Wayside Care Limited

Wayside Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection was unannounced and took place on 22 March 2018.

Wayside Care Home 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. Wayside Care Home is registered to provide accommodation with nursing and personal care for adults for a maximum of 31 people. There were 17 people living at the home on the day of the inspection.

This is the second time the service has been rated Requires Improvement. For services rated Requires Improvement (RI) on one or more occasions, we will take proportionate action to help encourage prompt improvement. You can see what action we asked the provider to take at the back of the full version of this report.

There was no registered manager in post. A manager had been recruited band told us they would be making an application to CQC to be registered. 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.

There had been a lack of leadership and direction for staff, with no oversight of clinical risks or key issues for people's care. Systems and processes for monitoring the quality of the care provision were inconsistent and there was no robust management of the service. At the time of the inspection there was a new management team in place. They had produced an action plan for improving all aspects of the service. However, it was too soon for us to assess the impact of this upon people's care.

People's care plans were not accurate and had not had up to date information about their current needs. Information was difficult to find or contradictory. Risk assessments were being completed; however, these were not always being followed or had been completed incorrectly to mitigate risks to people using the service. The knowledge staff had about people had not been recorded to ensure there was consistent care for people.

Staff had not been provided with training that reflected the needs of people who lived at the home. The training information showed that staffs knowledge had not been regularly updated. People had not always been involved in the planning of their care and records of their care were not accurate.

People had not always been supported to maintain their hobbies and interests that supported their needs. The provider had not been able to review any concerns raised as no records had been kept. Information was not available for the provider to improve the service.

People told us they felt safe and free from the potential risk of abuse. Staff told us about how they supported people's safety. People told us they liked the staff and felt they knew how to look after them and were included in day to day decisions about their care and support. People were supported to eat and drink enough to keep them healthy. People received their medicines as prescribed and at the correct time. People told us and we saw their privacy and dignity were respected and staff were kind to them. People had access to other healthcare professionals that provided treatment, advice and guidance to support their health needs.

We found breaches of the Health and Social Care Act (2008) Regulated Activities 2014 Regulations. 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People's risks need to be clearly recorded and regularly reviewed. People and relatives told us they felt there were not always enough staff on duty.

People felt safe and protected from the risk of abuse and received their medicines where needed. The home was clean and the provider had systems in place to manage the risk of the spread of infections.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff training was not updated and staff were not always following good practice.

The Mental Capacity Act (2005) code of practice was followed to ensure people were supported to make their own decisions.

People's dietary needs had been assessed and they had a choice about what they ate. Input from other health professionals needed to be recorded and used when required to effectively meet people's health needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

We found some staff required further support to ensure that people were treated in a way that made them feel included and valued at all times.

People had not always received care that met their needs in a timely way. Staff were respectful of people's privacy and dignity and took account of people's individual preferences.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

We saw people were able to make some everyday choices. However, people had not been engaged in their personal interest and hobbies.

People were supported by staff or relatives to raise any comments or concerns. However, these had not always been responded to or used to develop the service.

Is the service well-led?

Requires Improvement

The service was not well-led.

People had not been involved in developing or providing feedback on the quality of care provided. Improvements were needed to ensure effective procedures were in place to identify areas of concern.

The provider had employed a new manager to improve the quality monitoring and people's care experiences.

Wayside Care Home

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.

Inspection site visit activity started and ended on 22 March 2018 and was unannounced. The inspection team consisted of two inspectors and nurse specialist advisor and an expert by experience who had experience of residential care settings. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information we held about the home and looked at the notifications they had sent us. Statutory notifications include information about important events which the provider is required to send us by law. The inspection considered information of concern in relation to people's care that was shared from the local authority and the Clinical Commissioning Group (CCG) who are responsible for commissioning some people's care.

During the inspection, we spoke with eight people who lived at the home and six visiting friends and relatives. 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.

We also spoke with three care staff, three nursing staff, the manager and the nominated individual who was a provider representative present for the inspection. We reviewed the risk assessments and plans of care for five people and their medicine records. We also looked at provider records for Deprivation of Liberty Safeguards, staff meeting minutes and 'residents' meeting minutes and the new proposed daily records and governance audits.

Requires Improvement

Is the service safe?

Our findings

At the time of our last comprehensive inspection on 28 and 29 September 2017 we rated this question as requires improvement. We identified a breach of Regulation 12, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not actively supported to remain safe at the home through effective risk management, and safe medicine storage.

This question was rated as Requires Improvement and we have not improved the rating because there was a continuing breach of legal requirements.

Risks to service users were not appropriately assessed, recorded and planned for. For example, one person who had complex nursing needs had not had their skin integrity assessed and there were no records to show how the wound had been graded, managed and treated. There were no records of clinical input or advice that this may have required. Professional advice was not always sought in relation to service user's needs. For example, one person's catheter had no documentary evidence to show the care needed or when the risks had been last reviewed.

Guidance for staff about how to manage risks that have been identified was lacking. For example, two care plans we looked at had not mitigated the potential risks to people. The provider has assessed them as being at very high risk of developing pressure sores and staff were instructed to assist the person to change position every two hours, but it was not in the care plan if the person's pressure sore was healing.

There was limited clinical staff knowledge of people's needs within the home. The three nursing staff on duty were limited in their knowledge of service user's care as two nurses were agency staff and one nurse had recently been appointed. When the inspection team asked nursing staff about service user's care needs they were not able to fully detail each person needs and were only provided with information from the previous nurse on duty. In addition one relative told us that not all nursing staff understood how to provide catheter care to their family member, causing delays and discomfit to the person in the past. Service users were therefore at risk of not receiving care and treatment that met their needs as it was not evident that all service users' needs were recorded or known.

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

People told us the number of staff available varied day to day and this would impacted on their needs being met. People told us their personal requests for showers or nail care were not always happening. One person told us they had long nails as, "The carers [staff] do them when they have time but not lately as they are short staffed. One person told us, "Sometimes when I ring I have to wait as I need two [staff] of them". All relatives we spoke with told us that more staff are needed as people are often left in the communal areas with no staff to support them and how they would be safer if a member of staff was around. One relative told us, "I have helped people in the lounge there was nobody there and I have got them drinks".

People provided mixed views of the staff that supported them and that the high number of agency staff had lacked the understanding and knowledge of people in the home. One person told us, "There are a lot of agency [staff] you have to tell them what to do". One relative also commented on the number of agency staff and said, "A lot of agency, I can't understand a word they say, when we first came here carers [staff] were happier, that's gone, something has altered. The staff are rushed off their feet". One person told us they felt safe as there were staff around and told us. "People are about but they could do with a few more". One person told us, "I'm waiting to get up and have a shower but the carer [staff] was called away. I usually go down to lounge I prefer it".

We saw that people were left alone for long periods of time in the communal areas. Therefore people were not always able to express their wishes as staff were not available. We saw that staff mostly engaged and interacted with people when they were carrying out a task with a person. For example, when they offered people a drink, or when they helped people to mobilise. For some people, we noted the conversation was only to give instructions. We saw one person expressing a need repeatedly by calling out, with staff not asking what the person needed. The manager had identified this often happened in relation to their health needs but no information was available to show how best to support the person. One relative told us, "People can be heard shouting out, no staff to answer".

The care staff told us, "We have time to meet the basic care needs but it depends how many of us are on shift". One person told us, "I was going to have a shower today but they [staff] said they were too busy". Care staff consistently told us that once they had completed people's basic care needs they had not had the time for emotional care. For example, to individually support people with stimulation when they were in the communal areas. During our inspection we saw people sitting for long periods of time with no stimulation or occupation and only occasional, brief interactions from passing staff. Individual plans to support people's emotional needs had not been written down for staff to refer to strategies so people's particular needs were consistently and safely responded to. There was no tool to assess people's dependency levels so staffing levels were not based on their needs.

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

We spoke with care staff who provided us with an overview of the type of support people needed to remain safe and free from the risks of potential harm. For example using a hoist or assisting a person with their meals.

People we spoke with felt the home environment was safe and felt safe with the staff. One person told us, "I feel safe because I am not on my own". Staff we spoke with were able to tell us what they understood by keeping people safe and how they would report concerns to the manager or other professionals. For example, as the local authority if they suspected or saw something of concern.

The provider had completed DBS checks (Disclosure and Barring Service) for prospective staff. The DBS is a national service that keeps records of criminal convictions. This information supported the registered provider to ensure suitable people were employed, so that the risk of recruiting inappropriate staff was minimised. We reviewed the process for monitoring recruitment processes and saw that there was a system in place to ensure checks were completed on the suitability of staff before they commenced work.

People were supported by nursing staff to take their medicines every day. Nursing staff told us how they ensured people received their medicines at particular times of the day or when required to manage their health. We saw people were supported to take their medicines with guidance and encouragement. Records

were completed for people's routine prescribed medications. When people needed medicines 'when required', there were protocols in place in relation as to why and when the medication should be administered. People's medicine records were checked frequently by the management team to ensure people had their medicines as prescribed.

People we spoke with told us the home environment and their rooms were kept clean. The home environment was free from clutter on the day of the inspection. People's rooms and communal areas were kept clean by staff. People's laundry was collected and washed within a separate laundry area. Staff who prepared food were seen to observe good food hygiene and staff ensured the home's overall cleanliness was of a good standard to help reduce the risk of infection. Staff were seen to use personal protective items such as gloves and aprons. The provider told us that areas for improvement included repairs to the conservatory as it began to leak and some areas of heating. One relative we spoke to said, the radiator in their family member's bedroom was always on and not able to be turned off which had been reported to the provider but not repaired. The provider's maintenance checks and repairs need to maintain a clean and comfortable environment.

Requires Improvement

Is the service effective?

Our findings

At the time of our last comprehensive inspection on 28 and 29 September 2017 we rated this question as requires improvement. This was because people were not actively supported by staff that understood their needs and the staff training had not supported them to provide a consistence level of good care. This question was rated as Requires Improvement and we have not improved the rating because we found improvements had not made.

Staff told us there had not been any recent training courses to support their skills and knowledge and ensure they were up to date with current best practice. We saw staff showed they had been able to understand people's needs and had responded accordingly. Staff told us training would further improve their skills and knowledge and ensure they were up to date with current practice and guidance, for example caring for people living with dementia. The provider had not kept the staff knowledge up to date with training and records were not available to show when the staff had last received training. The provider and current manager had planned training with a training provider and was keen to support staff to ensure care practices were meeting the needs of people living at the home.

All people we spoke with told us they had a hot meal at lunchtime and were able to request an alternative if they did not like the meal on offer. One person told us, "Compliments to the chef". During lunchtime people were served their meal and staff told us people were asked earlier in the day about the lunch choice. People who needed assistance with their food and fluids were assisted by one staff member. We saw people were offered a variety of hot and cold drinks throughout the day. There were some people whose fluid intake needed to be monitored as they had been identified at risk of dehydration. There were no charts in place to show the amounts a person had drank or had the amount of recommended fluid to maintain their health or show if they were at risk of dehydration. The provider had introduced these daily records on the day of this inspection.

The management and nursing team had developed working relationships with local health and care team in relation to people's care. For example, the community nursing team had attended to provide people with specialised care or advice.

People had access to health and social care professionals. People had seen opticians, dentists and were supported to see their GP when they required it. The GP visited the home weekly to provide regular oversight of people's health needs and for routine appointments. People were supported to see the GP when needed with home visits arranged. Other professionals had attended to support people with their care needs, such as a referral for hearing aids.

The home environment and facilities was accessible to people and they had access to the outside garden area. People spent their time in the communal lounge or their bedrooms. The communal areas had been identified as requiring redecoration with some heating issues to resolve in the conservatory. Two family members told us that this impacted on their relatives comfort and preferred area to sit and that the provider had not yet provided dates when the repaired would be completed.

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.

All staff we spoke with understood all people have the right to make their own decisions. Staff also knew they were not able to make decision for a person and would not do something against their wishes. Where a person had been assessed as needing help or support to make a decision in their best interest this had been recorded to show who had been involved and the decision made.

We also looked at Deprivation Liberty Safeguards (DoLS) which aims to make sure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom. The manager told us that no one living at the home was currently being restricted or had a DoL authorisation in place.

Requires Improvement

Is the service caring?

Our findings

At the time of our last comprehensive inspection on 28 and 29 September 2017 we rated this question as requires improvement. This was because people were not actively supported by staff that were permanent or met their needs in a timely way. This question was rated as Requires Improvement and we have not improved the rating because we found improvements had not made.

We saw that on occasion where people were able to communicate verbally received more interaction from staff as they were able to call out for staff assistance or support. We observed three people sat alone that had not been able to engage in conversation. , They received minimal staff engagement and were left unoccupied for long periods of time, for example from mid-morning until lunch time. People were left sat in their chair unable to move and received no emotional support or guidance as staff were not available within the communal areas.

Staff told us they did not had the opportunity to sit and spend time with people to support their emotional needs. Staff provided the example that they would like to sit and chat with people during the lunch time so it was more sociable and enjoyable experience for people, but did not have the time. Staff said, in the evenings there maybe a little more time, as daytimes were very busy. They said they needed time to complete the charts to show what care they carried out with the person.

People gave us mixed views about the staff who looked after them and one person told us, "Staff are good and bad, some people have to wait". One person told us, "They [staff] come in and tell me how tired they are and they come in and talk over me like I don't understand". One relative we spoke with echoed this and told us, "I think there is a lack of compassion. They [staff] come in talk over [person] and they keep saying to [person] how rubbish the job is".

People commented the permanent members of staff often knew them better and one person told us, "I have been here a long time the people are nice all the staff know me and my sense of humour". People's views of the agency staff were they found it difficult to relate to them and understand as a s a result the agency staff members spoke in a louder voice.

People were supported to express their views and be involved in making decisions about their day to day care and treatment. However, staff were not always able to meet people's preferred care routines. For example people had requested baths/showers and the request were delayed or not met. People told us other care tasks, for example nail care depended on which staff were working and if they had time to sit and do their nails. Staff were not able to meet these requests at the time the person requested as they were busy with other people care needs.

People were confident to approach staff for support or requests and staff were aware of people's everyday choices and were respectful when speaking with them. For example, people were able to request drinks. All staff we spoke with told us that the non-essential care tasks often got left and would depend which staff were on the shift as to which tasks were completed. All staff we spoke with told us they would like more

social time with people, getting to know people and this was currently not in place as part of their role as well as providing care. The staff team had not been reviewed by the management to ensure their time was effectively spent and there were enough staff to meet these needs.

People received care and support from staff who respected their privacy and people we spoke with felt the level of privacy was good. The manager was aware of the need to maintain confidentiality in relation to people's personal information and personal files were stored securely.

Requires Improvement

Is the service responsive?

Our findings

At the time of our last comprehensive inspection on 28 and 29 September 2017 we rated this question as requires improvement. This was because people were not provided with the opportunity to have things to do and there were inconsistencies in the care planning records. This question was rated as Requires Improvement and we have not improved the rating because we found improvements had not made.

People and family members we spoke with told us they were not involved in planning and reviewing the care needs. They were not aware of the records kept about them or how these were used to plan their care and treatment going forward. Two people and two relatives told us that their relative's communication needs were not met. This had an impact on their ability to access the care and treatment they needed as they were not always able to understand what the care staff were asking or offering. The manager and provider agreed that further involvement from people in the review of their care would benefit people and would reflect changes in their needs. These could then guide staff in consistently responding to people's needs in the most effective way.

People's plans of care had been developed around their health and care needs; however, they were not clear, not consistent and contained limited amounts of information about personal preferences and lifestyle choices. The wishes of people, their personal history, the opinions of relatives and other health professionals had not always been recorded. The care plans had not been reviewed and updated regularly and people's involvement had not been recorded or reflected in the care records.

Information about people's daily care needs and experiences had not been recorded for staff to have access to the and shared across the staffing team where the staff changed shifts. This was particularly important as agency nursing staff had limited knowledge of the people in the home. One nurse told us, "We help each other figure it out. You pass it [people's clinical needs] on to the next nurse".

People had a limited variety of social and recreational activities, such as an external entertainment coming into the home every three months. People and their relatives told us that outings were rare and people were often left with nothing to do during the day. One relative told us, "We used to have an activity co-coordinator but she left and has not been replaced". The provider told us they planned to employ an activity coordinator at our last inspection in September 2017 and was still in the process of recruiting to the role. One person told us, "One thing that would make it better, a bit of entertainment".

During our inspection we saw people spending much of their time sitting with little or nothing to do. Staff told us that the need to prioritise physical care tasks left them with little time to respond to people's emotional support requirements. There were games and other resources available but staff had not had time to use these to support people in having fun and interesting things to do. Staff told us people were treated as individuals. Relatives told us that where it was necessary to speak with staff about their family member's care this did not always happen and only spoken with staff in passing.

All people and relatives we spoke with said they would talk to any of the staff if they had any concerns or

complaints. The manager told us they welcomed the opportunity to learn from complaints or to let staff know they were doing a good job.. Relatives felt their concerns were not always acted on. Two relatives told us the laundry was not well managed and their family members clothes were, "Often ruined". All people we spoke with said they talked with staff about their concerns if they had any, but these had not been recorded by the previous registered manager. The provider was not able to review and take learning from these and they advised any reported concerns will be recorded going forward.

Where completed Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) discussions had been done and were available in the care plans. The two we looked at had been completed when the person had capacity. End of life care plans were completed and where appropriate included people's family member's involvement.

Requires Improvement

Is the service well-led?

Our findings

At the time of our last comprehensive inspection on 28 and 29 September 2017 we rated this question as requires improvement. We identified a breach of the Regulation 17, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not had effective quality assurance systems in place we have not improved the rating because we found improvements had not made.

Since the registered manager left the service in September 2017 a new manager had been appointed who then left the service in March 2018. The provider then appointed one of the nursing staff as the manager who told us they would be applying to be the registered manager.

The provider current system in place to ensure the effective running of the service had failed. The registered manager had not completed checks which the provider had expected, to ensure people were experiencing good care. The provider had not assured themselves or supported the previous registered manager to have an effective system to check and improve the services offered. The system had failed to identify that records were not completed accurately or contemporaneously. Nursing staff told us they made stock checks of the medicines; however the previous manager had not completed any checks regarding people's medicines. Therefore the provider had a lack of oversight of people's medicines as they had not checked these. The current manager told us, "There is a lot to do yet, I need support to move the home forward". The provider confirmed that additional nursing hours had been agreed to support the manager going forward and the provider was planning to be in the home.

The culture within the home had not been open or transparent. People and their relatives had not been fully aware of the recent failings within the home management or how the provider was making changes or improvements in response to this.

Staff told us they had not been listened when issues or concerns had been raised in team meetings, such as the levels of staff needed to care for people. They told us as they had been ignored by the previous management team they had stopped asking for or providing suggestions to improve people's care.

People had not been consistently involved or asked for feedback about their care and treatment or listened to about improvements in the home. Where relatives had attended meetings they told us no action has been taken from their suggestions, such as an increase in staff and activities. One relative told us told us about the management team in the home, "Three meetings telling us what we want to hear [improvements], but does nothing about it". There had been no clear format for people to feedback or make suggestions about their home. One relative told us, "We are told they are fully staffed then agency comes in and not always able to understand them due to the language [accents]".

The provider had relied on agency nursing staff and there had not been consistent clinical oversight of people's health and safety needs. Staff told us any suggestions they had made for improvements were ignored by the previous registered manager. For example, they had not had time to sit and spend with

people and people were not supported with requests. The provider had not assured their management team had enabled improvements and to have an effective system to check and improve the services offered. The management team had not demonstrated current best practice in with staff in reference to people's overall care and support.

The provider had recently been visited by external agencies in response to concerns raised about the quality of people's care at the home. They had received support from these agencies to enable them to evaluate and reflect on where improvements were required. The manager provided us with their development plans to improve the service. The plan of action showed the improvements planned with dates for completion. However, the previous lack of leadership in the home had not demonstrated how the provider used best practice guidance to ensure that people's needs were met effectively. The new action plan needs to evidence an effective on going monitoring system to sustain any improvements made. Throughout our inspection we saw examples of how this had impacted upon people receiving care and support which was not based on good practices.

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

Care staff felt the new management arrangements were supportive and would assist in providing a good home for people. They were committed to supporting the provider to improve the service. The staff team told us they worked together and one staff member told us, "Staff work as a team".

The providers systems had not identified how they involved, included or reviewed how the service was learning from good care to continually improve and ensure that any such good practice was going to be sustained. The manager told us they were now in the process of reviewing all the care documentation with the involvement of people who lived at the home, their families and members of the staff team. The manager told us once the care records were up to date they would be reviewed on a regular basis to ensure they provided accurate and up to date information. In addition the manager told us they were introducing a 'Resident of the day' programme. This would include a full review of the persons care records and making the day special for them. The manager confirmed they were aware more emphasis needed to be placed on providing person centred care and encouraging people to become more involved in the care planning process.

Services that provide health and social care to people are required to inform the Care Quality. Commission (CQC), of important events that happen in the service like a serious injury or deprivation of liberty safeguards authorisation. This is so we can check that appropriate action had been taken. The manager understood their role and responsibilities and the requirements of the Health and Social Care Act 2008. They knew when notifications needed to be sent and we had received notifications when they were required.

The provider had a willingness to work in partnership with others including the local authority safeguarding and commissioning teams, to support and develop the service. This included reviews and advice from health and social care professionals; such as GPs, social workers and community nursing teams.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. We found the provider had conspicuously displayed their rating in the entrance hall way.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Information in people's care plans had not always reflected the information about people's choices and individual needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's risks had not been clearly recorded and regularly reviewed. Staff were not always available to meet people's needs/felt there were not always enough staff on duty.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There was no tool to assess people's dependency levels so staffing levels were not based on their needs. There were not enough staff on duty to meet people's needs.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have systems in place to ensure the effective running of the service.

The enforcement action we took:

Impose condition