Barchester Healthcare Homes Limited

The Mount & Severn View

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 24 August 2017 and was unannounced. At our previous inspection, in February 2015, no improvements were identified and we had rated the home as Good. At this inspection we have changed the rating to Requires Improvement.

The Mount & Severn View is a nursing home. It provides accommodation with nursing and personal care for a maximum of 58 people. On the day of our inspection 55 people were living at the home. People's bedrooms are over two floors and these are accessed by stairs or a passenger lift. There is a six bedded wing dedicated to the care of people living with dementia within the home called the Memory Lane unit. People have access to communal areas within the home and access to the home's gardens.

The registered manager had retired the day before our inspection. The provider had already moved a registered manager from another one of their homes and they had applied to become registered manager at The Mount & Severn View. They are referred to as the new manager in this report. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People, relatives and staff all expressed concern to us about there not being enough staff at the home. People's call bells were not always answered in a timely manner because staff were helping other people. This had impacted on people's dignity, safety and the way in which staff were able to meet their needs when they needed help. Improvement was needed to make sure staff were always available to support people when they needed it.

Managers were not aware of staffing concerns or the effect this had had on people and their dignity. People's needs were assessed to establish how many staff were needed, but this had not been effective in ensuring people received support when they needed it.

People could be at risk of not having their right to make their own decisions upheld. Staffs' knowledge about how to support people who did not have capacity to make their own decisions was good. But the records of the processes they had to follow did not reflect this level of knowledge.

People and relatives had opportunities to give feedback about the service provided. Relatives who raised concerns informally did not always feel these had been resolved. The provider had a complaints policy in place, which people and relatives were aware of. Complaints were investigated and responded to, in a formal manner, as per this policy.

People and relatives thought staff were well trained and understood how to support them. Staff had received training to give them the skills and knowledge needed to support people's individual needs. Some

staff felt they needed more specialised training to help them understand people's health conditions better. Training had already been identified for this to happen.

Staffs' experience of the support they received in their roles was varied. Some staff felt involved in what happened at the home whilst others did not.

Staff had received training in and understood how to protect people from any avoidable harm and abuse. Staff knew how to and were confident in reporting any concerns they may have about a person's safety. However, managers told us they had not been made aware of staff concerns about staffing levels.

People continued to have their health needs met. People had access to a range of healthcare services, when required.

Risk to people had been identified and assessments reflected how care should be provided to the person to minimise any risks to them. Staff knew what they needed to do to help reduce risk to people and keep them safe.

People were supported to take their medicines when they needed them. Medicines were stored safely and the processes in place helped to make sure they were managed safely.

People felt they had good relationships with staff and that staff respected their privacy. They were happy with the care and support they received and gave praise and positive comments about the staff at the home.

Systems were in place to assess and monitor the standards of care delivered at the home. The standards of care were assessed against our key questions. Action plans identified areas for improvement but had not identified the concerns we found at our inspection and what people, relatives and staff told us about the staffing levels.

The management team were receptive to our feedback and kept us updated on the improvements they planned to make after our inspection.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which relates to the staffing at the home. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.
There were not always enough staff to safely meet people's needs. Staff had been trained to protect people from harm and abuse and knew how to report concerns. People were supported to take their medicines when they needed them.

Is the service effective?

Requires Improvement

The service was not always effective.
Staff respected people's right to make their own decisions and supported them to do so. When some people could not make their own decisions about their care their records were not clear on why or how the decisions made were in their best interests. Where required, people were supported to eat and drink enough and access healthcare from other professionals.

Is the service caring?

Requires Improvement

The service was not always caring.
Staff were kind and caring but there were occasions when people's dignity was compromised due to there not being enough staff. People felt involved in their own care and treatment and had positive relationships with staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.
People received the care they needed but this was not always delivered in a way that was personal to them because there were not always enough staff. People and relatives had opportunities to give feedback and make complaints but did not always feel their concerns were resolved.

Is the service well-led?

Requires Improvement

The service was not always well-led.
People were positive about the support they got but felt there was not enough staff around when they needed them. Staff did not always feel involved in, supported or kept up to date with what happened at the home. Systems were in place that monitored the quality of the service provided.

The Mount & Severn View

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection visit took place on 24 August 2017 and was unannounced.

The inspection team consisted of two inspectors and one 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.

The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We also reviewed information held about the service. We looked at our own system to see if we had received any concerns or compliments about the home. We analysed information on statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We contacted representatives from the local authority, Clinical Commissioning Group and Healthwatch for their views about the home. We used this information to help us plan our inspection of the home.

During the inspection we spoke with 18 people who lived at the home, six relatives and three visitors. We spoke with 14 staff which included the housekeeper, the chef, care staff, senior care staff, nursing staff, the deputy manager, regional director and the new manager. We viewed care records for three people which included assessment of risk and administration of medicines and five records relating to consent. We also saw three staff recruitment records and records relating to how the service was managed.

We observed how people received care and support in the communal areas of the home and how staff interacted with people.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, we rated this key question as good. At this inspection, we have rated this key question as requires improvement. This is because we found there were not always sufficient staff to safely meet people's needs.

People told us there were not always enough staff to meet their needs. They spoke about feeling "helpless" and often lost their dignity whilst waiting for help. One person said, "There is not enough staff on duty. It is not their fault. Whilst I am waiting they are looking after someone else." Another person told us they had rung their bell for their medicine that morning but they did not get it when they needed it. They said, "They just don't bother. They are running around all the while, they are short of staff. Answering the bell varies from 10 minutes to 40 minutes. Dementia is the main thing here and it takes all of their time" Relatives we spoke with also shared their concerns with us about there not being enough staff.

Staff told us that they felt there were not always enough staff for them to offer safe and effective support. Staff spoke about the allocation of staff across the home and that they were "spread too thin". One staff member told us, "Staffing issues make the job harder. Some paperwork gets rushed also." Care records for some people were kept on the home's second floor. Staff had to leave the floor they were working on to complete these records. This further added to staffing problems. Another staff member said, "Some days are better than others. We have not got the time we should have. We rush to get things done."

Staff told us that one member of staff worked on the Memory Lane unit. They considered this to be inadequate. In the Memory Lane unit we saw that at least two people's support plans identified they needed to be supported by two staff when receiving care. Staff told us how they had to leave the Memory Lane unit and find a staff member from another area of the home to help them with this. As a result, people were kept waiting for their care and this would then leave the other areas of the home short a staff member.

Managers confirmed they used an assessment tool for establishing the ratio of staff to people at the home to safely meet their needs. The number of staff on each shift had been determined by this assessment tool and managers told us they had not been aware of any concerns relating to staffing. Staffing was arranged based on the dependency tool. The new manager, deputy manager and regional director told us they would look into this as a priority.

We found the lack of staff had an impact in all areas we looked during our inspection visit. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People continued to feel safe living at the home. They told us they felt safe because they were well looked after, they had people who cared for them and they liked being there. One person said, "I feel very safe here because they give me my medication when I need it. I never feel that I am not safe." Relatives also felt their family members were safe with the staff that cared for them. One relative said, "We feel [person's name] is safe in their hands. We feel just as confident when we drive away that they will be cared for just as though we were here."

Risks to people's safety and wellbeing had been assessed and were monitored regularly by staff. Risk assessments had been completed in relation to falls, nutrition, moving and handling and skin integrity. People's risk assessments and care plans were reviewed and updated following incidents such as falls. We noted that not everyone who was in their room had access to a call bell to enable them to call for help. A staff member told us most people were unable to use their call bells because "they did not have the capacity to". We saw that risk assessments had been completed and it was identified that staff were to complete hourly checks to ensure these people's safety. Staff we spoke with told us that because they constantly walked the corridors these checks were completed more frequently. We heard two people who had been assessed as not being able to use their call bells shouting for help. No staff were available to help them because they were supporting other people in their rooms. We saw the new manager and asked them to find staff to help the two people, which they did. One person, who was in their room, told us they did not know where their call bell was. We spoke with a member of staff who told us this person should have access to a call bell and confirmed there was not one in their room. They could not tell us why this person did not have their call bell.

Staff understood how to protect people from potential harm and abuse. Staff told us the signs they would look for if they suspected a person was being abused or treated poorly. Staff told us they had never witnessed poor practice but said they would not hesitate to raise concerns in order to protect the person. They felt that senior staff would listen and respond appropriately. Our records show that where allegations of abuse had been reported the provider had taken appropriate actions and notified CQC and other organisations as required.

We asked staff how they managed risks to people and their environment. They all told us risks were assessed and measures were put into place to reduce them. One staff member told us, "We have risk assessments for everything." One staff member told us how they had assessed risks to people who smoked. They told us how they reduced the risks as far as possible and staff were clear how these risks were managed. We spoke with a person who smoked and they told us they were happy with the safeguards put in place and understood what staff had to do to keep them safe. We saw this person's care plan accurately reflected the risk assessment, meaning staff could offer safe support.

People were supported by staff who had received appropriate checks prior to starting work with them. We spoke with one new staff member about the checks that had been done prior to them starting work at the home. They confirmed that the provider had requested their previous employers to provide references for them. They told us they had not been allowed to start work until criminal checks on their background had been completed to ensure they were suitable to work with people who lived at the home. These checks are called disclosure and barring service checks.

People's medicines continued to be managed safely and people were given their medicines as prescribed. People were involved in taking their medicine and staff explained what the medicine was for. They made sure people were comfortable and had a drink to take their medicine with. Some people had their medicines stored safely in their own rooms. Staff told us that this made the administration of people's medicine very personal and easy to manage. We asked one nurse how they ensured that timings could be managed and they told us they made sure appropriate time was left between doses. Some people had to receive their medicine at an identified time each day and some people had to have a specific amount of time in between their medicines. The nurse showed us how these processes were safely managed. Administration records reflected people's prescribed medicines and these were complete and up to date. There was a procedure in place to follow if staff identified any errors or omissions. We saw that protocols in place for medicines taken as and when required, such as painkillers and the reason for people needing this medicine was recorded.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection we had rated this key question as Good. At this inspection, we have changed the rating to Requires Improvement. This is because we found inconsistencies in how decisions had been made in people's best interests.

People were supported by staff to make day to day decisions about their care and support. One visitor praised the quality of the care given by staff. They told us staff always asked people's permission before doing anything and they always talked through what they were doing and why. We saw that staff asked for people's consent before they helped them. Throughout the day we heard staff ask people, "Would you like me to help me with that" or "Is that okay for you?" People were given choices which enabled them to make decisions about what they wanted to do, what they wanted to eat and how they wanted to spend their time.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw that applications had been made in people's best interests when they could not consent to the arrangements to keep them safe. One person constantly told us they wanted to go home. We saw that a DOLS had been authorised to ensure the person's safety in remaining at the home. The provider had submitted applications to legally deprive some people of their liberty and these were kept under review. These applications were deemed necessary because some people could not consent to the arrangements to keep them safe within the home.

Staff we spoke with understood their roles and responsibilities in regards to gaining people's consent. They understood what they needed to do when people did not have capacity to make their own decisions. The deputy manager showed a clear understanding of the MCA and the principles they needed to follow if decisions needed to be made on people's behalf. We looked at records relating to people's capacity assessments and their involvement in making decisions. We found these were not clear in showing how the agreed decision had been made and were not reflective of staff's understanding of the MCA process they needed to follow. A generic pre-printed form was used, which we saw had the same outcome for every best interest meeting that took place. We spoke to the new manager and deputy manager who told us they would review all capacity assessments and best interest outcomes to make sure they were specific to each person. We looked at one person's capacity assessment which had been completed to establish if they had the capacity to use their call bell. The assessment found that this person did not have the capacity to use their call bell. However, this person told us they called for assistance, at night, with their call bell, if they required staff support. These inconsistencies prevented people from making decisions they were capable of making, meaning their rights may not be upheld in this area.

People were supported by staff who had received training to meet their specific and individual needs. People and relatives told us that they thought staff were well trained and knew what they needed to do to support them. Staff told us that training was important but they also said that knowledge of people and trust is most important to ensure effective care. Staff were clearly very knowledgeable about people's care and support needs and also their life histories. This meant that they could talk with people in a meaningful way and people responded positively to it.

Staff told us they had the training they needed and were aware that they required regular updates to keep their skills and knowledge up to date. We spoke with housekeeping and care staff who told us they liked working at the home and felt that, overall, they had good training opportunities. Nurses were supported to keep their competencies up to date and retain their professional registrations. Some staff expressed a lack of knowledge in understanding people's specific health conditions such as diabetes. One staff member said, "Training is pretty good but would like more specialist training." Nursing staff told us they shared information and training with care staff. For example, what to look for if a person had urine infection. The new manager told us they had already identified more specific training for staff in areas such as dementia care. They also would be working with another one of the provider's nursing homes to share training and development resources.

People were supported by staff to have enough to eat and drink throughout the day. People told us they liked the meals they received and one person told us how their favourite meals were regularly on the menu. One person told us, "The food is very nice." They went on to say, "You can eat whatever you like and I help myself to drinks." Another person told us "The food is lovely." We heard staff offer people a choice of what to eat and if they wanted something different this would be provided. One person did not want to eat and we saw the chef came and spoke with them. The chef offered this person their one of their favourites, eggs on toast, which they accepted. The chef told us they liked to spend time with people to understand their like and dislikes. They were also aware of people's special diets as well as any allergies people had.

Risks associated with people's ability to eat and drink had been assessed and was monitored by staff. One person had been identified at being at risk of losing weight. Staff knew they needed to encourage this person to eat and drink. When this person did not want what was offered to them at lunch time a staff member immediately offered them something they knew they would like. They also offered the person extra cheese and told them this would help to "get their weight up".

People continued to be supported by staff to access healthcare services and receive the on-going support they needed to maintain good health. People told us they had access to other healthcare service when needed. One person saw a district nurse twice every day for an identified procedure. Staff made sure the person was available for them. The person told us they were happy with the arrangement and it worked effectively to keep them well. Health care professionals were consulted when people's needs changed and referrals made where necessary. We saw one person had been referred to a speech and language therapist to check their choking risk.

Requires Improvement

Is the service caring?

Our findings

At our last inspection we rated this key question as Good. At this inspection we have changed the rating to Requires Improvement. This is because people's dignity was sometimes compromised whilst they were kept waiting for support.

People told us that staff were caring and treated them with respect. One person said "Staff are kind and they treat you nice." Despite people and relatives telling us there were not enough staff, everyone we spoke with praised the staff that supported them. They told us they were happy with the care and support they received, despite being kept waiting. People told us they had to wait far too long for staff to answer their call bell, both at night and throughout the day. People's dignity was not always upheld because of the impact staffing had on them being kept waiting for help. This had led to people becoming distressed because they had soiled themselves whilst they waited for staff to answer their call bells. One staff member said, "Some people will be kept waiting if they need the toilet. We can't always get to everyone in time."

We saw staff knock on people's bedroom doors before entering and heard them introduce themselves as they went in. Staff showed a caring and compassionate attitude towards people when they were with them and spoke to them with respect. We spoke with a staff member who was also a 'dignity champion'. They shared examples of how staff promoted and maintained peoples dignity. For example, they closed curtains, kept rooms tidy and told us they "treated people as you would want to be treated". They told us that as part of their role as 'dignity champion' they carried out spot checks to identify if people were being offered napkins and were wearing clean clothes. They told us, "Even little things like putting people's chocolate in the fridge is important." Another staff member said, "Its lovely here, very homely and staff are very helpful."

People were supported to remain in contact with people who were important to them. Two people had family members also living at the home and staff facilitated them spending time together each day. Relatives told us they felt welcomed when they visited their family members. One relative said, "There is always a cup of tea when you visit, they [staff] make you very welcome." We saw there were plenty of communal areas where relatives could visit their family member and there was also access to the garden.

People were involved in their own care and encouraged to make their own decisions about what happened to them. One person told us that staff knew them well and knew their wishes. They talked to us about their routine and told us that staff knew it well. One relative told us they had never seen their family member so "settled, happy and fulfilled". They told us their family member was kept involved in making decisions about their support and had made many friends since coming to the home. We saw staff involved people in making choices about what they wanted to do, what they wanted to eat or where they wanted to sit as they walked with them into the communal areas of the home. People were unhurried and staff made sure people understood what had been asked.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we rated this key question as Good. At this inspection we have changed the rating to Requires Improvement. This is because staff were not always available when people needed them.

People told us that staff knew and respected their wishes and preferences. Although staff provided their care the way they wanted it, people and relatives felt there were not enough staff to be responsive to their needs all of the time. One visitor said, "I think the staff are very, very good but they are so shorted staffed. They are stretched too thinly and I feel sorry for them."

Staff told us they had enough time to get to know what people's care needs and preferences were. They understood how important it was for people to receive care that was individual to them and in accordance with their wishes. However, staff also told us that people did not always receive their care in a person-centred way. This was because they were often too busy to spend the time they wanted to when they helped people. One staff member said, "People get the care they need but we can't take our time and chat with them because we're so busy. It would be better for them if we could go slower and spend the quality time with them. We get the job done, but it's not good enough." Staff acknowledged that staffing was not always organised in a way that responded to when people needed help.

Although staff clearly knew people's care needs and preferences, we found differences in the amount of social interaction people received. Away from the main communal areas of the home there was very little social interaction for people. Staff acknowledged this and told us when they were able to they would sit and talk with people who were in their rooms, but this did not happen often. One person told us, "There's not a lot to do. I just watch the television. I get a bit bored but staff come and talk to me." Another person said, "I do get out. There seems nothing to do here, but the garden is lovely and time does go by very quickly." On the day of our visit we saw different events happened in the main communal area of the home, which included movement to music, a quiz and individual activities. These were enjoyed by the people that took part and staff told us they bought people through from their rooms to participate in these events. One person said, "They always knock the door and invite me to do things but I like to stay in my room most of the time." However, away from the main communal areas there was less social interaction. We saw one person sat in the conservatory area of the Memory Lane unit alone and was not seen by staff for over forty minutes. Staff told us this person chose to spent time on the memory lane unit because they were calmer in the smaller unit. This person appeared happy and content, although the opportunities for social interaction were limited for this person as staff were not available to support this. During the day of our inspection we did not see any activities taking place on the memory lane unit.

People and relatives had opportunities to give their feedback and raise concerns about their experiences of the care they received. Everyone told us they knew how to do this. Relatives told us any concerns they had raised were informal but these had not always been resolved in the past. One relative told us they had previously raised a concern about their family member's call bell not being answered at night. They told us they had asked the previous registered manager what an acceptable amount of time to wait would be. They said, "I have not had an answer yet."

The previous registered manager completed monthly 'drop in clinics' and the deputy manager told us they did weekly 'coffee and chat' meetings. They told us that although these meetings were in place, people and relatives would pop in the office and chat with managers regularly. The new manager told us they planned to continue with these arrangements. Where complaints had been received we saw evidence these were responded to as per the provider's complaints policy. Complaints we looked at were acknowledged in a timely manner and, following investigation, the complainants were given explanations of any actions taken.

Requires Improvement

Is the service well-led?

Our findings

People and relatives gave us positive feedback about staff at the home and the support they received, describing staff as friendly and welcoming. However, they did not feel their concerns were always addressed. People, relatives and care staff agreed there were not enough staff and this had an impact on the lives of the people that lived at the home. There was not enough staff deployed in the home to ensure people were supported in a safe, dignified and responsive way for all of the time. The provider's PIR identified that the previous registered manager was aware of concerns relating to staff not answering call bells quickly and this was an area they planned to make improvement in. From our discussions with current managers we found they were not aware of these concerns.

One relative told us, "We are totally involved since [person's name] came here. They [staff] telephone us and organise meetings to suit us. They telephone us if something happens to [person's name] to find out if it's happened before. They collaborate really well and the staff have been very comforting." We asked staff about the values of the home and one staff member told us, "We treat people as we would treat a member of our family. I think the provider reflects these values. Everyone has resident's best interests at heart."

The new manager had been in post for 24 hours prior to our inspection. They were in the process of taking over the role of registered manager at The Mount & Severn View, following the retirement of the previous registered manager the day before our inspection visit. The new manager had moved from another one of the provider's homes within Shrewsbury where they had been the registered manager. They told us they wanted to share resources, training and learning between the two homes. They and the other managers present at our inspection were receptive to our feedback throughout our visit. Although they were not aware of any of the concerns people, relatives and staff raised they told us they were committed to making any improvement required.

We spoke with staff about whether they felt supported in their roles and got a mixed response from them. Some staff told us they had previously had very little support in their roles and issues they had identified had not always been followed up by the previous registered manager. Other staff told us they had always felt well supported with opportunities to discuss their personal and professional development. They told us that although staff meetings happened they were not well attended. The minutes from these meetings were not always available to show what had been discussed and agreed and changes within the home were not always shared with them. However, all staff felt positive and "excited" about the appointment of the new manager. They told us they looked forward to being involved in the positive changes this would bring.

Staff were aware of the whistleblowing procedure and were confident to use it to report poor practice. One staff member told us how they had helped to implement changes after a safeguarding incident. The provider had supported their decision and key pads had been put on the insides of units to help ensure people's safety. They had felt listened to and the changes were made to improve the quality of the service.

The new manager told us the provider was involved in what happened at the home. As identified in their PIR, the provider had already agreed to make resources available to invest in staff training and the environment

which would help to drive continuous improvement within the home. The new manager had already identified that the storage of care records needed addressing so staff were not leaving the floors to complete these.

Systems were in place to assess and monitor the quality of care provided to people and managers at the home completed checks on areas including medicines, health and safety and accidents and incidents. The provider had systems in place to support managers in areas such as clinical governance and regulation. The registered manager was supported by a regional director, who also completed quality checks on the service provided. These checks followed our five key questions and identified areas where actions were needed to drive improvement within the home. However, these systems had not identified that people, relatives and staff all thought there were not enough staff at the home. The dependency tool that was used to identify the ratio of staff required had not been effective in ensuring people's needs were met in a timely manner.

Statutory notifications have been sent to us to keep us informed of specific events that have happened at the service. The registered persons are required by law to submit these statutory notifications. These ensure that we are aware of important events and play a key role in our on-going monitoring of services. We saw the ratings from our previous inspection were displayed within the home and on the website in accordance with the required regulation.

After our inspection, the provider's regional director contacted us to inform us of the actions they had put in place to address the issues we had raised at our inspection. They told us they planned to review the needs of people against staffing levels and the deployment of staff throughout the home and make changes as required. They also told us that records relating to people's capacity to consent to specific decisions would be reviewed and updated to ensure information was clear and accurate.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured there were sufficient staff working at the home to safely meet the current needs of people. Regulation 18(1)