Healthcare Homes Group Limited

Beaumont Park Nursing and Residential Home

Inspection report

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Date of inspection visit:
20 June 2016

Date of publication:
13 September 2016

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

We carried out an unannounced inspection on 20 June 2016.

The service provides accommodation and nursing or personal care for up to 46 adults, some of whom may be living with dementia and/or with life limiting conditions. At the time of the inspection, 46 people were being supported by the service, some of whom were accommodated in shared bedrooms.

The service had a new manager who was in the process of registering with the Care Quality Commission. 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 were systems in place to safeguard people from harm and staff understood when and how to report any concerns they had to the appropriate authorities. There were risk assessments in place that gave guidance to staff on how risks to people could be minimised.

The provider had effective recruitment processes in place but staffing numbers were not always sufficient to ensure that people's needs were met safely.

Staff had not received regular supervision or appraisal. Staff had been trained to meet people's individual needs. They understood their roles and responsibilities to seek people's consent prior to care being provided. However, the requirements of the Mental Capacity Act 2005 were not always met.

People were supported to have enough to eat and drink and to maintain a diet that was suited to their needs, although some people would have preferred more choice of meals. They were also supported to access other health and social care services when required.

Staff were kind and caring and most people were happy living at the service. The high number of shared bedrooms did not promote people's dignity or protect their privacy.

People's needs had been assessed, and care plans took account of people's individual needs but were not person centred and contained little information about people's lives and their preferences. There was a range of events and activities provided which was based on people's interests and hobbies and people were supported to maintain links with the local community.

The provider had a formal process for handling complaints and concerns, but did not always respond to people's complaints.

The service sought feedback from people and acted on the comments received to improve the quality of the

service although a formal survey had not been recently completed. The provider had systems in place to monitor the quality of the service although some aspects of this system had not been fully utilised in recent months. The lack of input from the provider in relation to quality monitoring had resulted in shortfalls to the service being overlooked.

We found the provider was in breach of a number of regulations of the Health and Social Care Act (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Up to date emergency evacuation plans were not in place.

People felt safe and there were systems in place to safeguard them from harm.

There were robust recruitment systems in place but there were not always enough staff to meet people's needs safely.

People's medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had sufficient knowledge and skills to meet people's needs

Although staff understood their responsibility to ask people for their consent before providing care, the requirements of the Mental Capacity Act 2005 were not always met.

People had enough to eat and drink and were supported to have their health care needs met.

Is the service caring?

Requires Improvement

The service was not always caring.

People were supported by staff that were kind, caring and friendly.

Staff understood people's individual needs and they respected their choices.

Staff respected and protected people's privacy and dignity. However, the provision of shared bedrooms for people who were not in a relationship, did not ensure that their dignity and privacy were protected sufficiently.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs were assessed and care plans were in place, although these were task centred rather than person centred.

People said their individual needs were met.

People were supported to pursue their hobbies and interests.

There was a complaints system in place, but it was not always effective in resolving concerns.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The manager was in the process of registering with the care quality commission.

The new manager promoted a person centred culture within the home and staff understood their roles and responsibilities when supporting people in meeting their needs. The provider did not demonstrate person centred values when making decisions about refurbishment.

People who used the service and their relatives were able to share their experiences of the service although a quality assurance survey had not been recently completed.

Quality monitoring audits were carried out regularly by the home manager, which were reviewed by senior managers, and the findings were used to drive improvements. However, there had not been any quality monitoring visits by the provider's senior team since October 2015. This lack of provider oversight meant that shortfalls in the service had not been picked up or acted upon.

Beaumont Park Nursing and Residential 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.

This inspection took place on 20 June 2016 and was unannounced. The inspection team was made up of two inspectors.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we held about the service, including the notifications they had sent us. A notification is information about important events which the provider is required to send to us.

During the inspection, we spoke with nine people who used the service, ten relatives and friends, the registered manager, the business manager, a regional manager responsible for overseeing the management of the service, the hairdresser, an activities coordinator, a nurse, and seven care staff.

We looked at the care records for six people who used the service, the recruitment and supervision records for five staff and the training records for all the staff employed by the service. We also reviewed information on how the provider handled complaints and how they assessed and monitored the quality of the service.

Requires Improvement

Is the service safe?

Our findings

The service had an evacuation plan held centrally in the office to guide staff in helping people to leave the building safely in the event of an emergency. However, this plan was out of date, so would potentially put people at risk because the information was no longer accurate. There were no personalised evacuation plans in people's rooms or care records to give staff information about people's individual support needs in the event of an emergency evacuation. This meant that the provider would not be sufficiently prepared to act on any emergencies and would not be in a position to safely remove people from the service.

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

On the day of the inspection there were enough staff on duty, although several people and staff said that there were not always enough staff. One person said, "The staff are lovely, there's just not enough of them." Another person said, "They are often very short staffed. Weekends particularly." A relative told us, "There is a lack of management at weekends." Some staff we spoke with confirmed that they also felt that there was insufficient staff on occasions. One member of staff said, "We could do with more carers as it can be a bit of a rush sometimes."

One person told us they had, on occasion, been unable to call staff for help because their call alarm had been left out of reach and they had been left alone for too long in an area where there was no means of calling for staff attention. They told us that on one occasion this had resulted in them standing up unaided, which put them at risk of falling. Other people said they had to wait a long time to be supported by staff when they rang their call bells. One person said, "Sometimes it's busy and staff do not always come quickly when I need help." Another person said, "Staff seem ever so busy at times and I have had to wait to be helped to the toilet." This was supported by a member of staff who said, "We answer call bells as quickly as we can. It is sometimes taking longer to support people because we are waiting for another staff to help." We observed that call bells were being answered fairly quickly during our inspection, but we did not always see whether staff provided the required support each time they switched off the call bell. On one occasion, we noted that it took six minutes before the call bell had been answered. The manager told us that they were monitoring this and taking it into consideration during the review of staffing numbers.

When we spoke with the manager about the staffing levels, they explained that a new dependency tool was now to be used and they were in the process of assessing staffing requirements to ensure that the right numbers of staff were on duty to provide people with safe, effective care.

These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people told us they felt safe living at the home overall. One person said, "Yes, I am safe here. I'm happy." A relative told us, "Yes, safer here overall I would say. They are great. I have no complaints. It's clean and they care."

The provider had up to date policies designed to protect people from abuse which included safeguarding and whistleblowing. Staff demonstrated a good understanding of abuse and their responsibility to protect people from avoidable harm. They were confident that if they reported any concerns it would be dealt with appropriately by the management. A member of staff said, "I would always report it to my manager, even if I wasn't completely sure." Staff had a good understanding of the provider's whistleblowing policy and one member of staff was able to tell us about an occasion when they had reported their concerns about a colleagues conduct and confirmed they were listened to and kept safe from any recriminations.

There were personalised risk assessments for each person to monitor and give guidance to staff on any specific areas where people were more at risk. The risk assessments included areas associated with people being supported with their mobility, risks of developing pressure area skin damage, falling, not eating or drinking enough. This maintained a balance between minimising risks to people and promoting their independence and choice. The risk assessments had been reviewed and updated regularly or when people's needs had changed so that people received the care they required. Records of incidents were kept and the computerised system enabled the management team to identify any trends so that action could be taken to reduce them.

We saw that there were processes in place to manage risk in connection with the operation of the home. These covered all areas of the home management, such as fire risk assessment, water temperatures, prevention of legionnaire's disease and electrical appliance testing.

We saw that robust recruitment and selection processes were in place and the provider had taken steps to ensure that staff were suitable to work with people who lived at the home. We looked at five staff files and found that appropriate checks had been undertaken before staff began work at the home. These included written references, and satisfactory Disclosure and Barring Service clearance (DBS). Evidence of their identity had been obtained and checked, and there was a clear record of the employees previous work experience and skills.

We saw that people received their medicines as prescribed and that medicines were stored and administered in line with current guidance and regulations. Trained nurses were responsible for the administration of medicines. Each medicines administration record (MAR) included information about any 'as and when required' (PRN) medicine a person had been prescribed, including information about the medicine and the circumstances under which it was required. We looked at the MAR charts for four of the people living at the home and saw that these had been completed correctly and medicines received had been recorded. We checked stocks of medicines held which were in accordance with those recorded. There were robust processes for auditing medicines administration.

Requires Improvement

Is the service effective?

Our findings

Most staff told us that they had not had regular supervision meetings and we saw evidence of this in the records we looked at. A member of staff said, "I have not had supervision for a while, but it was good when I had it. It was thorough and they always checked if I was happy with everything." Another member of staff said, "I have a supervisor, but I think I last had supervision last year." A third member of staff told us, "I have not had supervision for a while, but we can talk to nurses and the manager if we have a problem. They normally help to sort things out." We also found that annual performance appraisals had not been kept up to date. We discussed this with the manager and they showed us a plan they had put in place to ensure that staff had regular formal supervision, appraisals and support.

This is a further breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The Mental Capacity Act (MCA) 2005 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.

Some of the people's complex needs meant that they did not have capacity to make decisions about some aspects of their care and we saw that in most cases mental capacity assessments had been completed and decisions made on their behalf. However, we noted that the capacity assessments that were completed were generic rather than decision specific as required by the MCA. We noted some instances where neither consent or a capacity assessment and best interest decision had been recorded. For example, we saw that one person had been assessed as requiring bedrails for safety reasons. However, there was no evidence to indicate whether or not the person consented to this or who had made the decision if they lacked the capacity to make it themselves. This is important because bedrails can be seen as a form of restraint, and therefore, any decision to use them should be done with the person's consent or on their behalf when appropriate. We also found that there was no documented evidence that people had been asked for their consent to being accommodated in a shared bedroom, and no capacity assessments pertaining to this decision which meant we were unable to establish how this decision was made by or on behalf of each individual concerned.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated activities) regulations 2014

Where possible, some people had signed forms to show that they consented to their care and support, and their photographs being taken for identity purposes and to display around the home.

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. The application procedures for this in care homes and hospitals are

called the Deprivation of Liberty Safeguards (DoLS). We saw that the provider had taken appropriate steps to refer people for assessment if the way their care was provided could result in their liberty being restricted. Eight people had authorisations in place and the manager told us that they were going to send a referral for a person who had recently moved to the home.

People told us that staff supported them well and in a way that met their individual needs. One person told us, "They [staff] are all good, they do a lot for us." Another person said, "I find all the carers are great." A relative said, "The care is very good." Another relative said, "I am happy with how [relative]'s care is being managed."

The provider had an induction and a regular training programme for all staff in a range of subjects relevant to their roles. These included moving and handling, fire safety, infection control, and dementia awareness. The training records we saw showed that the majority of staff training was up to date and the manager had booked training for those staff who needed it. Staff we spoke with said that the training had been effective in helping them to develop the skills and knowledge they needed to support people appropriately. A member of staff said, "They are good with training here. I recently did 'moving and handling' training and I found this to be really good because I learnt new techniques. I had oral health training and I found this useful too." Another member of staff said, "I have had good training." A third member of staff told us, "They are very good on training. It is very excellent, actually. The previous manager used to put us on all sorts of training." We saw that some members of staff had also been able to gain nationally recognised qualifications in health and social care, including National Vocational Qualifications (NVQ). Nurses were also supported to develop their skills and knowledge in order to support people safely and maintain their registration with the Nursing and Midwifery Council (NMC).

People told us that they always had enough to eat, they had a choice of what they wanted to eat and they enjoyed their food. One person said, "The food is marvellous. Really good, considering there is 46 people to cook for. It is served up nice. We have a choice, if we don't like the pudding we can have fruit instead." Another person said, "The food is quite good. I know because I once used to work as a cook." A relative told us, "The food is good. [Relative] is given an alternative as they don't like sandwiches for tea. There is always variety and people don't have the same things every day." However, one person who had specific dietary requirements told us that the choice offered to them was limited and they would like to see healthier options, such as fresh fruit offered more frequently.

Staff we spoke with told us that people were given really good food, they monitored people's weight regularly and would know if people were at risk of not eating enough to maintain their health and wellbeing. A member of staff said, "The quality of the food is really good and always cooked from fresh. I know because staff eat food here too when we are working a long day." Another member of staff said, "Service users always have enough food and of good quality too."

We observed the lunchtime meal and noted that tables were set up nicely for people and the dining room was almost full, apart from a few people who were being supported to eat in the conservatory or their bedrooms. We saw that the menu provided a variety of options for people and the food appeared well-cooked and appetising. People were also given snacks and drinks throughout the day. However, when we arrived in the morning, we were concerned to see that a number of hot drinks for people who needed them thickened had been prepared and left on a serving hatch. Some were not covered and had cooled down by then. This was not a hygienic way of preparing and serving people their drinks.

We noted that people had been supported to access other health care services, such as GPs, dentists, chiropodists, and opticians when required. There was evidence that staff worked collaboratively with other

professionals to ensure that people's health needs were being met to maintain their wellbeing. For example, people had been referred to dietitians if staff were concerned that they were not eating properly or they were losing weight. A relative who told us that action had not been taken promptly when their relative had lost weight was now happy that improvements had been made to identify and act quickly if people were not well.

Requires Improvement

Is the service caring?

Our findings

People told us staff were caring. One person said, "The staff are lovely." Another person told us, "They are friendly and kind. Never bad tempered." A relative told us, "They are brilliant. The nurses are fantastic." We saw written feedback from another relative who said, "Very friendly staff who go the extra mile. You get the feeling they are passionate about providing personal care and attention, and with the relationships we have built there it feels like family care."

We saw people were at ease in the company of staff and that conversations were cheerful, compassionate and not restricted to discussions about care tasks. Staff were respectful and friendly when addressing people. We saw they knew people well and chatted warmly to them throughout our visit. Staff we spoke with showed empathy with the people they supported. One member of staff said, "We are being paid to come into someone's home. We need to respect their way of doing things, who they are and what they need to feel safe and happy." They went on to explain that they adapted their approach depending on the preferences of each individual person; some people preferring a friendly informal and 'on first name terms' relationship with staff, and others being comfortable with a more formal manner.

Staff worked hard to maintain people's dignity and privacy, working discretely when supporting people with personal care, ensuring doors were closed and that discussion about personal matters was kept as private as possible. However, there were nine shared bedrooms at the home which were occupied by people who were not in a relationship with each other. This meant that 18 of the 46 people who lived at the service were sharing a room. Although each person's space in their room could be separated with a full length privacy curtain, this did not allow for them to have private conversations with staff or visitors in their own room. Due to the layout of several of these rooms, one occupant had to walk through the other person's private space to enter or exit the room. Again, due to the layout, some people's wardrobes or drawers were positioned in the other person's space. Feedback we received indicated that some people did not mind sharing a room when this was the only option available to them. However, for some people, particularly those who lacked capacity to make the decision themselves, this decision had been made by others on their behalf.

It was not always clear from records whether or not the decision for a person to share a room was made because sharing a room was known to be the person's preferred choice or in their best interest. One relative we spoke with before the inspection told us that the space was too small to visit their family member when the privacy curtain was pulled across, and that the lack of privacy was undignified, especially as their family member had been very unwell and remained in bed. There was no consideration given to what provisions could be made to ensure people had dignity at the end of their life if they shared a bedroom. As all the rooms at the service were occupied, this meant that people could not move to a different room for more privacy at this stage of their life if they or their family wished. It also meant that people who were sharing a room with someone who was at the end of their life also had no option to move to a different room.

We found that although the shared rooms we looked at were large if used as single occupancy rooms, when divided by the privacy curtain, some of the spaces created were small, especially for people who had no other private space where they could receive visitors. When we discussed this with the manager, we were

advised that this was accepted practice in hospital and it is usual to have curtains to divide up communal space to afford a degree of privacy to patients in a shared space. However, unlike hospital, this service provides a permanent home for the people who live there, and as such, the current arrangements did not sufficiently promote people's right to a private life or uphold their dignity. The extensive refurbishment of the premises in September 2014 included the provision of nine additional single rooms at the service, but gave little consideration to significantly reducing the number of shared bedrooms to make improvements to the privacy and quality of life for those people who currently shared rooms. The number of rooms was reduced from 12 to nine rooms which meant that 18 people would continue to be accommodated in shared bedrooms.

Information about the service was given to people when they came to live at the home to enable them to make informed choices and decisions. Some people's relatives acted as their advocates to ensure that they understood the information given to them.

Requires Improvement

Is the service responsive?

Our findings

People's needs had been assessed prior to them using the service and care plans had been developed so that they received appropriate care and support. Some of the care plans we looked at lacked sufficient guidance to staff about people's preferences, wishes and choices about how they liked care to be carried out. There was sufficient information for staff about the care tasks that were required, but more individualised information was required to ensure that the care was person centred. The manager had identified that work to improve care planning was required and had made a start on this process. However, people told us they received individual care and that staff made the necessary changes when their needs changed. People's relatives said that they had been involved in planning and reviewing their relatives' care. One person said, "I always get the care I need, they are really good." Another person said, "I have no qualms about how the girls support me."

The provider had a complaints procedure in place so that people knew how to raise any complaints they might have about the service. Everyone we spoke with said that they would speak to staff or the manager if they had concerns about how they were being supported. A relative said that the provider had not always been responsive to concerns they had raised about their relative's care, but they were happy with the progress that had been made by the new manager. We noted that the provider had a system to record concerns and complaints raised by people or their relatives, with evidence of what action had been taken to resolve these.

The provider employed two activities coordinators who facilitated activities so that people were not bored and socially isolated. They also supported people to pursue their hobbies and interests within the home or the local community. A range of activities had been planned and provided to appropriately occupy people's time during the day and we saw photographic evidence of some of the activities that people had taken part in. The manager told us that they planned to display more photographs to evidence what people did. For example, we saw that they had arranged a celebration for a person's 100th birthday in May this year. We saw that some people regularly visited a lunch club, run by a local church. Some people received Holy Communion on a regular basis to meet their spiritual and religious needs.

People we spoke with found the activities provided at the home interesting and stimulating. One person said, "There is a lot more to do here than the previous home I was in. I mostly enjoy it." Another person said, "The ladies who run the activities are good. I don't go out much, but I go out on Tuesdays sometimes. Recently, we had a barbecue to celebrate the Queen's 90th birthday." Another person told us that they had played bingo and won a prize for a game of skittles last week. They told us about the choice of prizes they could win, including toiletries. When referring to the activities coordinators one person said, "They are brilliant those girls. A lot of people also come in to entertain us and give talks. It's good for everybody to join in." A relative said, "They always have things for families to be involved with like barbeques and lunch at the church."

Requires Improvement

Is the service well-led?

Our findings

The manager completed a range of audits to monitor the quality of the home. These audits were entered onto a computerised system which was accessed by senior management at the provider's head office. The regional manager told us that, when issues were identified through these audits, the senior team addressed the matter with the home manager and monitored what action they had taken to make improvements. The provider also had a system for quality monitoring visits to be completed by the senior management team. However, we noted that there had not been a visit since October 2015. This meant that no audits were carried out by managers based outside those involved directly with the service in order to corroborate the home manager's audits. This lack of provider oversight meant that issues such as the lack of staff supervision and appraisals, insufficient staffing levels and poor emergency planning resulting in breaches of regulations were not addressed at the service prior to the new manager taking up post.

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

One person told us, "[Manager's name] is great. I haven't seen too much of her yet, but I think I'm going to like her."

At the time of our inspection the new manager had been in post for five weeks and was in the process of registering with the Care Quality Commission. We noted that the manager was a registered nurse and had many years of experience within a leadership role. During their first few weeks in post the manager had reviewed the service and identified a number of improvements they wished to make as a priority, and some of these were already completed. For example they had made improvements to the systems to monitor specific risk such as weight loss and food intake. This ensured that changes in people's needs were identified early and swift action could be taken to address new risks. They had also identified and started work towards improving other aspects of the service, including some which we identified during the inspection, such as care planning and record keeping. The manager had identified that, although care plans contained essential information, they needed to be more person centred. They were very clear that they wanted to promote an open and person centred culture within the service and that this must be reflected in documentation as well as in staff practice. Staff we spoke with had a person centred approach to their work and a good understanding of their role and responsibilities.

The provider made a decision not to significantly address the high number of shared bedrooms at the service when undertaking a large refurbishment project in September 2014. This decision calls into question their commitment to the values of promoting a person centred service that prioritises people's quality of life and protects their dignity and privacy. This is particularly the case for those who are at the end of their life or for those who are sharing a room with a person who is dying. Staff were positive about the new manager. One member of staff said, [Manager's name] is really good. We can talk to her." All staff we spoke with said they had confidence that they could speak with the manager about any concerns or ideas for improvement that they had and that the manager would listen and take action as appropriate.During the inspection we asked about the decision that had been made to retain so many shared rooms during the refurbishment.

The provider's representative told us there had been substantial improvements made to the premises but acknowledged that the retention of so many shared rooms was not ideal. They said that the cost of the refurbishment had to be financially justified and that retaining shared rooms supported an increase in occupancy as a result of the work completed.

People and their relatives confirmed that they felt confident to share their views about the service and that they had opportunities to do this at residents meetings, and informally through discussions with staff and management. The provider had previously sought the views of people, relatives and staff through an annual quality assurance survey. However, we noted that this had not been completed since 2014. We were told by the regional manager that this was because the provider was looking for an external organisation to manage this survey in future but this had not happened yet.

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 11 HSCA RA Regulations 2014 Need for consent The care of people with complex needs was not always managed in line with the requirements of the Mental Capacity Act 2005.

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 There were no personalised evacuation plans in people's rooms or care records to give staff information about people's individual support needs in the event of an emergency evacuation.

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 lack of provider oversight meant that issues such as the lack of staff supervision and appraisals, insufficient staffing levels and poor emergency planning had not been addressed in a timely manner.

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 was not always enough staff to support people safely. Staff had not had regular formal supervision, appraisals and support.