involved and provided input when required. We saw people were involved with continuing healthcare nurses, occupational therapy, GP's and speech and language therapists.

The premises offered ample communal spaces and nicely designed outdoor space although during our inspection there were very few people supported to access the outdoor areas. The games room for Hilltop was well equipped, however during our three day visit we did not see this facility being used.

Requires improvement

Is the service caring?

Our findings

People told us the staff were kind and treated them well. One person said, "I'm very happy here and the staff are nice and kind." Another said, "Anything I want they try and deliver." A relative also told us, "The staff are very friendly and quick to help in any way they can" another said, "I trust the staff implicitly."

Despite these positive comments we found staff did not always protect people's dignity and recognise when this may be compromised. During our inspection we observed that a number of people were asleep or at rest within their rooms with the doors left open. We saw one person was asleep on their bed and was lying in a position which compromised their dignity by exposing their underwear. The staff we spoke with accepted it was quite undignified for the individuals asleep in their room to have their doors open whilst people were able to observe them. However, they took no action to close people's bedroom doors until we asked them to do so. On return to observe another area of the service within Hilltop we noticed that the room door of the same person asleep had been left open again.

On another occasion again within the Hilltop unit we saw that one person in an upstairs lounge was sitting in a position which exposed their bare legs and continence pad. We spoke to staff about this and staff went to get a blanket to try and cover the person up. The person clearly did not like being covered by the blanket and removed it immediately. We then spoke with staff about the possibility of exploring different clothing options to protect the person's dignity however one member of staff was adamant that the person should be able to wear the clothes they had always preferred. Staff had not considered consulting with this person's family about different clothing options to protect their dignity.

During day two of our inspection we observed there was a strong odour of faeces in the upstairs lounge on Hilltop. We brought this to the attention of the support staff who proceeded to walk around the lounge smelling each of the people in the room. Once the staff member had identified who required support with personal care they sat down and stated the girls would be round to toilet soon. We asked the staff member what times this took place and they confirmed it happened between 11am – 12.30 midday and 2pm – 4.30pm. We noted that the person requiring personal care support was still waiting for assistance 10 minutes after we had raised this with a staff member. We then left the area to inspect other parts of the service so we are unsure how long this person had to wait until support was provided.

A relative told us when they visited the service they often saw people walking around with their trousers undone, upper clothing garments removed or without any shoes or socks on. During our inspection of Hilltop we saw that seven people were walking around with only their socks on and another two people had bare feet. We spoke to the registered manager about this who said they weren't sure why this was happening and they would check to see if people were wearing slipper socks.

On the Hilltop unit there was a lack of signage and colour used to assist people living with dementia to navigate around the service. We saw limited opportunities from staff encouraging people to promote their physical independence and overall wellbeing. People living in Hilltop were not encouraged to assist with meaningful activities including light domestic tasks, preparing the dining areas for meal time or assisting with making drinks. The Overfields unit did encourage people to get involved and participate if they wanted to. However, we also saw that one of the kitchen areas had a sign on the door saying 'keep locked'. We spoke with the team leader about this who confirmed it was probably being too risk averse and immediately removed the sign.

During our observations of Hilltop we saw one person was sleeping and a staff member approached the chair they were sleeping in and gently woke them up to give them a drink. We were unsure whether it was necessary to wake this person up to give them a drink. We also saw another person was given a drink of blackcurrant squash without being asked if they would like one or if they would prefer something different.

During the second day of our inspection in the Hilltop unit, we saw one person who used the service shouting out and becoming quite agitated. A staff member asked the person if they would like to watch TV or listen to music to which the person replied music. The person then started to sing old songs and appeared very happy with other people joining in After a few minutes we saw another member of staff put on a CD of modern music quite loudly, which immediately stopped this person singing. The member of staff did not ask anyone if they wished to listen to this music or give thought to activities already taking place.

Requires improvement

Is the service caring?

This was a breach of Regulation 10 (Dignity and respect); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw some positive interactions between staff and people who used the service in both the Hilltop and Overfields unit. We saw staff addressed people using their names and we observed staff spoke with a gentle and compassionate tone. Some staff also came down to people's levels and made eye contact when speaking to them.

We saw evidence that the service requested the support from local advocacy networks when required. The registered manager told us relatives were welcomed to visit the service at any time. We saw many relatives visiting during our inspection. One relative also told us, "I can visit when I want to and they are always very welcoming."

On one occasion during our observations we saw one person who lived in the Overfield's unit became distressed, however the staff recognised this and knew what approaches to use in order to manage the situation, offered distraction techniques and the person very quickly calmed down. The member of staff was calm and caring throughout this period and clearly recognised and understood the person's support needs very well.

Requires improvement

Is the service responsive?

Our findings

The care records we looked at for both the Hilltop and Overfield units contained relevant information about people's needs, care preferences, 'getting to know you information' and their likes and dislikes. One relative told us they were kept updated with any changes to their loved one's care needs and was invited to attend reviews.

We saw some of the personal hygiene records for Overfields had not been completed and there were gaps in the recordings. We looked at a person's oral hygiene and shaving records and this showed the recording had not been completed on 13 separate occasions during the month of August 2015. There were no records to demonstrate what attempts staff had taken to provide this care and no reasons were given as to why the care had not been provided. We spoke to a senior care worker about this and also raised this with the registered manager during the feedback at the end of the inspection. The registered manager agreed that if someone refused personal care it should be documented to show what efforts staff had gone through to encourage the person to accept this.

During our observations in Hilltop we saw that for most people no therapeutic activities took place and most people were sat in communal areas or in lounges which lacked interaction or stimulation. Most people sat in chairs looking into space, sleeping and without any means to entertain themselves. We observed three separate occasions during our inspection when people were sleeping due to lack of activity. On the first occasion we observed nine people in the Bistro area on Hilltop four of which were asleep. On the second occasion we observed eight people in the upstairs lounge are on Hilltop and Five people were asleep and on the third occasion again in the Hilltop lounge area we observed ten people seven of which were asleep.

Twenty four people across both units were supported with additional one to one support, which meant that a staff member supervised them continuously for the duration of this time. Our observations of the Hilltop unit found people were watched by their one to one support member of staff whilst they were sleeping, there was little or no communication between the staff member providing the one to one and the person they were supporting and there was a lack of activity and appropriate social stimulation taking place. A relative told us, "My husband gets one to one support and I wish staff would speak with him more, he has so much experience and things to talk about but they just seem to leave him sat and they stand outside his room door."

The only consistent stimulation came from either the TV being on or music playing. We did observe dominos being played in Hilltop on two occasions with one staff member and three people who used the service, which was positive. The registered manager also confirmed that the service did not employ an activities co-ordinator as this role was left for the staff to undertake. However, one staff member told us, "We don't have time, personal care is the priority and activities are left for the afternoon staff." Some staff also told us that they felt activities training would be useful.

We looked at the activities schedule which showed on the days of our inspection activities planned included cake decorating, 'who's who' quiz and a pampering day. We saw a member of staff come round with cakes and decorations and asked people what they wanted. There was no request for people to participate or get involved in the activity. We didn't observe the other scheduled activities taking place during our inspection. One relative told us, "I don't think my [relative] is occupied enough. In three weeks they have only been in the garden and to Marks and Spencer."

There was a games room in Hilltop with a dart board and pool table, but we did not see anyone using this facility during our inspection. The weather was also very pleasant during our visits, however few people were encouraged to venture outside and enjoy the sunshine and warm weather. A relative told us, "A summer fair was held which was good but they could do more things outside and encourage families to join in."

There were very few dementia friendly activities taking place and there was no rummage boxes; tactile items for people to use; limited availability of newspapers, magazines or puzzle books for people to occupy their time with.

This was a breach of Regulation 9 (Person Centred Care); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans were generally detailed and comprehensive. Evidence of regular reviews and evaluations were documented, however some of the evaluations lacked the

Requires improvement

Is the service responsive?

detail to demonstrate improvements or deteriorations in behaviours or health. We spoke to the registered manager about this who took the advice on board and agreed to commence the reviewing of the documentation.

We observed a singer entertaining people in one of the lounges in Hilltop on the second day of our inspection. We also saw the service had organised a Macmillan coffee morning and brought cakes round for people and their relatives. People told us they had enjoyed both activities and had eaten lots of cakes too.

We looked at the complaints and concerns file which showed that any concerns raised had been appropriately investigated and outcomes recorded. Relatives told us, "If I need to raise any issues they are always dealt with." Another person told us they had to make a formal complaint about the care their loved one received. They explained they were initially not happy with the response but it was looked at again and things have improved.

We saw people were appropriately supported when either moving into the service or moving on. There were comprehensive records which demonstrated how the service worked with local commissioners and health care professionals to ensure people moving between services were supported appropriately.

Inadequate

Is the service well-led?

Our findings

Relatives told us, "The manager will always do their best to help you." "The manager is friendly and always about to have a chat." Another said, "The manager is time pressed".

During the three days of inspection a number of documents were requested from different members of the inspection team, but many of these were not provided following numerous requests. We also provided the registered manager with a list of documents we required to review on day one of our inspection, but we did not receive everything requested. We also provided a revised list of documents still required for day two of our inspection, but again some these documents were not provided or were not readily available even though they had been requested in advance. We found that the registered manager did not provide documentation in a timely way. Following the inspection we had to request further evidence using our regulatory powers, in order to complete our inspection process.

We spoke with the local police authorities who were currently undertaking an investigation at the service. They also confirmed that information they had requested had been delayed or not provided. They told us that information which related to the same incident was not easy to locate and management administration systems within the service did not appear to be accessible or efficient.

We found the registered manager and registered provider had failed to understand the need to ensure robust risk assessments were in place to minimise the severity of incidents. We were concerned to find they were unaware of allegations of abuse made at the service about the staff they had employed. Also that the registered manager adopted practices such as using mechanical restraints without consideration of the risks this posed for people or the need to ensure practice is undertaken within the MCA.

We also found that the registered manager and registered provider had failed to ensure new starters were appropriately supervised and were not placed in situations that compromised their safety. The registered manager and registered provider had failed to ensure new starters were appropriately supervise and were not placed in situations that compromised their safety. The registered manager and registered provider did not recognise people's safety was at risk due to the lack of training available to staff.

We also found that existing staff could not provide information about whether people were under sections of the Mental Health Act 1983 [amended 2007] such as guardianships or risk histories for people who had previously been subjected to sections of this Act. We found it concerning that when we asked for this type of information that the registered manager and staff pointed us to the 109 care files, as the means to obtain this. They failed to recognise this absence of readily available information meant new staff were providing care without the ability to readily become familiar with people's needs. We had discussions with new staff about the people they cared for and they told us they had not had the chance to look at the care records. These staff could not tell us what people's individual care needs were, the risks and what behaviours people might display even though some were providing one to one care for people who displayed behaviour which challenged the service or others. We found no evidence to show the registered manager took action to ensure presenting risks were mitigated.

During the inspection we requested to see how the accident and incident records were evaluated and audited for reporting purposes. The audits we were shown were not as detailed or clear as they could have been and it was difficult to determine who the information related to, what action had been taken and any lessons learned for the registered provider or service. We also requested several times, but not were not provided with evidence that the board of directors for the company had oversight of the incident management system. We could not determine if any feedback or actions plans had been passed back to the service to improve reporting, recording and service delivery and to also ensure that care practices within Phoenix Park were safe, effective or well led.

We found it of concern that the registered manager and registered provider had not recognised the need for urgent action when staff had not received physical intervention training. We discussed this with the registered manager and the impact this could have on people who used the service and this meant people were at risk from being inappropriately restrained by untrained staff.

Inadequate

Is the service well-led?

The auditing systems in place at the service to monitor and review areas such as: the environment, activities, training and use of restraint were not as comprehensive as they could have been and this meant that issues within the service had not being recognised and addressed by the registered provider. The findings of our inspection identified there was not enough management oversight and scrutiny of routines during the day in terms of staffing levels, activities, cleaning and good practice.

We found the systems the registered provider used for ensuring the service operated effectively, failed to identify the breaches in regulations. They also failed to ensure people were not subject to risks to their health and safety or to risk from others. We found the mechanisms being adopted within the home to check the practices of staff; complete needs analysis; or mitigate risk for the people who used the service and the staff were insufficient.

This showed us that the governance systems within the service were not as effective as they could have been.

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

The service and registered manager did not demonstrate a good knowledge or understanding about good practice or specialist knowledge about supporting people with learning disabilities or mental health conditions. Since the inspection and due to the level of concern at the service the registered provider has agreed to a voluntary suspension on placements with the Commission.

The staff we spoke with confirmed that they enjoyed working at the service and felt well supported. Relatives told us they were asked for their opinion of the service and were given questionnaires to complete. Some of the areas they were asked about included staff attitude, cleanliness of the service, activities available and choice of meals. The feedback analysis from 2014 stated that the key priorities were social activity and social involvement. It was unclear whether this had been achieved as there were no targets set or actions to measure progress.

There were monthly meetings for staff and separate meetings for night staff. Some of the key areas for discussion at staff meetings included best practice methods, training and general discussions. The registered provider also held monthly meetings for people who used the service, relatives and carers to encourage feedback and service improvements. We reviewed the quality monitoring analysis in place at the service which covered key areas including care and support, safety and security, activities and value for money. We found the outcomes from the analysis was to increase social activity but again there were no records to say if this had been achieved or what methods had been utilised to make the necessary improvements. We saw evidence from the records we reviewed of partnership working with local authorities and key agencies.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Activities and stimulation at the service were limited and people were not encouraged to participate in meaningful activity.** Regulation 9 (1)(a)(b)(c)(3)(e).

The enforcement action we took:
We have judged that this has a major impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The registered provider did not always ensure people who used the service were treated with dignity and respect.** Regulation 10 (1)(2)(a)(b).

The enforcement action we took:
We have judged that this has a major impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The registered provider did not always ensure that the Mental Capacity Act 2005 was implemented to protect the rights of people who lacked mental capacity.** Regulation 11 (1)(3).

The enforcement action we took:
We have judged that this has a major impact on people who use the service. This is being followed up and we will report on any action when it is complete.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Care and treatment was not always provided in a safe way. Systems to support infection prevention and control were not always effective.** Regulation 12 (1)(2)(a)(b)(c)(h).

The enforcement action we took:
We have judged that this has a major impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The registered provider did not have adequate arrangements in place to protect people from harm or abuse.** Regulation 13 (1)(2)(3)(4)(b)(5)(7)(a)(b)

The enforcement action we took:
We have judged that this has a major impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The management systems in place at the service were not as effective and robust as should have been.** Regulation 17 (1).

The enforcement action we took:
We have judged that this has a major impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The registered provider had failed to ensure staff were appropriately trained to support people in a safe way.

Regulation 18 (1).

The enforcement action we took:
We have judged that this has a major impact on people who use the service. This is being followed up and we will report on any action when it is complete.