Lotus Care (Finch Manor) Limited

Finch Manor Nursing Home

Inspection report

Finch Lea Drive
Liverpool
L14 9QN

Tel: 01512590617

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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

About the service
Finch Manor is a care home providing personal care for up to 85 older people. The service is purpose built and the accommodation is in five units over one floor. Each of the units support people living with different conditions such as dementia and nursing needs. At the time of the inspection there were 78 people living at the service.

People's experience of using this service and what we found
People did not always receive their medicines safely. Medication was not managed and administered in a safe way.

Care plans were inconsistent and did not contain the most up to date information about people's health care needs and requirements. Care records lacked person centred detail. Risk assessments were not always in place or adequate to minimise risks to people.

The safety of the environment was not routinely monitored or assessed. Many areas of the service appeared worn and tired. Bathrooms were not maintained and appeared unclean. The service was in need of a full refurbishment.

Systems in place to monitor, assess and improve the safety and quality of the service being provided were not effective. The safety and oversight of the service was inadequate.

Not all staff had received the necessary training to help them carry out their role in a safe and competent manner.

Safe recruitment practices were in place for staff. People and relatives spoke positively about the registered manager and the staff. We observed some positive interactions between staff and people living at the service.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

Rating at last inspection (and update)
The last rating for this service was requires improvement (published March 2019) and there were multiple breaches of regulation.

The provider completed an action plan after the last inspection to show what they would do and by when to

improve. At this inspection, we found not enough improvement had been made and the provider was still in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Finch Manor on our website at www.cqc.org.uk.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Finch Manor Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 team
This inspection took place on 16 September 2019 and was unannounced. The team consisted of two inspectors, one medicines inspector and two experts by experience (ExE). An ExE is a person who has personal experience of using or caring for someone who uses this type of care service.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did
Before the inspection, we reviewed information we had received about the service. This included details about incidents the provider must let us know about, such as safeguarding events and statutory notifications sent by the provider. A notification is information about important events which the provider is required to tell us by law, like a death or a serious injury. We sought feedback about the service from the local authority and other professionals involved with the service. The provider had completed a Provider Information Return (PIR). This is a document that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information

provided in the PIR and used this to help inform our inspection.

We spoke with twelve people living at the service, nine relatives and five care staff. We also spoke with the registered manager, the office administrator, a registered nurse, the chef, activities co-ordinator and eight staff in relation to medication. We looked at records in relation to people who used the service including six care plans and fifteen medication records. We also observed the delivery of care and support throughout the day.

We observed the administration of medicines. We looked at records relating to recruitment, training and systems for monitoring the quality of the service provided.

Details are in the Key Questions below.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely
At our last inspection we found that medicines were not always managed and administered safely. This meant that people were at risk of not receiving their medicines as prescribed, and in line with best practice guidance.

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

At this inspection we found not enough improvement had been made and the provider remained in breach of regulation 12.

• The management of medicines was ineffective and placed people at risk of harm. Although there had been some improvements since the last inspection, and appropriate staff had completed their medicines competency assessments; we found medication errors during this inspection which had not been found by staff.
• People had not always received their medicines as prescribed, there were discrepancies between records and stock. There were no records to confirm that topical medicines (creams) had been applied safely.
• People were at risk of receiving incorrect medication. Medication administration records (MARs) did not record enough information to keep people safe. Handwritten records were not always signed by two staff to ensure the accuracy of the information recorded.
• There was a lack of guidance for staff on how to safely administer medicines prescribed to people. This included covert medicines (disguised in food or drink) and medicines to be given 'as required' (PRN).
• Staff did not record the date that liquid medicines were opened. Fridge and room temperatures were not always recorded and so we could not be sure that medicines were always safe to use.
• People's prescribed thickener (thickener is used for people with a swallowing disorder and helps minimise the risk of choking) was not managed safely. Information on how to thicken drinks was not always available to staff and some staff were unsure of which people required thickener. Staff did not record the amount used when added to drinks so there was no evidence that this was done correctly.

We found no evidence that people had been harmed however, there was a failure to manage medicines safely. This placed people at risk of harm. This was a continuing breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Preventing and controlling infection

At our last inspection the provider had failed to provide enough oversight of checks in place to monitor health and safety concerns in the service. We also found people's risk assessments had not been completed effectively and some people did not have appropriate risk assessments in place. This meant people were at risk of avoidable harm.

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

At this inspection we found not enough improvement had been made and the provider remained in breach of regulation 12.

• Checks to monitor the safety of the environment had not been completed, which placed people at risk of harm. For example, the nurse call bell system had not been checked to ensure it was in safe working order since April 2019. There had not been a fire alarm test since March 2019 and the last full fire drill took place in January 2019. People's bedroom door closers had not been checked since April 2019. Fire extinguisher checks had also not been completed since April 2019.
• Not everyone had appropriate risk assessments in place. This meant that staff did not always have guidance on how to manage and mitigate any identified risks to people.
• Although some improvement had been made to the cleanliness of communal areas since the last inspection, standards of cleanliness remained poor in some parts of the service.
• This was particularly evident in the bathrooms. Some of the baths appeared dirty and the enamel surfacing had worn, preventing effective cleaning of that area. The flooring in some people's rooms was also damaged, which again prevented adequate cleaning.
• Staff used personal protective equipment as required to minimise the spread of infection, such as aprons and gloves.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continuing breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
At our last inspection the provider did not have an effective system to monitor trends arising from accidents and incidents and using this information for learning, to help improve the quality of the service.

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

At this inspection we found not enough improvement had been made and the provider remained in breach of regulation 17.

• At the last inspection, we found that water temperature checks showed that the temperature of water supplied to people's bedrooms was in excess of safe temperatures. This meant that people were at risk of being scalded. At this inspection, we found that whilst hot water temperatures were at a safe level, they had not been checked since April 2019. This meant the service did not show that an effective system was in place to learn from lessons and improve practices going forward.
• Although a system was in place to monitor any incidents or accidents, the recording of the information was not effective for monitoring any trends and prevent any future risk and reoccurrence.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to prevent reoccurrence of incidents. This placed people at risk of harm. This was a continuing breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• People and their relatives told us that there wasn't always enough staff. During our inspection we observed a person fall, and we had to seek out a staff member to provide the person with support. One person told us, ''Staff are always rushed off their feet.'' Staff rotas showed that staffing levels were sufficient, however, the service used agency staff to cover absences, meaning that people were not always cared for by regular members of staff who were familiar with their routines and care needs.
• Recruitment of new staff was safe. Pre-employment checks were completed to help ensure staff members were safe to work with vulnerable people.

Systems and processes to safeguard people from the risk of abuse
• Not all staff had received safeguarding training. However, staff we spoke with understood how to safeguard people from abuse and how to report any safeguarding concerns.
• People and their relatives told us they felt the care provided by staff was safe. People told us, "Very safe living here, all very good" and "I wait my turn but if I pull my cord they come quickly and that makes me feel safe.''
• The registered manager sent us statutory notifications to inform us of any events that placed people at risk.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained as requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience
At our last inspection the provider had failed to support staff to carry out their roles by failing to provide, training and regular supervision and appraisals. This meant that not all staff had the knowledge and skills required to support people safely.

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

At this inspection we found not enough improvement had been made and the provider remained in breach of regulation 18.

• Staff did not have the necessary knowledge, skills and experience to perform their roles and care for people effectively. Although most staff had received support through supervision and appraisal, not all staff had received the necessary training to carry out their roles. We discussed this with the registered manager who confirmed that training courses had been booked for staff to complete in the near future.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to ensure staff training was kept up to date. This placed people at risk of potential harm. This was a continuing breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• New staff completed an induction when they started working at the service. This included the completion of 'shadow shifts'. Staff told us they felt the induction process prepared them adequately for employment at the service.

Adapting service, design, decoration to meet people's needs
• Parts of the service appeared worn and in need of re-decoration. Whilst we observed that one unit had recently been painted, progression, in terms of refurbishment since the last inspection had been slow. Staff also told us they felt the service required refurbishing.
• Bathrooms were in a poor state and were damaged and unclean. Bath panels were split and damaged and, in some bathrooms, tiles were missing or cracked. We saw what appeared to be dried faeces on the floor of one bathroom. One bathroom had mould on the sealant around the wash basin. Two toilets were out of order, but it was not evident that the bathrooms were out of use. One bathroom did not have a door and we

were told by the registered manager it had been missing for some weeks. We were unable to locate any records that the damage had been recorded on an audit to determine if any action was planned to address this. We also noted a strong smell of urine on one of the units. This compromised people's dignity.
• Equipment in use to support people with their mobility was not safely stored and maintained. Wheelchairs were stored in bathrooms, and some people told us that wheelchairs were faulty. One person's wheelchair did not have footplates. We followed this up and found that maintenance checks on wheelchairs were not up to date.

This was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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

At our last inspection the provider failed to act in accordance with legislation regarding the Mental Capacity Act 2005. Mental capacity assessments had not always been completed for people when needed and there was no evidence best interest's decision meetings had taken place for some people who had been assessed as not having capacity. Consent from people had not been appropriately sought, in line with MCA (2005).

This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found enough improvement had been made and the provider was no longer in breach of regulation 11.

• The registered provider was complying with the principles of the MCA. People's mental capacity had been assessed, in line with the person's best interests.
• Most staff had received MCA training and assumed people had the capacity to make decisions, unless assessed otherwise.
• Staff ensured people were involved in decisions about their care and support. Staff asked and explained to people before giving care and support. A relative told us; ''Staff always ask for [person's] consent before giving care.''

Supporting people to eat and drink enough to maintain a balanced diet
• Information regarding people's nutrition and hydration needs was not always recorded in their care records. There was a lack of guidance for staff on how to support people with their dietary requirements, for example, people who required a diabetic diet. We spoke to the registered manager about this and they told us these care records were in the process of being updated.
• We received mixed feedback about the food from people and their relatives. A menu was available each

day so people were able to choose what they wanted to eat in advance. One person told us. ''I get second helpings and a choice for my meal.''

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support

• People's needs were assessed before admission to the service. Care plans had been developed from these assessments. However, some care plans lacked detail about people's choices and preferences regarding their care recorded, for example, preferred gender of staff .

• Some people had not had their choices and preferences regarding their care recorded, for example, preferred gender of staff.

• The service worked with other health and social care professionals to help ensure people's healthcare needs were met. We saw evidence that appropriate referrals had been made.

Requires Improvement

Is the service caring?

Our findings

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

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

Respecting and promoting people's privacy, dignity and independence
• People, relatives and our observations told us that people's dignity was not always respected. As the service had not addressed our concerns raised at the last inspection, this did not demonstrate a sufficiently caring attitude.
• People's dignity was undermined by the lack of consideration given to the cleanliness and decoration of the environment.
• During our inspection, we observed a person who had just had a shower enter a communal lounge unclothed, this caused some people to become distressed and also severely compromised the person's dignity.
• However, staff were able to describe how they protected people's dignity and privacy, including closing doors and curtains when providing personal support and helping people to remain covered with towels.
• Records regarding people's care and treatment were stored securely.

Ensuring people are well treated and supported
• We observed some positive interactions between people and staff throughout the day. Staff were kind and tactile. They addressed people by name and explained before any support was carried out.
• People and their relatives told us the staff knew people's needs and treated them well. One person told us, ''[Staff] here are about the best I've come across.'' Comments from relatives included; "Staff are good to [person], never had any concerns about the staff.'' Another relative felt that the staff's approach was "Quite good, couldn't complain, they do a little bit more than other homes.''
• Relatives told us communication between them and the home was good, but some felt there was some room for improvement.

Supporting people to express their views and be involved in making decisions about their care
• People's feedback was sought via resident meetings. We saw that action was taken based on this feedback.
• A service user guide was available to people. This provided information about the service and what people could expect. This guide was available in different formats to support people's communication needs.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained as requires improvement. This meant that people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation

• At the last inspection people's care plans did not provide enough detail to enable effective care to people. At this inspection we checked to see if improvements had been made and found that they had not.

• Care records did not always contain plans for people with specific physical health conditions, such as diabetes. Although the registered manager told us appropriate care was being provided, this was not documented appropriately, and meant people were at risk of not receiving appropriate care and treatment.

• Care plans did not always reflect people's current needs. Although care plan reviews were recorded, care plans were not always updated with the most up to date information. Advice from external health care professionals, such as dieticians, had not always been incorporated into people's care plans. For other people who required emotional support, care records did not contain guidance for staff on how to manage these needs.

• Some care plans did not contain enough person-centred information such as people's preferences, likes and dislikes. People and their relatives told us they hadn't been involved in their care plan. This meant people were at risk of not receiving support in line with their wishes.

• Some staff told us that not all care plans contained enough information and they would ask senior members of staff if they were unsure of a person's needs.

• Although the service employed a full times activity co-ordinator to help facilitate and deliver activities for people, given the large size of the service, it was evident more support was needed.

• On the day of our inspection, we did not see people engage in activities and the activities co-ordinator was out shopping for people. People told us they enjoyed some of the activities when they were offered but would like to go out more. One person told us, ''There's not much activities in here."

End of life care and support

• People's care records did not contain details of their end of life wishes. Every record we looked at documented that the person did not wish to discuss this topic or had been left blank. We spoke to the registered manager about this who told us they would ensure people's wishes were recorded where appropriate. The service was not supporting anyone with end of life care at the time of the inspection.

• Staff training was not fully complete for end of life care.

Improving care quality in response to complaints or concerns

• There was an appropriate complaints management system in place. People and their relatives told us they knew how to raise a complaint and felt confident any concerns would be acted upon.

Meeting people's communication needs

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

•Staff understood how people communicated and used appropriate methods when communicating.
• Not everyone who was supported by the service could communicate verbally. Staff communicated in nonverbal ways, such as by using body language and with pictures and symbols.
• Staff told us how they supported a person whose first language was not English. They told us that speaking a few words to the person in their native language was a source of great comfort to the person.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained as inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Planning and promoting person-centred, high-quality care and support

At our last inspection we found systems to monitor the service were either not in place or fully embedded to demonstrate safety and quality was effectively managed.

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

At this inspection we found not enough improvement had been made and the provider remained in breach of regulation 17.

• Risks to people's health, safety and well-being were not identified and mitigated.
• Although there were systems in place to assess and monitor the quality and safety of the service, the provider and registered manager did not use them effectively to identify and address concerns found at this inspection.
• Monthly medicines audits were undertaken but failed to identify the issues found during our inspection.
• Incidents had not been fully analysed to provide effective learning and so help drive forward the quality and safety of care.
• There was no effective oversight of people care records. Where people's needs had changed, this had not always been reflected in the person's care plan.
• Where audits had highlighted issues, there were no adequate action plans in place and it was not evident if actions had been carried out.
• There was a lack of appropriate planning for the service, for example, organising cover for key members of staff during long term absences. This meant that some audits had not been carried out during these absences and concerns which had previously been identified had not been appropriately addressed. This placed people at risk of harm.
• Although manager's meetings took place, minutes were poorly completed and there was not a clear follow up of actions set in one meeting to the next.
• The provider or registered manager did not plan, promote and ensure people received person centred and high quality care. We received positive feedback about how staff delivered care and support; one member of staff told us, "We all work together as a team,'' however, outcomes for people were not always person

centred.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate the safety and quality of the service was effectively managed. This placed people at risk of harm. This was a continuing breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Policies and procedures were in place to help guide staff in their roles; they were up to date and referenced nationally recognised best practices.
• Most people living in the home told us they knew who the manager was and would tell them if they had any concerns.
• Staff told us they felt supported in their roles. Comments included, "If I had any concerns I'd tell [manager], they are approachable. There's an open door policy" and ''There is good communication with managers, the manager is good."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• The registered manager knew their responsibilities in line with regulatory requirements. They knew to notify CQC of incidents and events that occurred at the service.
• Records showed staff had received regular supervision. Staff also told us they felt they could speak to the manager any time and they felt supported in their roles.
• Referrals to external agencies such as external health care practitioners were made as and when required.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
• Feedback was sought from people, their relatives and staff. Meetings were held for people and their relatives, for any relatives who were unable to attend, they were provided with meeting minutes.
• Staff attended regular team meetings and told us their views were listened to and acted upon by the management team.
• The service worked in partnership with others such as commissioners, safeguarding teams and health and social care professionals. This helped to ensure positive outcomes for people.

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 management of medicines was ineffective and placed people at risk of harm. Care plans and risk assessments did not contain sufficient guidance for staff to help keep people safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Premises and equipment were not properly maintained, cleaned and suitable for use to ensure safe delivery of care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes to monitor the quality and safety of the services provided were ineffective and did not sufficiently mitigate risks to people. Processes were inadequate in improving the quality and safety of the care provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive adequate training to enable them to carry out their duties and meet people's care and treatment needs.