Elm Tree Care Home Limited

Elm Tree

Inspection report

Elm Tree Avenue
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Essex
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Website: www.elmtree.hunthealthcare.com

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16 December 2020
17 December 2020

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Elm Tree is a residential care home providing personal and nursing care for up to 46 older people aged 65 and over; and people living with dementia. At the time of the inspection, 38 people were living at the service.

People's experience of using this service and what we found
The leadership, management and governance arrangements did not provide assurance the service was well-led. Quality assurance and governance arrangements were not reliable or effective in identifying shortfalls in the service. The management team and provider did not understand their responsibility to ensure notifications relating to specific incidents and safeguarding concerns had been made to the Care Quality Commission. Relatives stated the arrangements to communicate with them were not effective. Lessons were not consistently learned to improve the quality of care for people using the service.

Suitable arrangements were not in place to ensure the safe management of medicines and this placed people at risk of harm. Information relating to people's individual risks were not always recorded or mitigated and did not provide enough assurance that people were safe. Appropriate measures were not in place to prevent and control the spread of infection. Staffing levels were not always being maintained to meet people's care and support needs

Not all staff had received up to date training and not all staff felt supported or valued. People were not always supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. People had access to healthcare services and support when needed however this was sometimes delayed and not all relatives were informed and updated about their family member's healthcare needs.

Care plans covered most people's individual care and support needs. However, further improvements were still required to ensure each person's care plan was updated and accurate. People were not routinely supported and encouraged to take part in social activities.

Staff were recruited safely. People's comments about the quality of the meals provided were positive. Arrangements were in place for gathering people's views of the service they received, those of people acting on their behalf and staff employed at the service.

We have made recommendations about safeguarding, training, staff induction, communication with relatives and complaints management.

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

Rating at last inspection

The last rating for this service was Good (published 28 April 2020).

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

We received concerns in relation to staffing levels, the management of medicines and training. As a result, we undertook a focused inspection to review the key questions of Safe, Effective, Responsive and Well-Led only.

The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Elm Tree on our website at www.cqc.org.uk.

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

We have identified breaches in relation to risk, including infection, prevention and control, medicines management, staffing and quality assurance.

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

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

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the Local Authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Elm Tree

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was completed by an inspector and assistant inspector. Following the visit to the service, an Expert by Experience completed telephone calls to people's relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

The service did not have a manager registered with the Care Quality Commission. At the time of the inspection, Elm Tree was being managed by the provider. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We sought feedback from the Local Authority prior to the

site visit and reviewed information held by the Care Quality Commission. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service about their experience of the care provided. We spoke with the manager and deputy manager of Winsford House, the manager of Gairloch House, care staff, staff employed by an external employment agency, the provider's IT expert and the provider. We reviewed a range of records including people's care records and medication records. We looked at four staff files in relation to recruitment procedures.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

After the inspection
We continued to seek clarification from the provider to validate evidence found. This related to the service's quality assurance arrangements. We contacted six members of staff and asked them to contact us so that we could speak to them about their experience of working at Elm Tree. Unfortunately, only one member of staff contacted us and responded. The Expert by Experience spoke with 10 people's relatives on 17 December 2020.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as 'Good'. At this inspection this key question has now deteriorated to 'Inadequate'.

This meant people were not safe and were at risk of avoidable harm.

Using medicines safely
• Suitable arrangements were not in place to ensure the proper and safe management of medicines and this placed people at risk of harm.
• Not all people using the service had been given their prescribed medicines in line with the prescriber's instructions or received their prescribed medication as there were insufficient stocks available.
• We found omissions in the records made when medicines were administered. We found the Medication Administration Record [MAR] for three out of six people was blank giving no indication of whether the medication was administered or not.
• Appropriate arrangements were not in place to ensure controlled drug medication was stored securely for safekeeping. The provider was requested to raise a safeguarding alert but at the time of writing this report the provider had failed to complete this.
• Following the inspection, the provider confirmed three members of staff administered people's medication. Although confirmation of staff's competency to administer medication was received, evidence of training was not provided despite several requests.

Preventing and controlling infection; Learning lessons when things go wrong
• The provider was not following up-to-date Government guidance on how to operate safely during the COVID - 19 pandemic. We were not assured staff were using Personal Protective Equipment [PPE] effectively and safely. Although there was no outbreak of COVID - 19 at the service, some staff were using reusable face masks rather than surgical masks and wearing their masks inside out. Where staff had direct contact with people using the service, staff did not sanitise their hands between individual interactions.
• Suitable arrangements were not in place to ensure social distancing rules were being routinely applied and monitored. People were seated too closely together within the main communal lounge and at dining tables. This placed people at increased risk of contracting COVID – 19.
• Suitable arrangements were not in place to prevent people from spreading infection. Newly admitted people were not being isolated in line with Government guidance to ensure theirs and other's safety. Staff were deployed from the provider's other services or from an external employment agency and not working exclusively at Elm Tree.
• Suitable arrangements were not in place to ensure safe prevention and infection control measures in the event of a COVID - 19 outbreak. A plan to demonstrate how appropriate measures would be put in place to isolate people who tested positive and to zone environmental areas of the service should there be an outbreak of COVID - 19, had not been considered or completed.
• Arrangements to assess current and emerging risks presented by the pandemic had not been identified for

people residing at Elm Tree and staff employed at the service. This meant people and staff who may be at increased risk of contracting COVID - 19, for example, those with underlying health conditions, had not been assessed.

Assessing risk, safety monitoring and management
• Where risk assessments were in place, these identified how risks to people's safety and wellbeing were to be reduced and the actions required to keep people safe. However, not all risks to people's safety and wellbeing were recorded or being monitored.
• Where people had a daily fluid target to be reached because they were at risk of dehydration, where this was not achieved, there was no evidence to demonstrate how this was being monitored and addressed to ensure people's safety and wellbeing.
• Where people had a catheter in place, related risks were not always identified and recorded. A catheter is a medical device used to empty the bladder and collect urine in a drainage bag. Risks associated with the catheter had not been considered or recorded, for example, the risk of Urinary Tract Infections [UTI's], bladder spasms, leakage around the catheter, blood or debris in the catheter tube, blockage and dehydration.

This was a breach of Regulation 12 [Safe care and treatment] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

Staffing and recruitment
• Prior to the inspection concerns were raised with the Local Authority and Care Quality Commission about the service's staffing levels. Specifically, concerns were raised between May and December 2020, citing staffing levels at night were not being maintained.
• Relative's comments about staffing levels were not positive. No relatives spoken with felt there were enough staff at Elm Tree. Comments included, "No, there are not enough, everything seems in a hurry", "I think there is a skeleton staff, I don't think there are enough", "[Name of person using the service] likes to sit in the hallway or lounge, but there are never staff in the lounge" and, "I went to visit and no one [staff] answered the door, there were other people waiting and we waited ages."
• Staff spoken with told us there were occasions when the service was short staffed. One staff member told us, "They [people using the service] are not getting any one-to-one time because we have limited staff."
• Observations demonstrated the deployment of staff was appropriate and there were enough staff on duty in line with what we were told by the provider. Despite this, the level of care and support provided by staff was primarily 'task and routine' focused, not person-centred and staff interactions often excluded people using the service.
• A review of staffing rosters for the period 23 November 2020 to 16 December 2020, demonstrated staffing levels as told to us by the provider, were not being maintained, particularly at night. This placed people at risk of not receiving support in line with their care needs.

This was a breach of Regulation 18 [Staffing] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

• Staff had been recruited safely to ensure they were suitable to work with the people they supported.

Systems and processes to safeguard people from the risk of abuse
• People told us they felt safe, but relatives' comments relating to their loved one's safety and care were variable. Comments included, "[Name of person using the service] won't come to any harm. They are safe physically but neglected", "No I don't think people are safe" and, "Yes, they [person using the service] seem happy in there [Elm Tree]."

• Although staff demonstrated an understanding and awareness of safeguarding and how to escalate concerns, they did not know where the service's safeguarding policies were kept and told us they did not have access to the correct forms to complete.
• The provider did not understand their responsibilities to act on and report safeguarding concerns.

We recommend the provider refers to current guidance to ensure they are familiar with local policies and procedures relating to safeguarding and the Care Quality Commission's regulatory requirements.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as 'Good'. At this inspection this key question has now deteriorated to 'Requires Improvement'.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience
• The training matrix was not up-to-date and demonstrated not all staff had received recent training. Numerous members of staff had not received required training in moving and handling, infection prevention and control, fire safety, health and safety. This also included specialist training to meet people's needs, such as, catheter care and nutrition and hydration.
• Staff told us they had not always felt supported and valued by the previous manager or senior management team. Comments included, "I did not feel supported or appreciated" and, "We [staff] feel like we have just been left and it is extremely stressful, but I am starting to feel 100% more reassured."
• Staff told us they received formal supervision every few months.
• Newly employed members of staff had received an induction, including completion of the 'Care Certificate'. The Care Certificate is a set of standards that social care and health workers should adhere to in their daily working life. However, inductions for agency staff deployed to the service were badly organised and did not provide agency staff with the information they required.

We recommend the provider refers to current guidance and seeks advice from a reputable source to ensure staffs training is up-to-date and inductions for agency staff are robust.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• Information viewed suggested people had access to healthcare services and support when needed. However, information from people's relatives conflicted with our findings.
• One relative told us, "[Name of person using the service] was complaining of a bad back, we told them [staff], but they didn't do anything." The relative stated a video conferencing call was only placed with the person's GP a few days later. A second relative told us they had raised concerns with the service about their family member's pressure ulcer management and stated required equipment had not been sought in a timely manner and was only received when healthcare professionals intervened.
• Not all relatives were informed and updated about their family member's healthcare needs. Relatives told us there had been occasions whereby they had visited the service and found their family member had been admitted to hospital and they had not been notified. Comments included, "If you phone them, they [staff] answer within reason, but they are not over friendly", "The hospital said that the care home hadn't given them much information. The social worker asked the care home to send it to the hospital, but they didn't"

and, "The care home don't tell me much but if I ask my relative, they would ring me and let me know what is happening."

We recommend the provider takes action to update their practice accordingly to ensure peoples relatives are informed and updated about their family member's healthcare needs.

Supporting people to eat and drink enough to maintain a balanced diet
• People's comments about the quality of the meals provided were positive. Comments included, "The food is fine, I have no complaints", "The food is very nice" and, "I like the food".
• People were not rushed to eat their meal and where they required staff assistance this was provided. However, everyone received their meal or drink in plastic tableware, dining tables were not laid [tablemats, cutlery, condiments and napkins] and not everyone was routinely offered a choice of drinks.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were assessed prior to their admission to the service but the quality of the completed assessment was variable and required improvement.

Adapting service, design, decoration to meet people's needs
• People had personalised rooms which supported their individual needs and preferences.
• People had access to comfortable communal areas within the service. However, paintwork to doors, doorframes and skirting boards were either scuffed or had peeled off exposing bare wood.
• Suitable adaptations and equipment were in place to enable people to maintain their independence. However, some hand-gel dispensers which were affixed to the wall were either not working or empty.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

• The provider did not act in accordance with the Mental Capacity Act 2005. People's capacity to consent or where people did not have the capacity to consent to COVID - 19 testing had not been sought and recorded. The 'best interest' process was not being routinely followed. A 'best interest' assessment determines the person's wishes and whether any restrictions in place are in the person's best interest.
• Staff asked for people's consent before providing care and support.
• Staff demonstrated a basic understanding and knowledge of the key requirements of the MCA and DoLS.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as 'Good'. At this inspection this key question has now deteriorated to 'Requires Improvement'.

This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

• Care plans covered most people's individual care and support needs, including how the delivery of care and support was to be provided by staff. Nevertheless, information showed improvements were required to ensure each person's care plan was person-centred, reviewed, updated and accurate to reflect people's current care and support needs.

• End of life care plans were variable in content relating to people's end of life care needs, wishes and preferences.

• Relatives told us they had not seen their family member's care plan or been involved in any care reviews. This related to both newly admitted people to the service and those who had resided in Elm Tree for some years. Comments included, "No, I've never been involved", "I've not discussed with the home but I talk to the social worker" and, "[Name of person using the service] care has not been discussed, the social worker asked them [management team] to send me information, but they didn't." The relative told us this had been outstanding for the past 10 months.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

• We did not see enough evidence of how the Accessible Information Standard has been applied. The activity programme and menu were not in an easy read or large print format to enable people with a disability, living with dementia or sensory loss to understand the information.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

• People told us there were limited social activities provided but reported the television was always on and they could sit in the communal lounge areas or in their bedroom. Relatives told us there was a lack of opportunities for their loved one to participate in leisure and social activities. Comments included, "There are no activities, just the TV always on and no one watching it", "There isn't much for them to do apart from a few birthday parties" and, "The care has been good but [name of person using the service] has dementia and there is no stimulus. There should be more entertainment."

• People were not actively encouraged and supported to take part in leisure and social activities.

Throughout the day of inspection, people were observed to sit in communal lounge or dining areas. There was an over-reliance on the television, but few people were seen to actively watch this.
• The provider told us, arrangements were made to enable people using the service and their relatives to maintain contact during COVID - 19. The provider confirmed window and garden visits were facilitated and electronic devices had been purchased.
• However, the above contrasted with what we were told by people's relatives. Relatives told us limited arrangements were made for their family member to maintain contact with them during COVID - 19. Comments included, "We did a few garden and door visits but there was no iPad or similar available", "I have not seen relative for months as they can't answer the phone. The home hasn't done anything, I tried phoning them but there was no one in."

Improving care quality in response to complaints or concerns
• Not all relatives felt concerns and complaints were dealt with in an open and transparent way. One relative told us, "I have had several concerns and they have not always been dealt with." Another relative told us they had raised their concerns with the Local Authority because their concerns were not being addressed.
• The complaint log for Elm Tree demonstrated there had been three complaints since our last inspection in March 2020, all of which had occurred in June 2020. Though a record was maintained detailing the specific nature of the complaint, one complaint remained outstanding, nearly six months after it was first made. The complaint log provided no detail to confirm if the investigation had been completed by the provider and the outcome.

We recommend the provider refers to current guidance or seeks advice from a reputable source to ensure concerns and complaints are dealt with in an open and transparent way.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as 'Good'. At this inspection this key question has now deteriorated to 'Inadequate'.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care

• The provider's arrangements to assess and monitor the service were not effective. This meant there were missed opportunities to mitigate risks and to make sure people living at the service were safe and received good quality care.

• The provider's oversight of the service was poor as were unaware of the extent of the issues as detailed within this report and the level of non-compliance with regulatory requirements.

• The provider told us data from the service's computer systems had either been deleted or password protected by the service's manager. The provider told us they were not able to access the password protected data and this could account for a lack of information being readily available. IT support was present in the service two days prior to the inspection to try and retrieve the information and they confirmed to us that 90% of the data had been recovered.

• Though audits were in place, they needed to be used more effectively, as they failed to pick up the issues identified at this inspection. This included, the provider's arrangements to ensure the proper and safe management of medicines, making sure risks relating to the quality of the service were identified and recorded, including risks relating to the service's infection prevention and control measures.

• The management team and provider did not understand their responsibility to ensure notifications relating to specific incidents had been made to the Care Quality Commission.

• Findings at this inspection demonstrated the management team did not lead by example. Effective role models, for example senior members of staff, were not able to provide valuable support and guidance to staff to enable them to effectively carry out their roles. There was a lack of oversight by the management team to identify and pick up poor practice, such as, staff not wearing their PPE correctly and staff not effectively communicating with people when providing care and support.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

• The service had not had a registered manager in post since March 2020. The provider had promoted an existing member of staff at Elm Tree to the role of manager but following an incident in December 2020, the service was being overseen by the provider.

• The provider confirmed a new manager and senior member of staff had been appointed and were due in post week commencing 21 December 2020, but they could not tell us either person's name. We requested evidence of their records to be forwarded to us, but to date this information has not been provided.
• Relatives comments regarding the management arrangements at the service were variable. Not all relatives spoken with had confidence in the management team or provider and most stated, communication with the service had not been positive. Comments included, "The admin side seemed okay but I never knew who the manager was", "I never knew who the manager was, messages are not passed on to [people using the service]" and, "If you ring up and ask anything, they [management and staff] never know and say they will get back to you. The office staff only work Monday to Friday, so you can never get through at the weekend."
• Not all members of staff felt the service's previous manager and senior management team were supportive. Staff told us up until the last seven to 10 days, they had had limited contact with the provider. One staff member told us, "I've seen them a lot recently but before that not very often at all unless there was an incident. I feel like we as staff were very neglected."

Effective arrangements were not in place to assess and monitor the quality of care provided, to ensure compliance with regulations. This was a breach of Regulation 17 [Good governance] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Arrangements were in place for gathering people's views of the service they received, those of people acting on their behalf and staff employed at the service. Comments recorded were positive and included, "Elm Tree is a lovely home with lovely staff" and, "Elm Tree is an excellent place to live, the staff do an excellent job."
• Staff meetings were held to give the management team and staff the opportunity to express their views and opinions on the day-to-day running of the service. Comments recorded were positive and included, "I enjoy my job, I have a good rapport with both residents and staff."

Working in partnership with others
• Information available showed the service worked in partnership with key healthcare organisations.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Effective arrangements were not in place to ensure risks to people were mitigated, medicines and infection, prevention and control measures kept people safe.

The enforcement action we took:

Warning Notice Served

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective arrangements were not in place to assess. monitor and improve the quality and safety of the service provided.

The enforcement action we took:

We Imposed Conditions on the Provider's Registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Suitable arrangements were not in place to ensure there were sufficient staff to meet the needs of people using the service.

The enforcement action we took:

We Imposed Conditions on the Provider's Registration