

Dovecote Care Homes Limited

Longmead Court Nursing Home

Inspection report

247 London Road
Black Notley
Braintree
Essex
CM77 8QQ

Tel: 01376344440

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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

Longmead Court Nursing Home is a residential service and provides personal and nursing care to older people in Black Notley near to the town of Braintree in Essex. The service specialises in providing care to people living with dementia. The service can support up to 54 people and there were 50 people being supported when we inspected.

People's experience of using this service and what we found

Care was not consistently good, or person centred. Most staff were kind, but delivery largely focused around the completion of a task.

There was not always enough staff to meet people's needs. There was a reliance on agency staff which impacted on the support and care provided. Staff received training, but it was not always in depth.

Mealtimes were poorly organised, and people did not receive the support they needed.

The environment was generally clean but there was a lack of dementia friendly signage which meant that it was difficult for people to orientate themselves around the building.

People had care plans in place to guide staff on people's preferences and how to support people. However, information was not always up to date or sufficiently detailed which meant that people were at risk of not having their needs met in a safe and effective way.

There were some daily activities, but they were limited, and people were at risk of isolation.

People were not 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.

Information about how care was delivered was not always documented. Oversight systems were not effective as they were not identifying shortfalls.

Complaints were investigated and responded to in a timely manner.

Incidents had been notified to the CQC in line with the legal requirements however notifications had not been undertaken for people who had been deprived of their liberty. This had been identified and was underway at the time of the inspection.

The provider had systems in place to audit the care provided but there were gaps in audits and they had not prevented some of the shortfalls in the quality of service provision.

A new manager was in post and recruitment was underway for a new deputy manager and clinical lead. The manager had identified some of the shortfalls and had a plan with timescales for addressing the issues.

Rating at last inspection

Longmead Court Nursing Home was rated good at the last inspection which was published on 01 April 2017. This was a planned inspection based on the rating at the last inspection.

We have found evidence that the provider needs to make improvements. You can see what action we have asked the provider to take at the end of this full report.

Follow up

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

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

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 always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement ●

Is the service caring?

The service was not always caring.

Details are in our caring 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 always well-led.

Details are in our well-Led findings below.

Requires Improvement ●

Longmead Court Nursing Home

Detailed findings

Background to this inspection

The inspection

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

Inspection team

The inspection was carried out by one inspector, a professional advisor who was a nurse and an expert by experience. The expert by experience had experience of supporting older people and people living with a diagnosis of dementia.

Service and service type

Longmead Court Nursing Home a 'care home'. People in care homes receive accommodation and nursing or personal care as 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.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

Prior to our inspection we reviewed information we held about the service. This included any safeguarding referrals and statutory notification that had been sent to us. A notification is information about important events which the service is required to send us by law.

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.

During the inspection

We spoke with the manager, area manager, business manager as well as eleven members of staff. We spoke with eight family members and one professional who visiting a person who lived in the service. We reviewed care and support plans, medication administration records, recruitment files, staffing rotas and records relating to the quality and safety monitoring of the service.

After the inspection

We arranged to meet with the provider to discuss our findings and their action plan.

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 requires improvement. At this inspection this key question has remained the same.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

- Staff were not always available to support people when they needed support and we identified issues with the deployment of staff and the impact of a high level of agency use.
- Relatives expressed concern about staff changes and told us that there were times when there were not enough staff available. One person told us, "I come in here a lot and staff not always around. Another told us, "My relative wanted the toilet yesterday we had to wait for carer to come back, then she had to find someone to help her."
- Staff told us that they were very busy and there was an impact of having so many agency staff on shift. One member of staff told us, "We try and do our best, but we are overwhelmed ...you have to explain things over and over.... I don't feel people are safe." They told us that there should be one member of staff in the lounge, but this was not always possible. One relative told us, "Yesterday the staff member in the lounge left for about 15 minutes." They told us that they had to intervene when a person started to mobilise.
- The manager told us that they had identified issues with deployment and the impact of staff breaks. They were consulting on reviewing staff working hours.

The shortfalls in staffing put people at risk and demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Checks on staff suitability were undertaken on all new staff prior to their appointment. Identity checks, criminal records check, and appropriate references had been obtained on newly appointed staff. The registration of nursing staff was checked with the Nursing and Midwifery Council

Assessing risk, safety monitoring and management

- Risks were not always assessed and managed effectively to reduce the risks of harm.
- The service supported people living with dementia and some people exhibited distressed behaviours. The guidance for staff on how to support people safely was not in place. People with a diagnosis of epilepsy did not have a clear assessment or management plan in place as to how this should be managed or overseen.
- There were several standard tools to calculate risks to people such as those arising from skin integrity and nutrition. People were provided with equipment such as specialist mattresses to mitigate the risk of harm however mattresses settings were not clearly recorded and checked. The manager informed us on the second day of the inspection that they had all been checked.
- Records showed that people at risk of skin damage were not always repositioned at the intervals specified

and staff did not always follow the care plan regarding the positioning of pillows. A relative told us, "I don't think they do proper room checks here either, my relative is supposed to be turned regularly, but it is not always done."

- The manager told us that there were reviewing their electronic records to identify shortfalls and ensure that risks were being managed.
- There were no documented checks on clinical equipment such as the suction machine to demonstrate that it clean and was safe to use. It was agreed that this would be immediately actioned.
- Records showed that checks were completed on the building to ensure that it was well maintained. Water temperatures were tested, and fire equipment checked to ensure that it was working effectively. The provider did not commission regular health and safety audits on the environment.

Systems and processes to safeguard people from the risk of abuse

- There were systems in place to protect people from abuse however they were not fully effective.
- Staff received training on safeguarding but not all of them could recall when they last had their training or could recall what the content of the training was They were not aware of a safeguarding lead within the organisation
- Staff were able to tell us about different types of abuse, but they were less clear about the role of the local authority and how to make a report.
- Body maps were completed when changes were noted in people's skin and we saw that some concerns had been reported to the local authority for investigation.
- The new manager had identified that there were shortfalls in the training programme and were planning to introduce a new training package.

Using medicines safely

- Medicines were satisfactorily managed but auditing needs to be strengthened to ensure that the systems are effective.
- There were systems in place for the ordering, administration and monitoring of people's medicines. The service had recently changed to an electronic medication recording system, and staff were positive, telling us the system was clearer.
- Medicine administration charts were in place and were well maintained. Anticipatory medication was prescribed for two patients who were end of life, but it was not clear within the medication system that this was anticipatory use only and not for general use. This was raised with the nursing staff.
- People on regular antipsychotic drugs were reviewed by the GP who visited the home every week. The manager told us that they were reviewing the system for covert medicines and had a plan to strengthen the arrangements.
- We checked a sample of medicines including controlled drugs against the records and saw that they all tallied.
- There were three drug trollies which were locked and locked away in the treatment room, but they were not tethered to the wall. The manager told us that they would immediately address this.
- Medication audits were not being undertaken on a regular basis.

Preventing and controlling infection

- Infection control audits were not being undertaken on a regular basis to identify shortfalls. The service was largely clean, but we did identify some rusty equipment which made cleaning difficult.
- Staff were aware of their responsibility in terms of Infection Control and what this meant. They received training on this at their induction. However, the application of the policy was not consistent, for example we observed one member of staff went from feeding different people in the dining area but did not wash her hands in between. The member of staff serving up the meals did not have a tabard over her clothes
- Staff had access to personal protective equipment such as gloves and aprons. People had individual slings

to reduce the likelihood of infection when being assisted with their mobility.

- Staff were aware of the use of appropriate coloured coded bags for the disposal of waste.

Learning lessons when things go wrong

- There was limited use of systems to record and report safety concerns and near misses.
- Accident and incidents were logged and reviewed by a senior member of staff. Equipment such as crash mats were in place for those individuals who had been identified as being at risk of a further fall. 24-hour monitoring was not always undertaken for those individuals who had sustained a head injury when falling.

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 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

- Staff had received some training, but this was not always in depth and did not address conditions such as Parkinson's or Diabetes care. The service supported people living with dementia, but most staff had only completed dementia awareness training. A Relative told us, "No I do not think staff are well trained in dementia or depression and anxiety."
- We saw from the training matrix and certificates on staff records that staff completed up to nine training modules on the same day and it was difficult to see how this could be in enough depth to meet the complex needs of people being supported in the service.
- As outlined in the safe section staff did not always demonstrate an understanding of areas such as infection control and safeguarding. There were no competency assessments in place to evidence that staff fully understood and were implementing what they had learnt.
- One of the new members of staff spoken with had a week's induction then shadowed a senior carer but was unable to recall if they had been assessed or had to worked through any competencies. They told us that they did not have any regular meetings in how they were performing. Another member of staff told us, "No one tells you if you are doing a good job."
- The manager told us that they were looking at the training and competency of staff and had plans to extend the training and develop champions and or leaders to drive improvement.

Supporting people to eat and drink enough to maintain a balanced diet

- People required more support with eating and drinking.
- Mealtime was not a sociable or well organised event. The tables were not set with cutlery or condiments. People were not asked if they wished to sit at the table and most people were served a meal where they were sitting. People were not assisted to wash their hands before they ate.
- The meals served on the days of the inspection looked appetising, but people were not offered a choice or told about the meal they were about to eat. In some parts of the service people did not eat well and plates were returned to the kitchenettes with only a few spoonful's of food eaten
- Some people had been assessed as needing staff to monitor their food and fluid intake, however this was not consistently undertaken, and we observed that some people's recorded fluid intake was very low. We could not see that they had drunk enough to keep them adequately hydrated. The monitoring systems were not effective as they were not identifying this.
- Drinks were not always available within peoples reach. People who had been assessed as requiring

thickener in their drinks did receive this.

- The systems in place for the monitoring of those at risk of weight loss did not work effectively. There was a matrix which listed people's weights but there were significant gaps and we could not see that people were being regularly weighed. The new manager told us that they had identified this and by the second day of the inspection had organised for most people to be weighed and the matrix updated.

The shortfalls we found demonstrated a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs

- The service was purpose built and people had all single rooms. Rooms had not been highly personalised. Corridors were long with closed doors, there were some pictures but there was not a lot signage to help orientate people and promote their independence.
- The communal areas were comfortable however some of the furniture looked tired, with stained arms. The dining areas did not have enough seating to enable people to sit at the table should they wish to do so.
- There was no evidence that environmental audits were being undertaken and we could not see that issues were being promptly identified and being addressed. We found sinks with missing plugs, a damaged toilet and cords for people to pull in an emergency tied up.

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.

- Staff had a limited understanding of mental capacity and best interests, although had undertaken some training.
- The manager told us that they had written to relatives to clarify where they had power of attorney.
- People had sensor alarms on their doors to alert staff to their movements. This is a restrictive practice unless this action is taken in people's best interests. We could not see that best interest decisions were in place.
- We found that people were being deprived of their liberty and applications had been made to the local authority but the CQC had not been notified of these. The manager had identified this and had started to make notifications.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- People were supported to access healthcare support.
- Care records evidenced ongoing involvement of health professionals and we saw good external links with

the Specialist Palliative Care team, Dietician, Occupational therapy and the local surgery. The GP visited the home every week and staff told us that they had a good working relationship.

- The assessment outcomes, goals and evaluation from wound assessments were incorporated into the care plans. There was evidence of the use of the Tissue viability nurse to support those people who had complex wounds. The frequency of dressing change, and management of the wounds were documented, and there was evidence of body maps and photographs with accurately updated records of progress.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were assessed before the service started to support them. This assessment was used to form the basis of the plan of care
- There was some evidence of the appropriate use of technology such as alarms to alert staff to people moving around the building.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

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

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

- Individual staff were observed to be kind and caring in their interactions with people. We saw some staff providing comfort to people or being patient, however alongside this we also noted interactions which were task orientated.
- We observed people being served their meal and saw that people were not told what the meal was or engaged in conversation about the food. Staff focus was ensuring that a meal was placed in front of people and the call bells answered. One person was 'shouting' out they wanted to use the toilet but there was no member of staff to support them.
- A new computer recording system had recently been introduced and this may have impacted on interactions, but staff were observed to spend significant periods on mobile devices inputting data including when they were supporting people to eat.

Respecting and promoting people's privacy, dignity and independence

- Care delivery was not always person centred and this impacted on people's dignity.
- Some people looked unkempt, their hair was untidy, and their fingernails needed cleaning and cutting. People who walked around bare foot had hard dry skin on the bottom of their feet which was discoloured.
- There was limited information about people's life history, religion, culture and sexuality within care planning documentation. The management team told us they had recognised this as an area of care planning that needed improvement.

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

- People and relatives were provided with opportunities to feedback their views as to how the service was run.
- Relatives told us they were able to visit without restriction and, where appropriate, involved in the planning and review of care plans. The care plans were reviewed monthly when the resident was 'resident of the day.' It was not clear from the documentation how meaningful the reviews were, as recordings were not always detailed.
- Questionnaires were sent to relatives to complete on a yearly basis and we saw the results of the last questionnaire which had been undertaken in January 2019. In response to the survey the previous manager had taken actions including clarifying role of the key worker, a review of staffing levels and held a meeting with laundry staff. The new manager told us that they intended to increase the frequency of meeting to twice yearly and introduce a 'you say we did' board so that relative and people could see the actions being taken.

- Resident and relative meetings were held.

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 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

- The provider had recently implemented an electronic care planning system. People had care plans in place to guide staff on people's preferences and how to support people. However, information was not always up to date or sufficiently detailed which meant that people were at risk of not having their needs met in a safe and effective way.
- A significant number of people were cared for permanently in bed and it was unclear from their records why this was the case. Six out of the ten people in one lounge were not wearing socks or slippers and some were sitting with their feet on the floor. There was no evidence in the care plans that this was people's choice or guidance within the care plan on how to prevent people slipping, sustaining injuries from the equipment in the environment or preventing them from getting cold. We expressed concern about those individuals to the manager and it was agreed that their care would be reviewed.
- Care was not always provided in line with people's care plan. Daily records were maintained but the records were not comprehensive, and we could not always see when people were for example being supported to shower or bath. One person's room smelt strongly of urine but when we checked their care records there was no reference to this and their continence records were not up to date. We heard one person requesting to use the toilet and they were told, "you have a pad on."
- Relatives told us that communication was not always good and some had concerns about their relatives' needs. One told us, "The regular staff here are good but does run on a lot of agency staff and communications break down....." Another said, "I am not always sure my relative receives personal care and they don't encourage it. They use wet wipes a lot."

The shortfalls we found demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 had limited access to interesting and meaningful activities to promote their wellbeing.
- There was a display board in the entrance to the service which listed activities which were available.
- On the first day of our inspection we saw that the activity listed was a 'movie club' but we observed that only three people attended and watched the film, the sound of music. Most people sat in the lounges and looked disengaged and asleep. We asked a member of staff what people had been doing and they told us, "A couple have been playing with their teddy, one played with her elephant." On the second day of our

inspection we were told that some people had been assisted to go out in the minibus.

- People's daily records did not evidence that people had accessed or participated in activities. One person's records for the previous month, had only one entry for activities, which was that they had been offered hairdressing and refused.
- Relatives told us that this was an area which could be improved. One relative told us, "I did ask if someone would come in and read to my relative at times but not happened." Another said, "Overall here the majority of staff do their best, I do see there is not much stimulation goes on here though, as there used to be."

End of life care and support

- People had end of life plans in place, but these were not always completed in a timely manner.
- We reviewed the care of two people who had been identified as being at the end of life. The care plans were completed on the day of the inspection yet both people had been identified as being at end of life some time previously. One family member told us, "I have put things in place like funeral arrangements in place, but no end of life care plan has been discussed."
- Do not attempt resuscitation (DNAR) documentation were present and highlighted in people's electronic records. The hard copy of their DNAR status was kept with the clinical records to prevent people being inappropriately resuscitated.
- There were no syringe drivers on site, if the nursing staff, needed one they told us that they could ask the local hospice. But no training was in place and one member of staff stated that all the time she had been working at the home she had never used a syringe driver. This is not good practice and could mean that people needing help to manage end of life care symptoms would need to have an invasive procedure of injections.

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.

- People had access to information in different formats. One member of staff told us how one person sometimes became distressed but when they had spoken to them in their first language this had helped them. In another example we were told that staff had learnt phrases which were important to a person.
- In the PIR the provider told us that they would use the services of a British Sign language interpreter or a language interpreter if this need was identified. Information could be provided in different format such as audio, braille, easy read or large print.

Improving care quality in response to complaints or concerns

- The service had a complaints procedure and we saw evidence that where written complaints had been received they had been taken seriously and investigated promptly.
- We saw that the service had received several compliments and thankyou letters regarding the care provided.

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 deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider did not have effective systems in place to promote person centred care.
- People did not lead full and meaningful lives. Risks were not always effectively managed. Some staff were committed and had worked at the service was some time, but morale was low. The service was dependent on agency staff.
- The systems in place to oversee quality were not effective as they had not identified when support was not being delivered in line with best practice.

The shortfalls we found demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- There was no registered manager in place, the previous registered manager had deregistered prior to the inspection. A new manager had been in post three weeks but had not yet made an application for registration.
- There was no deputy manager or clinical lead. The manager was being assisted by the business manager and clinical team leaders all of whom were relatively new in post.
- The service had recently implemented several significant changes simultaneously such as a new electronic medication system and a new care planning system. The manager told us that they were looking at halting the implementation to ensure that staff had the information that they needed, and people were safe. They had introduced new flash meetings daily to drive improvement.
- We found significant shortfalls in recording and oversight. For example, the records did not provide us with assurance that people were being checked regularly or that they were receiving the correct levels of fluids. We saw that the electronic system flagged alerts when activities were not completed and were outstanding. Some alerts had been outstanding for several days and we had concerns that there was inadequate oversight of the system.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The new manager understood the requirements under the duty of candour to be open and honest. They

told us that they had identified shortfalls at the service when we provided our initial feedback. They showed us the action plans which they had developed since taking up the role. The action plan had clear timescales and responsibilities and we saw that some matters had already been addressed.

- Notifications had been sent to us to inform us of incidents and accidents however they had not been completed for DOLs and the new manager told us that they were in the process of addressing this.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- There were systems to engage with people and staff such as questionnaires. Relatives and staff expressed concerns at the recent level of change and told us that they thought that senior management should be more visible in the service.
- The manager told us that they were working with the provider and the regional manager to make improvements at the service. They told us that they had links with projects such as prosper, which was set up to reduce hospital admissions, and planned to strengthen this further.

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 9 HSCA RA Regulations 2014 Person-centred care People did not always receive person centred care which met their needs
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People required more support with eating and drinking to ensure that their needs were met. Peoples access to fluids needs to be better monitored
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems were not effective as they had not identified or addressed shortfalls
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not always available to meet peoples needs and this placed people at risk