Red Homes Healthcare Grantham Limited

Red Court Care Community

Inspection report

12 St Edmunds Court
Grantham
Lincolnshire
NG31 8SA

Tel: 01476576811
Website: www.redhomes.com

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 17 December 2018 and was unannounced. Red Court care community is 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. It provides accommodation for older people and those with mental health conditions or dementia. The home can accommodate up to 49 people in one adapted building. The home is divided into two units, both on ground floor level. At the time of our inspection there were 32 people living in the home.

At the time of our inspection there was not a registered manager in post. 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.

This was the first inspection for this home since registration in September 2017. At this inspection we found breaches of regulation 18, regulation 12 and regulation 17. There were insufficient numbers of suitably skilled staff. The provider had failed to put systems and processes in place to ensure the safe delivery of care and improvement of quality. A system was not in place to carry out suitable quality checks and action plans were not always in place to address issues identified.
Risks to people's safety had not been consistently assessed, monitored and managed so they were supported to stay safe while their freedom was respected.

Guidance was not in place to ensure people received their medicines when required. Processes were not in place to manage medicines safely. Where people required their medicines in food arrangements had not been put in place to ensure the method of administration did not affect the efficacy of the medicine.

People were not consistently treated with dignity and respect. Arrangements were in not place to ensure staff received training to provide care appropriately and effectively. People were not helped to eat and drink enough to maintain a balanced diet. People had access to healthcare services so that they received on-going healthcare support.

People, their relatives and members of staff had been consulted about making improvements in the service. However, actions were not always taken. There were arrangements for working in partnership with other agencies to support the development of joined-up care.

People told us that they received good care. Sufficient background checks had been completed before new staff had been appointed according to the provider's policy.

Where people were unable to make decisions, arrangements were in place to ensure decisions were made in people's best interests. Best interest's decisions were specific to the decisions which were needed to be

made.

There were systems, processes and practices to safeguard people from situations in which they may experience abuse including financial mistreatment. The environment was clean.

People were supported to have choice and control of their lives. Staff supported people in the least restrictive ways possible. The policies and systems in the service supported this practice.

People were usually treated with kindness and compassion and they were given emotional support when needed. They had also been supported to be involved in making decisions about their care as far as possible. People had access to lay advocates if necessary. Confidential information was kept private.

Information was provided to people in an accessible manner. People had been supported to access a range of activities. The registered manager recognised the importance of promoting equality and diversity. Formal complaints were responded to according to the provider's policy to improve the quality of care.

Arrangements were in place to support people at the end of their life.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is
still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Where people required their medicines in food arrangements were not in place to ensure the method of administration did not affect the efficacy of the medicine. Protocols for 'as required' (PRN) medicines, were not consistently in place. Medicine administration records (MAR) were incomplete. Medicines were not managed safely and medicine records were not fully completed.

Effective arrangements were not in place to ensure there were sufficient experienced staff to ensure people were cared for safely.

Risks to people's safety had not been consistently assessed, monitored and managed so they were supported to stay safe.

Arrangements were in place to prevent the spread of infection.

There were systems, processes and practices to safeguard people from situations in which they may experience abuse. Recruitment checks were fully completed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had not received sufficient training and support to assist them to meet the needs of people who used the service.

People did not have their nutritional needs consistently met. People had access to a range of healthcare services and professionals.

Arrangements to ensure support where people who were unable to consent was provided by a person who had the legal authority to consent were not consistently in place.

The provider acted in accordance with the Mental Capacity Act 2005. Arrangements were in place to protect people from having their liberty restricted unlawfully.

The environment was appropriate to meet people's needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People did not always have their dignity maintained. However, staff usually responded to people in a kind manner.

People were supported to make choices about how care was delivered and care was provided according to people's choices.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Reviews had not been carried out to ensure care records were up to date and reflected people's current needs.

People had access to a range of activities and leisure pursuits.

The complaints procedure was on display and people knew how to make a complaint.

The provider had arrangements in place to support people at the end of their life.

Is the service well-led?

Inadequate

The service was not well led.

Quality assurance processes were not effective in identifying shortfalls in the care people received and improving the quality of care. Actions had not consistently been taken to ensure any identified issues were addressed and the service improved.

Staff and relatives did not feel they were listened to.

The provider had notified the Care Quality Commission of events in line with statutory requirements.

A registered manager was not in post.

Red Court Care Community

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the 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 was a comprehensive inspection.

This inspection took place on 17 December 2018 and was unannounced.

The inspection was carried out by two inspectors and an inspection manager. Prior to the inspection we examined information we held about the service. This included notifications of incidents that the registered persons had sent us since our last inspection. These are events that happened in the service that the registered persons are required to tell us about.

The provider had completed a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report

During the inspection we spoke with one person who lived at the service, four relatives, two members of care staff, the administrator, one nurse and the manager. We also spoke with two visiting professionals and looked at six care records in detail and records that related to how the service was managed including staffing, training and quality assurance.

Inadequate

Is the service safe?

Our findings

Staffing arrangements did not ensure there were sufficient staff to provide safe care to people. One person said, "You can wait up to 45 minutes before staff come to you." On the day of inspection, we observed call bells were continuously ringing. A relative told us, "We don't see many carers (staff) around, the bells are ringing constantly." Another relative said, "The bells are going constantly, sometimes they come and turn them off and go, you then have to ring again." Another said, "At weekends you don't see any staff around," and added, "Sometimes if they are short staffed people don't get a drink in the afternoon."

One relative we spoke to told us, "There are simply occasions when there are insufficient staff." They told us they were concerned for their family members safety because they had diabetes and often had their meals late because of the lack of staff.

A dependency tool was used to assess the amount of staff required to support people safely. However, we found despite the use of this tool and the inclusion in staffing numbers of care staff, nurses, deputy manager and the activities co-ordinator, staffing numbers remained insufficient to consistently meet people's needs. The manager told us they had suffered significant staffing shortages and had difficulty obtaining agency staff in a timely manner. At the time of our inspection the home had 99 vacant care hours per week. We observed the home was using agency staff to cover these hours but this was not always easy to obtain. For example, we saw on the day of inspection they were two staff down but were unable to fill these.

On the day of inspection, we observed the lack of staffing affected the quality of the care received. For example, at lunchtime there were a number of people who required assistance with their meals in their bedrooms. We observed people waiting for this support for approximately 35mins and consequently when staff were available the person's meal was cold. A visiting professional told us they had also observed a person having their breakfast delivered before they were able to eat it and as a result it being too cold to eat.

They also told us they had found a person lying flat in bed trying to eat porridge. When we checked the person's care plan it stated they required full assistance with meals and had some difficulty swallowing. There was a risk of the person choking as a result of not receiving care according to their assessed needs. A relative told us they had visited at 11am and found their family member still in their nightclothes and wet with urine because they had not been attended to. We saw in the records where people required regular checks at night to keep them safe these were not being carried out at the specified intervals. For example, a person was recorded as requiring checks every 30 minutes. We saw checks were being carried out on an hourly basis. Another person should have received support with turns on a two-hourly basis to protect their skin and we saw in the records they had only been supported to turn once on the day of inspection.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. There were insufficient suitably skilled and knowledgeable staff available to meet people's needs.

We observed the medicine round and observed the nurse administering medicines was disturbed on two occasions to assist with the care of people. There was a risk they would lose track of their medicine round

and people could receive the wrong medicine as a consequence.

Two people received their medicines in food. We saw one person did not have the appropriate arrangements in place to ensure the medicine was being administered appropriately and the method of administration did not affect the efficacy of the medicine. People were at risk of their medicines not being effective due to the method of administration.

One person had not received their medicine from 19 November 2018 to 12 December 2018. It was not clear from the records what the reason for this was and advice was not sought until 12 December 2018. When we spoke with staff about this they told us this medicine had now been stopped by the GP practice, however it was not clear from the care records why the medicine was stopped and the medicine care plan had not been updated to reflect this.

Another person had also not had their medication for a month because it was not available. There was no record of this within the medication care plan or the daily notes as to the risk presented by the lack of medicine. The medicine was prescribed to treat high blood pressure and there was a risk of the person suffering a stroke or heart attack because of not receiving the medicine. There was no evidence of discussion with the GP or monitoring of the person to ensure their safety.

Protocols for 'as required' (PRN) medicines, were not consistently in place to ensure people received their medicines when they needed them. We looked at nine people's medicine administration records(MAR) and found seven instances when medicines were prescribed on a PRN basis and protocols were not in place. There was a risk people would not receive their medicines when they required them, as staff did not have guidance to follow.

Medicine administration records (MAR) were incomplete. For example, where people were prescribed variable doses, for example, one or two tablets the records did not detail how many tablets had been administered. There was a risk people would receive an inappropriate number of tablets. Where a letter code was used on the MAR staff were not recording the reason why. This meant it was unclear if people had received their medicines and there was a risk their health could deteriorate as a consequence.

The registered persons had not undertaken the necessary employment checks. In two of the four staff records we looked at suitable references had not been obtained. These measures are important to establish the previous good conduct of the applicants and to ensure that they were suitable people to be employed in the service. The registered persons had carried out checks with the Disclosure and Barring Service to show that the applicants did not have relevant criminal convictions and had not been guilty of professional misconduct.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. The provider did not have arrangements in place to ensure the safe delivery of care including the administration of medicines.

People told us they felt the home was clean. We observed suitable measures were in place for managing hospital acquired infections. However, the Legionella Risk Assessment for the service was last carried out in 2015. National guidelines state that assessments should be 'reviewed regularly' and the recommended frequency is two yearly.

It is recommended the location consider the national guidance in relation to the review of the Legionella Risk Assessment.

We found that most risks to people's safety had been assessed, however there was evidence these were not being consistently managed so that people were supported to stay safe while their freedom was respected.

Arrangements were in place to protect people in the event of situations such as fire or flood. For example, personalised plans to instruct staff how to support people in the event of an emergency were in place. Staff told us they received feedback on incidents and accidents. Records showed that arrangements were in place to record accidents and near misses, however arrangement to analyse these so that they could establish how and why they had occurred, were not in place.

There were systems, processes and practices to safeguard people from situations in which they may experience abuse. Records showed that care staff had completed training and had received guidance in how to protect people from abuse. We found staff knew how to recognise and report abuse so that they could act if they were concerned that a person was at risk. Staff told us they thought people were treated with kindness and they had not seen anyone being placed at risk of harm. We also noted that the provider had established transparent systems to assist those people who wanted help to manage their personal spending money to protect people from the risk of financial mistreatment.

Staff were supported to promote positive outcomes for people if they became distressed. For example, guidance was available in people's care plans so that staff supported them in the least restrictive way. Relatives told us that staff dealt well with people who were confused or distressed.

Requires Improvement

Is the service effective?

Our findings

Staff had not received refresher training to keep their knowledge and skills up to date. We looked at four staff records and found all four staff members had not had refresher training on a range of issues including, first aid, moving and handling and hand hygiene. There was a risk staff did not have the up to date skills to ensure they were able to provide safe care.

Staff told us they did not feel supported. One member of staff told us although they had been in post for six months they had not had a probationary meeting yet. They said they had raised this with the organisation. They said they felt, "Unsupported by the organisation." In addition, seven staff had not received supervision on a regular basis during the past year. The manager told us supervisions were behind and they were intending to address this. Supervision is important to ensure staff have the appropriate skills and support to deliver care effectively.

Introductory training was in place in line with the National Care Certificate for new staff. The National Care Certificate sets out common induction standards for social care staff. People told us they thought staff knew what they were doing and had their best interests at heart. Members of staff told us and records confirmed that they had received introductory training before they provided people with care.

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 law 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We found that arrangements had been made to obtain consent to care and treatment in line with legislation and guidance. Staff supported people to make decisions for themselves whenever possible. Records showed that when people lacked mental capacity the registered manager had put in place a decision in people's best interests. These were decision specific as required by national guidance.

Where people could consent, documentation was included in the care records. There was evidence in the records of who had legal authority to consent on people's behalf however this was not consistently reflected in the consent documentation. Do not attempt cardiac pulmonary resuscitation orders (DNACPR) were in place where appropriate and had been reviewed.

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 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 were being met. We found where DoLS were in place conditions were being met.

We observed lunchtime. Staff were familiar with people's needs and likes and dislikes and where people required adapted cutlery and plates these were available. However overall the experience was not a social experience and any communication with people tended to be focussed on a task when assisting people

with their meals. For example, a member of staff said to one person, "Do you need some help?" and "Do you need assistance cutting your food up?"

Staff did not have guidance to ensure people drank enough. We observed drinks were provided throughout the day however fluid charts did not detail an optimum target for people. In addition, a care plan for a person who used a catheter did not include information about the importance of ensuring they received fluids on a regular basis. This is important to ensure they do not become dehydrated and prevent urinary tract infections which are more common when people use catheters. Fluid records for this person showed more output than input of fluids which put them at risk of infection and dehydration. Where people had specific dietary requirements, we saw these were detailed in care records and staff were aware of these. Where required adapted equipment was available if people needed them to assist them with eating.

Records confirmed that people had received the help they needed to see their doctor and other healthcare professionals such as specialist nurses, dentists, opticians and dieticians. However, we observed two occasions when staff had not contacted the GP for advice in a timely manner. Where people had specific health needs for example diabetes, care plans reflected this and detailed how to meet these needs.

The home was purpose built with wide corridors and plenty of natural light. Arrangements were in place to assist those people who were confused or had difficulty with orientation around the home. Doors were painted different colours and people's bedroom doors were numbered. Memory boxes to enable people to identify their room more easily were also in use. Where people required specific equipment to assist them with their care this was in place and appropriate checks made regularly to ensure it was safe.

Requires Improvement

Is the service caring?

Our findings

We found people's dignity was not consistently respected. For example, one person had had their toilet door removed to accommodate for their wheelchair, however this meant they had to ensure they shut their bedroom door before using the toilet area and there was a risk people could walk in whilst they were using it. They also said they did not get a bath very often and would like to have a bath in the morning. We looked at care records and saw the last recorded bath for this person was 2 December 2018 although there were two recorded occasions after this date when they asked for a bath. We also observed a person in a corridor calling for assistance. We observed they had been unable to fully pull their trousers up and were walking in a public area in a state of undress. Eventually they reached the area where a member of staff was running an activity and they received assistance after walking 50 yards.

We observed staff knocked on people's bedroom doors and called them by their preferred name. People told us staff were respectful when supporting them with personal care and they had never felt undignified or embarrassed.

A relative told us, "Carers are kind and polite." Another said, "The care is good." We observed when staff supported people with their care they chatted with them and spoke kindly to them. We observed staff support a person to move and saw they did this at the person's own pace and encouraged them in a kind manner.

Where people required specific support to prevent them from becoming distressed this was detailed in their care records and guidance was in place to support staff. When we spoke with staff they explained how they reassured people and tried to distract them from the issue that was making them upset.

We found that people had been supported to express their views and be involved in making decisions about their care and treatment as far as possible. For example, a care record stated about a person, that they did not wish to provide information about their past life. Another explained a person preferred a bed bath on a regular basis.

Where people were unable to communicate verbally arrangements had been put in place to support them. We observed people had specialist equipment in place to assist them with their communication such as computers and wipe boards.

We found that suitable arrangements had been maintained to ensure that private information was kept confidential. Computer records were password protected so that they could only be accessed by authorised members of staff.

Most people had family, friends or representatives who could support them to express their preferences. Furthermore, we noted that the provider had access to local lay advocacy resources. Lay advocates are independent of the service and can support people to make decisions and communicate their wishes.

Requires Improvement

Is the service responsive?

Our findings

Care plans were not regularly reviewed and did not consistently reflect people's changing needs and wishes. Care records were electronic, however staff had not received comprehensive training in the use of these and as a consequence records were not fully completed. For example, one person had fallen and as a result of their injury were now cared for in bed. The care record did not reflect the fall or the change in their needs. People were at risk of receiving inappropriate care.

We found that people did not receive care that was responsive. For example, people had to wait for support with their care and meals. People said they had not been involved in discussions about their care plans. However, where people had made specific requests for support with their care such as bathing we observed these were not always met. Staff were unable to respond on an individual basis to people's needs outside of the routines of the home. These issues have been dealt with in detail elsewhere in this report.

A daily handover sheet was provided which detailed issues about people's care needs for example, if they required a specialist diet and any short-term needs such as infections or recent falls. However, the manager told us they were in the process of reviewing this so it could provide more detail to staff.

Care plans and other documents were written in a user-friendly way in accordance with the Accessible Information Standard so that information was presented to people in an accessible manner. The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need.

People's views on and experience of the activities provided in the home were positive. People were supported to maintain and develop links with the local community. People told us they had regular sessions from external entertainers such as a ukulele group and local singers. In addition, links had been made with local groups such as the local nursery and the University of the third age(U3A).

We saw a board in the foyer displaying the activities planned for the week. People were encouraged to suggest activities and events at the resident and relatives meeting. For example, suggestions had included contacting the local college regarding an art instructor and looking at external groups such as the local fishing club so that people could continue to pursue their preferred hobbies.

Relatives told us they felt welcomed at the home. However, we did not observe interaction between staff and relatives. We noted that staff understood the importance of promoting equality and diversity and people were treated as individuals when care was being provided. Furthermore, the provider recognised the importance of appropriately supporting people if they identified as gay, lesbian, bisexual and transgender.

There were arrangements to ensure that people's concerns and complaints were listened and responded to, to improve the quality of care. However, one relative told us, "I wouldn't know who to speak to, I don't know who the manager is." We saw in the minutes of the residents and relatives meeting concerns had also been raised about poor communication with the manager and senior management.

At the time of our inspection there was no one who required end of life care. However, the provider had arrangements in place to support people at the end of their life if required. For example, where people chose to, care plans included information of what they wanted to happen in the event of illness and subsequent death.

Inadequate

Is the service well-led?

Our findings

Arrangements for checking the quality of the service were not consistently effective. Checks were in place for a variety of issues. For example, these had been carried out on areas such as medicines, health and safety, and skin care on 28 November 2018. However, despite this, these audits had not identified some of the issues we found at this inspection. For example, the failure to provide medicines to people had not been identified in the audit. Where actions had been identified as necessary we observed they were not always addressed. For example, audits had been carried out on incidents and accidents but these had not been analysed to identify any patterns or trends, to reduce the likelihood of incidents reoccurring. A meeting had been held with staff in October 2018 to discuss staffing concerns however we found at inspection that issues still remained.

The provider had not put in place effective arrangements were in place to ensure there were sufficient experienced staff so that people were cared for safely. This was a breach of Regulation 18 which is dealt with elsewhere in this report. Visiting professionals, we spoke with also expressed concern about the lack of staffing and support provided by the provider. For example, there was no system in place to support the manager and assist them with their nurse registration for revalidation. The manager told us this had to be arranged by them. This is important for nursing staff to revalidate their registration and ensure they are up to date with their skills.

The provider did not have arrangements in place to ensure national guidance were followed. At this inspection we found that where people required their medicines in food arrangements were not in place to ensure the method of administration did not affect the efficacy of the medicine. We also found the policy for DNACPR did not reflect best practice guidelines to ensure people received appropriate care at the end of their life. A Legionella Risk Assessment had been carried out in July 2015. The Health and Safety Executive(HSE) recommend regular review of risk assessments to ensure they are up to date and good practice guidance suggests at least 2 yearly review. There was a risk the assessment was out of date and did not reflect best practice.

The provider had put an electronic system in place for care planning, however when we spoke with the manager they told us they had not received training on the system and were unsure of what back up arrangements were in place should the system fail.

We found that people who lived in the service, their relatives and members of staff had been engaged in the running of the service. For example, regular meetings were held with relatives and people who lived at the service. However, we saw from the minutes of meetings held in November and December 2018 that issues people had raised had not been addressed. For example, three instances were raised about people not receiving their meals and drinks in a timely manner however we observed similar issues still occurring.

We looked at minutes from a staff meeting and saw that issues such as staffing were discussed. However, staff told us they were not confident that any concerns they raised with the provider would be taken seriously so that action could quickly be taken.

All these issues showed that the systems in place to monitor and manage the quality of care people received and to drive improvements were not adequate. The service lacks the systems to provide sustainable improvement and good quality care.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

There was no registered manager in post at this inspection. A registered manager from another home owned by the provider had recently started at the home and was in the process of registering as registered manager for this home.

Records showed that the registered persons had correctly told us about significant events that had occurred in the service, such as accidents, incidents and injuries. The provider had displayed the rating of their previous inspection according to CQC guidelines.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to have processes in place to ensure the safe delivery of care and management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to have systems and processes in place to monitor and manage the quality of care

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 Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient suitably skilled and qualified staff available to provide safe care to people.

The enforcement action we took:

Urgent condition