Bupa Care Homes (CFHCare) Limited

Amerind Grove Nursing Home

Inspection report

124-132 Raleigh Road
Ashton
Bristol
BS3 1QN
Tel: 0117 953 3323
Website: www.bupa.co.uk

Date of inspection visit: 20 February 2015
Date of publication: 17/04/2015

Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Overall summary

The inspection took place on 20 February 2015 and was unannounced. The last full inspection took place in June 2014 and at this time two breaches of regulation were found in relation to hygiene and cleanliness and records. These breaches were followed up as part of our inspection.

Amerind Grove is a nursing home with a total of 171 beds. The home is split between five individual houses. Kingsway provides nursing care, Picador is a residential house for people with dementia and Embassy, Regal and Capstan provide a mixture of residential and nursing care.

There was no registered manager in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage

Summary of findings

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.

Our inspection highlighted a number of shortfalls in the service which had a significant impact on the care that people received. These concerns included two continuing breaches of regulation found at our last inspection in June 2014. We found that there continued to be shortfalls in cleanliness and infection control as well as continuing concerns in relation to record keeping. We found some areas of the home were not cleaned to an appropriate standard and in one bathroom we saw a used continence pad discarded on the floor. Records were not always accurate and this placed people at risk of unsafe care.

We had feedback from both staff and people in the home that the current staffing arrangements were detrimental to the quality of care that staff were able to provide. This was supported by our observations. For example, in one house, in the morning when we arrived, staffing levels were at half the level that they should have been. This placed people at risk of unsafe care. The provider told us that recruitment was a current priority for the service in order to establish a stable staff team.

We received positive feedback about the care staff and their approach with people using the service; however we observed occasions when people's dignity had been compromised. For example, we observed one person walking around in the secure outside area of one house with wet clothes.

People weren't always protected from the risks associated with malnutrition. We found that referrals to relevant professionals had not been made when a person was found to be losing weight. We also observed that in some cases people didn't receive adequate support and encouragement to eat their meals.

Overall we found that quality and safety monitoring systems were not fully effective in identifying and directing the service to act upon risks to people who used the service. Despite significant levels of staff vacancies, there was no risk assessment in place to ensure that the risks this posed to people in the home were minimised. We were told that staffing levels were decided in October. The provider told us that they monitored staffing levels; however there was no formal written documentation to evidence this.

We found some good examples of care. For example we saw some good practice in relation to the management of pressure ulcers, where photographs and documentation were used to chart the healing progress.

Staff were generally positive about the training and support they received although a number of staff mentioned that they would like specific training in relation to the needs of people with dementia. This was significant given that the service provides support for a large number of people living with dementia.

Not all staff understood their responsibilities to protect people's rights under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). This is legislation that protects the rights of people who are unable to make decisions about their own care and treatment. DoLS provided a legal framework to deprive a person of their liberty if it is in their best interests to do so and there is no other less restrictive option. Applications to deprive people of their liberty had been made where appropriate.

Although staff told us that their ability to provide good quality care for people was compromised by the staffing situation, staff showed kind and caring attitudes towards people in the home.

We found six breaches of regulations at this inspection. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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.

We found a continuing breach of standards relating to cleanliness and infection control.

There were insufficient numbers of suitably qualified staff to ensure people's safety and wellbeing.

We found some concerns in relation to the storage and disposal of medicines.

Staff were trained in safeguarding adults and understood their responsibilities to protect people from potential abuse.

Inadequate

Is the service effective?
The service was not effective.

Records relating to people's care and treatment were not sufficient to protect people from the risks of unsafe care.

We saw examples of good practice; however not everyone received effective care in relation to specific medical conditions.

Not everyone was protected from the risks of malnutrition.

There was some good knowledge and awareness amongst staff of the Mental Capacity Act 2005 and DoLS, however the principles of the act were not yet fully embedded in to practice.

Inadequate

Is the service caring?
The service was not always caring.

We received positive feedback about the care and support that people received. However our observations showed that at times, people's dignity was compromised.

People were given choices in their daily routines; however feedback about how families had been involved in care planning was inconsistent.

Requires Improvement

Is the service responsive?
The service was responsive.

Staff tried to meet people's individual requests and preferences. Attempts were made to gather information about people's backgrounds and interests.

There were systems in place to respond to complaints.

Good

Is the service well-led?
The service was not always well led.

Requires Improvement

Summary of findings

Staff did not feel confident that their views and concerns would be listened to.

The systems in place for monitoring quality and safety were not sufficient to ensure that the risks to people were identified and managed.

Amerind Grove Nursing 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.

The inspection took place on 20 February 2015 and was unannounced.

The inspection team was made up of six inspectors and two experts by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection, we viewed all information we held about the service, including information of concern and notifications. Notifications are information about specific important events the service is legally required to send to us.

As part of our inspection, we spoke with 26 people who used the service, 14 visiting friends or family, and 28 members of staff including care staff and nurses.

We tracked the care and support provided to people and reviewed 15 support plans relating to this. We viewed documents relating to the health and safety of people, such as risk assessments and information relating to fire safety.

We made observations of the care that people received, including a formal SOFI observation of the care provided in Picador at lunchtime. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

People in the home were not safe. Staffing levels were insufficient to ensure people's safety and wellbeing. Staff from across all houses reported that, due to staff sickness and absence, staffing levels were frequently not at their expected levels. Staff told us that they were not able to deliver care effectively due to pressures placed on them by insufficient staffing levels. Comments included; "It's unrealistic for the service to improve until the staffing issues are resolved." Another staff member told us that the number of care staff fell to "four or five regularly" (expected staffing levels were eight care staff) and that it was "not a safe environment" when this happened.

Staff told us they were frequently moved from one house to another to make up shortfalls in staffing. This meant that often houses were operating at under the required staffing levels. We asked the provider how they kept track of this movement of staff and we were told this would be recorded on rotas in individual houses and a note made in the file of the manager responsible for cover on that day. However, staff told us the rotas in individual houses were not an accurate reflection of actual staffing levels as they only showed the planned staffing for the day rather than reflecting any subsequent movement in staff. We were told a more robust system for tracking staff would be introduced following feedback from our inspection.

In Regal, the morning shift started with three care staff and one nurse. This was half the expected staffing levels that the provider had planned as required to meet people's needs. During the morning another care worker arrived. There were 29 people in Picador and two care staff scheduled to be on duty in the afternoon, one of whom was an apprentice and therefore should not have been included in the rotas as the provider considered them as supernumerary. We discussed this with the provider during our inspection and asked for action to be taken to ensure that people would be safe. In response to this, staff were brought in from other houses in the afternoon

In Regal we found that on 18 February 2015 there was no nurse on duty during the night. An agency nurse had been booked but did not arrive. This meant that there were not the planned numbers of nurses on duty to meet people's needs. This placed people at risk of unsafe care.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we inspected the home in June 2014, we found a breach of regulations relating to cleanliness and infection control. A compliance action was issued and we asked the provider to make improvements in order to meet this regulation. At our inspection in February 2015, we found that although some progress had been made, more needed to be done in order to fully protect people from the risks associated with cross infection and maintain the standards required by The Department of Health published Health and Social Care Act 2008 Code of Practice On The Prevention And Control Of Infections And Related Guidance.

In Kingsway, lounge chairs were stained and dusty. We also observed a slide sheet labelled for a named individual, hanging in the corridor. It was marked and stained; we brought this to the attention of care staff who removed it to be laundered. In one of the bathrooms we saw a used continence pad, discarded in the corner of the room.

In Regal we found some people's bedrooms were dirty. In one room, the floor was sticky and smeared and there was dirt at the head and wall side of the bed. In one of the toilets the lino around the bottom of the toilet was stained.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not fully protected against the risks associated with the administration and storage of medicines. In Picador house the temperature of the fridge used to store medicines had been recorded as being outside the recommended range of 4-8 degrees on every day in February. Temperatures had been recorded up to 14.8. This meant medicines stored in this fridge were at risk of degrading before they were used.

In Picador and Regal, unused medicines were not disposed of securely. In Regal house the container in which unused medicines were placed, was an open box, meaning medicines could easily be removed. In Picador we saw records of waste medicines consigned for destruction. Staff

Inadequate

Is the service safe?

showed us blue bins in the treatment room where wasted medicines were placed, awaiting collection. Staff were unable to give us assurance that medicines were safely disposed of and were not aware of any receipts for returned drugs. Following our inspection, the manager confirmed that an outside contractor collected unused medicines and they were signed for electronically. A receipt was then sent to head office. We were told that in future, the manager would request a copy of the receipt.

People were protected against the risks of abuse and staff received training in safeguarding adults. Staff told us they felt able to recognise and report signs of potential abuse. People in the home gave positive feedback about how they were treated by staff. Comments included “Staff care for me very well, they are nice staff, they never hurt me” and “The girls are lovely and kind, we have a laugh”.

We found risks relating to the care of individuals were recognised and assessed with measures put in to place to guide staff. For example we saw risks assessment in relation to the use of a wheelchair for one person. A standard tool for identifying people at risk of developing pressure ulcers was used.

People were cared for by suitable staff as there were systems in place to support safe recruitment decisions. We viewed the records relating to the last 10 members of staff employed at the home and saw that Disclosure and Barring Service (DBS) checks and two references had been sought for each of them. DBS checks give prospective employers information about any criminal convictions a person might have and document whether they are barred from working with vulnerable adults.

Inadequate

Is the service effective?

Our findings

When we inspected the service in June 2014, we found a breach of regulation relating to records. A compliance action was issued and we asked the provider to take action to meet the regulation. When we returned to the service in February 2015, we found a continuing breach of the regulation. Records were not always accurate or complete and this meant there was risk of people not receiving safe and effective care. One person had specific needs relating to the care of their feet. Staff described the care routine that was carried out, however this was not detailed in a support plan. Another person was prescribed a PRN (as required medicine). Staff told us the reasons for doing so should be recorded. We found three dates when this had not been done and so the use of the medicine could not be effectively monitored. We found examples of where notes about a person's medical visits were out of date order, making it very difficult to understand the support they had received.

Several short term care plans and risk assessments had been put in place when people had sustained skin tears, developed eye infections and other short term conditions. Where skin tears were described, the records were not consistent regarding the size or description of the wound to monitor improvement or deterioration. There were no accident forms to accompany the conditions we looked at, where appropriate. There were no records of the treatment or care provided, or any evaluations of the progress of the conditions. Where the records showed cream had been applied to people, the name of the cream was omitted to confirm that the correct cream had been applied. One record showed an unnamed cream had been applied to a person on 21/1/15 and 22/1/15, but there was no other information available. The house manager explained a full care plan should be written if the condition extended beyond 14 days, however, these had been put in place to ensure that staff had full information.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were positive about the opportunities for training that they received. They completed five full days of training for their induction. Training identified as necessary for the service by the provider such as manual handling, infection control and safeguarding training was covered during induction, and refreshed annually. Comments included; "Support and training is brilliant and we can ask for extra training." A number of staff mentioned that they would like specific training in the needs of people with dementia. This was particularly significant given that a high number of people across the home were living with dementia. This meant there was a risk that staff were not supported to develop skills necessary to care for the particular needs of people using the service.

We found a mixed picture of the effectiveness of the care that people received. There were examples of good practice that had led to improvements in people's health and wellbeing; however we also found examples of where people's care and support had not been managed effectively and had placed them at risk.

Examples of care that placed people at risk included one person with diabetes who had blood sugar levels taken. On two occasions the reading had been higher than the stated upper limit . Staff were unable to say what measures had been taken to protect this person's health in response to the high blood sugar readings. No blood sugar readings had been taken in January 2015. Following our inspection, we were told that further advice had been sought from the person's GP.

We found some evidence of good practice in relation to the monitoring of people's nutritional needs. For example, assessments were used to identify people at risk of malnutrition. However concerns about people's nutrition were not always followed up. One person was found to be underweight according to their BMI (Body Mass Index) measurement. This person had lost weight since being in the home but no action had been taken to discuss this weight loss with the person's GP or another healthcare professional. This meant the person was placed at risk of malnutrition.

Not everyone received support and encouragement when being assisted with their meals in order to help ensure they had sufficient to eat. For example one person had a meal brought to them but they did not eat it. A member of staff noticed and took the meal away and asked if the person would prefer some pudding, they were already walking away as the person shook their head. The staff member returned with the pudding and the person ate one spoonful. Three staff members tried to encourage eating, as

Inadequate

Is the service effective?

they walked past. A fourth member of staff picked up the bowl and took it away. Apart from one spoonful the person did not eat any lunch and they were not offered any alternative.

We reviewed the fluid intake chart of one person and saw that only 300mls had been consumed by 16:00 hours on the day of our inspection. This was not an adequate amount of fluids to support their health and wellbeing as the recommended amounts are 1.6 to 2 litres per day.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Good examples of effective care, included the treatment provided to some people with pressure ulcers. In one house staff told us three people had pressure ulcers currently at "grade one to two" but that these were improving. They showed us photographs to illustrate this improvement. One person had been admitted recently with an existing pressure ulcer. The nurse was able to describe the interventions used to bring about improvement including creams and dressings used, pressure mattresses and regular repositioning. We checked a positioning chart for a person and saw that the person's position had been changed within the specified time (four hourly) on the day of our inspection.

We identified some specific examples of where staff had not followed up concerns about a person's health with a relevant healthcare professional, detailed above. However, across the home we found some good practice. People could use other healthcare services when necessary. For example, in one house we found clear information about when healthcare professionals had visited the service and the advice they had provided. Letters from health clinics that people attended were included in their support files so that all staff were aware of the advice provided.

Not all staff understood their responsibilities under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). This is legislation that protects the rights of people who are unable to make decisions about their own care and treatment. DoLS provide a legal framework to deprive a person of their liberty if it is in their best interests to do so. However, practice in relation to protecting people's rights under the act was inconsistent. In one house we found that staff in day to day charge were unclear about who in the house had DoLS applications or authorisations in place. However all staff said that they would stop a person from leaving if they attempted to do so. Without having clear knowledge of who had applications or authorisations in place, staff would not be able to ensure their rights were being effectively met.

We saw examples of best interest decision making on behalf of people who lacked capacity, for example in relation to the delivery of their care routines. We also saw examples of where applications for both standard and urgent DoLS authorisations had been made. An urgent authorisation for DoLS can be put in place by staff alongside a standard application being made to the local authority in order to keep a person safe. This showed that staff had some knowledge of the appropriate procedures to follow when depriving a person of their liberty. However across the service protecting people's rights in line with the MCA was not fully embedded into practice.

Requires Improvement

Is the service caring?

Our findings

People's dignity and respect were not always protected. We observed several examples of people's dignity being compromised. For example, we saw one person sitting on the side of their bed who was naked from the waist down; they could be seen from the corridor as their bedroom door was open. We saw another person walking around outside in the garden. This person did not have a coat on and their trousers were falling down.. Another person was seen in their room at various times over a period of two and a half hours, with food debris evident on them. There was also a strong smell of urine. For this period of time, the person's dignity had been compromised.

Observations and discussions with relatives suggested that people didn't always receive the care and attention they required. One relative told us that they had arrived to find their relative's feet dirty and had to request staff to clean them. We also observed some people in the home had long fingernails which appeared unclean.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed feedback from people about the care and support they received; however a number of positive comments were made. Where people had concerns about the quality of care provided, they felt this was due to low staffing levels rather than the abilities and approach of individual staff members. Comments included; "these ladies [the carer staff] in here, they're wonderful", and "My relative has poor mobility but staff know how to handle them; it's no problem when there are enough staff, but that's not always the case". One resident told us that staff were "kind and helpful" but we were told that this person was to move to another home because family were concerned about staffing levels.

Staff were kind and caring in their approach. For example, we observed a member of staff encourage a person into the lounge, who was upset, by reminding them that they could have some chocolate when they got there. We later observed this person calm and settled, with some chocolate and a hot drink. We saw another person being supported to be physically comfortable by being taken to an armchair in the lounge. Staff told us this person liked to have their hand held in order to feel settled and content and later the activities coordinator gave this person a hand massage, whilst the person looked relaxed.

Staff were attentive in their approach when supporting people with their moving and handling needs. We observed one person being supported, to move from their wheelchair to armchair, by two care staff using a hoist. Care staff gave the person calm clear instructions, talking to and reassuring them at each stage of the procedure; a third member of staff made sure the person's feet were correctly positioned.

People told us that they were given choices in their daily routines which helped ensure that their views were listened to and that they were involved in planning their own support as far as they were able. One person told us; "oh yes, we have choices but you have to be sensible" and, "they allow me to do things my way". We also observed staff offering people choices in day to day matters such as where they would like to sit and how high they wished their chair to be.

We received mixed feedback from relatives about whether they had been included or involved in care planning. Some relatives told us that they had not been consulted by staff on their views and opinions, while other relatives confirmed that they had been involved in decision making, for example in relation to the use of bed rails. The level of involvement of relative and other representatives was inconsistent. This meant that where people were unable to express their opinions about the care they wanted, there was a risk that important information about their care would be overlooked.

People were able to maintain relationships with friends and family. Several residents said that friends and family could visit at any time and visitors confirmed this. One resident said that their family visited nearly every day. Another said he got lots of visitors and they could come when they wanted.

Good

Is the service responsive?

Our findings

We found that some attempts were made to gather information about a person's individual needs on admission to the service. For example, in some people's files we saw a record entitled 'Who am I?' This gave details about people's preferred activities and their wishes for how they wanted to be cared for. However this was not in place in all files that we viewed.

There were three full-time activities co-ordinators and two part-time bank co-ordinators employed who arranged activities for each house. They provided a wide range of activities for groups or on an individual basis depending on people's needs.

Information was displayed about the activities provided for people in various areas of each house; this included information about events such as outside entertainers coming in to the service. Although we observed no organised activities taking place during our inspection, we received positive feedback from people about the programme available. One person told us "the staff were very good, they took me to Capstan House for a concert." Visitors commented that the activities were good and their relatives enjoyed them.

In each of the houses there were bags of tactile objects and games that could be used by activities co-ordinators or care staff. However, staff said they seldom had time to use them. We observed that one person was watching a television in their room; staff had tuned this into a station of their country of origin. This showed that staff understood and responded to this individual's cultural needs.

We saw examples of staff responding promptly to people who required support. One person became unwell when walking down a corridor. Staff responded to this person quickly and efficiently and treated them with kindness and respect. In one house, in the afternoon we observed cakes being offered to people as an afternoon snack. One person requested a particular condiment to go with their cake, which staff sought for them and then offered to other people in the lounge. This demonstrated that staff made attempts to accommodate people's requests and preferences.

Individual bedrooms were well furnished and residents were encouraged to personalise their rooms with photographs and memorabilia from home. This helped ensure that people's rooms were arranged in accordance with the person's wishes and preferences.

People in the home and their relatives confirmed with us that their views and opinions were sought through regular surveys; this gave people opportunity to express their opinions and raise any concerns that they may have. Relatives meetings also took place as a means of keeping them up to date with developments in the home.

There were systems in place to respond to people's complaints and we saw that the procedure for making a complaint was advertised in various areas of the home. We were given positive feedback from relatives about how complaints had been managed and responded to. We viewed examples of formal complaints that had been addressed by the manager and saw that the concerns had been responded to with openness and transparency, identifying where errors had been made.

Requires Improvement

Is the service well-led?

Our findings

There had been no registered manager in place at the home since January 2015. A new 'whole home' manager was in place but had not yet registered with the Commission. The whole home manager was supported by leaders in each of the five houses making up the home. Leaders in each house were given supernumerary hours to complete management duties.

There were shortcomings in the leadership of the service. We identified a number of breaches of regulations at our inspection, two of which were continuing breaches from out last full inspection in June 2014. This demonstrated the provider had failed to take sufficient action in response to shortfalls previously identified.

There were systems in place within each house to monitor quality and safety, however these had not been fully effective in ensuring consistent and good quality care was delivered throughout the service. We saw that individual houses reported on a monthly basis for example in relation to the number of pressure ulcers, information about people's nutrition and the number of infections. The information from individual houses fed in to a whole home 'quality metrics report'. We viewed the report produced for January 2015. However there were no comments or actions recorded on the report to show whether any action was being taken in response to it.

Senior staff within the organisation reported that a priority for them was recruitment in order to establish a stable staff team and reduce their reliance on agency staff. However, we found that despite there being a high level of staff vacancies, there was no risk assessment in place to demonstrate how the risks of inadequate staffing were being managed. We were also told that staffing levels were assessed in October but there were no formal records of staffing level reviews to show that this was being continuously monitored to assess any impact on people. People were therefore placed at risk due to the lack of effective quality and safety monitoring systems.

This was a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed comments from staff about how well they felt able to raise concerns or issues. Comments included; "we don't feel valued and they expect too much from us. Staff on long term sick leave have not been replaced", and "Management do not give us the support we need nor acknowledge the work we do and how hard we try. For example when we have our full number of staff everything works like clockwork, we all know what needs to be done and it enables us to have more time to spend with our residents. This is rare, because if we have a full team, someone will be moved to another house". Five out of a total of seven staff in one house told us they didn't feel listened to by the management within the organisation. This meant that a culture of openness and transparency was not established in the service.

Attempts were being made to encourage staff to raise their concerns. We saw that in individual houses there were 'barrier boards' where staff were able to post notes about any issues or concerns they had. In one house staff had posted concerns such as 'New staff don't get told about A/L', 'Lack of sheets/towels' and 'Staff feel abused – overtired'. We were told that the manager would collect and review these comments regularly.

Staff were aware of the term 'whistle blowing'. Whistle blowing describes the action that a member of staff can take if they are concerned about bad practice in the work place. Some staff told us that if they felt their concerns were not being addressed by the provider then they would go to other organisations such as CQC. Other staff were unclear about the organisations they could approach but were aware of their responsibility to raise concerns about the welfare of people in the home. This meant people in the home were protected because staff knew the processes to follow if they were concerned about poor practice.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing There were insufficient numbers of staff to ensure people's safety and wellbeing. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services People were not always treated with dignity and respect. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs People were not all protected from the risks of malnutrition This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The systems in place for monitoring the service were insufficient to ensure people's safety and wellbeing. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records People were not protected against the risks of unsafe care because complete and accurate records were not kept. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control People were not protected from the risks associated with cross infection because effective standards of cleanliness were not implemented across the home. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:
Warning notice