Bramcote Nursing House Limited

Bramcote House Nursing Home

Inspection report

Town Street
Bramcote
Nottinghamshire
NG9 3DP
Tel: 0115 9257316
Website: N/A

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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?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

We inspected the service on 06 and 08 January 2015. Bramcote House Nursing Home is a nursing home for 22 people. On the day of our inspection 16 people were using the service.

The service did not have a registered manager in place at the time of our inspection. There had not been a registered manager in post since May 2013. 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.

Summary of findings

People's safety was being compromised in a number of areas. These included, allegations of poor practice and incidents not always being shared information with the local authority, how well medicines were managed, the recruitment of staff and the poor standard of cleanliness

People were supported by staff who had not been given appropriate resources in relation to training and support. Some staff did not have adequate knowledge and skills to provide safe and appropriate care and support.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The DoLS is part of the MCA, which is in place to protect people who lack capacity to make certain decisions because of illness or disability. DoLS protects the rights of such people by ensuring that if there are restrictions on their freedom these are assessed by professionals who are trained to decide if the restriction is needed. We found people were not always protected under the MCA. Systems were in place to ensure assessments for a DoLS would take place if the need arose.

People were supported to maintain their nutrition. People were not always supported with their health care when their needs changed.

Choices were not always respected and some staff were not always caring in their approach.

People enjoyed the activities and social stimulation they were offered. People also knew who to speak with if they had any concerns they wished to raise. However concerns raised were not responded to appropriately and improvements did not happen as a result of these.

People were not given the opportunity to give their views on how the service was run. There was a lack of oversight and direction in the service which had a direct impact on the people who lived there.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this 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?

Inadequate

The service was not safe.

People felt safe in the service. However people were placed at risk of harm due to a lack of systems to recognise and respond to allegations or incidents.

People did not always receive their medicines as prescribed. The service was not clean in some places and there was a risk of the spread of infection.

There were not enough staff to provide care and support to people when they needed it and staff had not always undergone the required checks to ensure they were safe to work with vulnerable adults.

Is the service effective?

Inadequate

The service was not effective.

People were supported by some staff who did not have adequate knowledge and skills to provide safe and appropriate care and support.

People were supported to maintain their hydration and nutrition. Their health was monitored, but was not always responded to when there were changes.

People were not protected under the Mental Capacity Act.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with kindness, compassion and respect.

People were not always encouraged to make choices and decisions about the way they lived and were not supported to be independent.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not fully involved in planning their care or supported to pursue their interests and hobbies.

People felt comfortable to approach the acting manager with any issues. However complaints were not always investigated or responded to appropriately, if at all.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of appropriate governance and risk management framework and this resulted in some negative outcomes for people who used the service. There were no systems in place to develop and improve the service, based on the needs of the people who used it, their families and staff.

Summary of findings

People were not given the opportunity to give their views on the quality of the service or have a say in how the service was run.

Bramcote House 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.

We inspected the service on 06 and 08 January 2015. This was an unannounced inspection. The inspection team consisted of three inspectors and an expert 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 our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We contacted commissioners (who fund the care for some people) of the service and asked them for their views. We also contacted two external health care providers who visited the service and asked them for their views of the care people received in the service. 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.

During the visit we spoke with ten people who used the service, four relatives, eight members of nursing and care staff, the cook and the acting manager. We observed care and support in communal areas. We looked at the care records of five people who used the service, staff training records, as well as a range of records relating to the running of the service including complaints received by the manager and provider.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

All of the people who used the service that we spoke with told us they felt safe. They told us that if they were concerned they would be able to speak up about it. The relatives we spoke with felt their relations were safe with the staff. However we found that people could not be assured that incidents would be responded to appropriately and information shared with the local authority safeguarding team.

We spoke with the acting manager and they had a limited understanding of the local authority safeguarding protocols and their responsibility to share information relating to incidents in the service. We found incidents which should have been shared with the local authority's safeguarding team. For example, we saw one person had twice raised concerns about the care they had received from a member of staff and this had not been acted upon or shared with the local authority in line with local safeguarding protocol. Another person had fallen and sustained an injury whilst being supported by two staff. These incidents had not been shared with the local authority for consideration under their safeguarding procedures.

Although staff had received training in protecting people from the risk of abuse and had a good understanding of how to recognise and respond to allegations or incidents of abuse, these were not always being reported to the local authority. This meant that people were not always protected from the risk of abuse.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Risks to individuals were not always recognised to ensure their safety. For example, we saw one person had rails fitted to their bed to prevent them falling out of bed. However we found these rails had been fitted to a divan bed and there was a risk of the person becoming trapped as the rails did not fit this bed properly. We looked at the person's care records and saw the risk assessment for the use of bedrails had not been completed which meant the risk had not been assessed. We discussed risk assessments with the acting manager and they told us they recognised that the risk assessments had not been completed.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People could not be assured that the staff supporting them had been assessed as fit to work with vulnerable adults. We looked at the staff files of three registered nurses and found that none contained documentation to show they were registered with the Nursing and Midwifery Council (NMC). Two of these nurses had been recently recruited. The acting manager was not aware that this could be checked online and we had to demonstrate how this was done. The provider did not have any systems in place to check that staff were being recruited safely. This meant that the provider could not be assured the nurses were fit to practice and people could have been supported by nurses who were potentially unregistered.

The files we looked at contained references but it was not clear who supplied the references and so the provider could not be assured that the staff were of good character. We also found one of the nurses, who was going to be in charge of the service in the afternoon, had not undergone a criminal records check, through the Disclosure and Barring Service (DBS) as part of the recruitment process. These checks are to assist employers in maker safer recruitment decisions.

This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People felt there needed to be more staff on duty to give them appropriate care and support. All of the people we spoke with told us that staff were always busy and they often had to wait for assistance. One person said, "There are good days and bad days. Sometimes everyone is desperately busy. There isn't enough staff." Another person said, "I do have to wait a long time if I need the toilet but they tell me that there are a lot of people to see to."

There had been a number of complaints made to the provider and to us by relatives regarding staffing levels and people having to wait for long periods of time for staff to assist them. We saw that people had to wait for assistance as there weren't enough staff around and on two occasions we had to find staff ourselves to assist people. One of these people were distressed owing to the length of their wait.

Staff told us that cover wasn't always able to be found when there were staff absences and this left them short staffed. On the day of our inspection the service was short

Inadequate

Is the service safe?

staffed and we observed this led to people having to wait for support and assistance. There was no system in place to assess the dependency of people who used the service against how many staff would be needed to support them.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Medicines management was not always safe and we could not be assured that people were receiving their medicines as prescribed by their doctor. The staff who were responsible for administering medicines had not been assessed as being competent to do so. We found discrepancies in medicines, with gaps in recording and in some cases the medicines in the service did not tally with the records. Because staff were not always recording new medicines coming into the service it was difficult to ascertain if extra medicines had been delivered, or if people had not been given their medicines as prescribed

We found creams and ointments in people's bedrooms which had not been dated on opening and so it wasn't clear if they had exceeded their shelf life. One person had an ointment in their bedroom which had been prescribed for another person. Where people had been prescribed external creams and ointments, these were not always signed for as administered. For example, We observed two people needed to have a prescribed cream on their legs due to a health condition. We asked one of them if staff monitored when the cream was applied to their legs and they told us, "Not really. They'll put a bit of cream on now and again but they are so busy." The other person told us, "They are supposed to put cream on but that hasn't happened today. They never do it if I don't remember and ask them."

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service effective?

Our findings

One person who needed help to move around told us, “They (staff) don’t care how they throw you around.” We observed staff transferring people who needed support to move from one chair to another. Staff did not always use a hoist or other equipment to do this and instead used an unsafe practice described as ‘drag lifting’ which placed people at risk of injury. One person had fallen and sustained a fracture whilst being supported by staff to move from a chair to a wheelchair. There was no evidence of these staff being assessed to ensure they had used safe moving and handling practices.

There were no effective systems to provide staff with the support and resources needed to effectively fulfil their roles. People were being supported by staff who did not have the skills and training to support them appropriately. Records showed that not all staff had been given the necessary training to carry out their role and support people safely. Our observations showed that this had a negative impact on people who used the service.

We observed several occasions where staff used unsafe practice to support people to move. For example we observed two staff who did use a hoist to move a person and they were not skilled in the use of this. We looked at staff training records and we saw that staff had not received training in safe moving and handling for some time and half of the staff working in the service had not received this training.

One person, who was in bed at 10am, told us they were waiting for one of the nurses to attend to a healthcare need. The person told us they were uncomfortable and we observed they did not receive the support they needed until 1400 when the afternoon nurse came on duty. We were told this was because the nurse on duty in the morning did not have the skills or training to carry out the procedure.

People could not be assured that they were cared for by staff who were given supervision to ensure their practice was being monitored and addressed. In the six staff files we looked at there were no records of staff receiving regular supervision from the acting manager or the provider, to discuss how they were working or what training needs they had. The acting manager told us that regular supervisions were not taking place and staff we spoke with confirmed this. We found concerns had been rasied about a particular staff member but there was no evidence that this had been discussed with them.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People’s health needs were not always monitored or their changing needs responded to. Although there were care plans in place which gave guidance for staff on how to monitor the people’s changing health needs, staff did not always respond to these. People told us they were supported to see a doctor when they needed to and a relative told us staff checked their relation frequently when they were poorly. However there were occasions when people were not supported with their health. One person told us, “My mouth is sore and I'm ashamed of my teeth.” They told us they had not seen a dentist recently. We looked in their care records and saw the person was supposed to see a dentist every six months, however there were no records to show when they had last seen a dentist. We checked this out with the person’s dentist and found they had not seen a dentist in 18 months whilst living in the service.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us they could make decisions about their care and support. However some people who lacked capacity to make decisions were not protected by the MCA. We saw that one person’s care records held an assessment to determine if they had the capacity to make a specific decision and the person’s family had been involved in this. The acting manager and staff we spoke with had an understanding of the MCA. However we saw staff had recorded that three people did not have the capacity to make certain decisions including managing their own finances. There were no assessments in place to show how this decision had been reached or what decision had been made in the person’s best interests.

The manager displayed an understanding of the DoLS and told us there was no one who currently used the service who required an application for a DoLS. They told us they had made an application for one person when they felt this was required previously. All but one of the staff we spoke

Inadequate

Is the service effective?

with had a basic understanding of DoLS and told us there was further training being given on this topic. The manager had the required information to enable them to make an application if the need arose in the future.

People we spoke with told us that the food was good and that they were given enough to eat. One person said, “The food is very good here, we have a good cook.” Another person said, “I enjoy the meals, they are very good.”

We observed the lunch time meal and saw that where people needed support to eat this was given by staff. The meal looked appetising and nutritious and people had been given a choice of what to eat. Two people had a special diet and this was provided to them. One person needed an adaption on their plate to support them to eat independently and we saw this was provided.

We spoke with the cook and they had a good knowledge of people’s preferences and needs in relation to their diet. They told us one person had some difficulties swallowing and they had been in discussion with external professionals to make sure they were giving the person the correct diet. The cook had a list of who was on a special diet, such as a soft diet.

Requires Improvement

Is the service caring?

Our findings

We found people were not always treated with kindness and compassion. We received mixed feedback about the care people received. One person we spoke with told us, 'They (staff) tell me; you're not the only one that needs to be looked after there are a lot more besides you**."** One relative we spoke with told us they had witnessed a person using the service ask staff for help and said they, "Could not believe it when the member of staff just said, 'No' and carried on walking past." Some people told us they were happy in the service and felt staff cared for them well. One person said, "I am very happy here, I feel well looked after." A relative told us that the laundry and activity staff were very good and did their job well.

During our observations throughout the morning we witnessed occasions where people were treated in an uncaring way and did not receive care and support when they needed it. We heard staff repeatedly give people excuses for why they couldn't give assistance, when they asked for support. We heard one person being told they could not have assistance when they asked, and the person told us, "They tell me they are desperately busy and they explain to me that they have to have their breaks." We observed staff did not take opportunities to interact with people when they were supporting them and showed very little interest in people.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Although during the afternoon saw examples of kind and compassionate care, during the morning staff did not display warmth or a caring attitude to the people they were supporting. We observed two members of staff supporting a person with their care. This person had a high level of need and we observed the staff did not speak with warmth to the person or offer any reassurance whilst they were supporting them. This person was concerned about their relative and we heard them ask staff in the morning and again at lunchtime if they could call their relative and see how they were. Staff replied both times that they would, 'do it later.' Staff gave assistance to another person who was very distressed and we observed they didn't show any warmth towards the person, they simply gave the person the item they requested.

In the afternoon when different staff came on duty we noted a difference in the atmosphere, with staff interacting with people in a cheerful way. When the afternoon staff came on duty they asked the person who was waiting to hear about their relative if they had heard how they were. This provided the person with warmth and compassion which they had not been given by the staff working in the morning.

People's choices in relation to how they received care was not always know. People's wishes in respect to end of life care had not been sought. None of the care records we looked at contained information for staff on how to care for individuals when they were approaching the end of their life. This meant there was a risk that people's wishes would not be respected in the lead up to and when they reached the end of their life.

People we spoke with felt staff respected their privacy and dignity. The acting manager told us that all staff had received training in 'dignity in care' and staff confirmed this. We observed staff knocking on bedroom doors prior to entering and staff we spoke with knew the appropriate values in relation to respecting people's privacy and dignity. However we saw examples of where staff did not respect choice or dignity, for example, we saw staff ask a person if they wanted an apron to protect their clothing at lunchtime. The person declined this but staff ignored this and physically pushed the person forward whilst they were eating their meal and put the apron on anyway. Another person had expressed a preference for a female member of staff to assist them with personal care. On the day of our inspection this person's choice and dignity was not respected when they were assisted by a male member of staff without being asked if this was okay.

Requires Improvement

Is the service responsive?

Our findings

People were not assured their concerns would be responded to appropriately. Prior to our inspection we were alerted to a complaint a relative had made to the provider and during our inspection we became aware of another complaint which a different relative had also made to the provider. Neither complaints were responded to in a timely way and the investigation and response to the relatives was inadequate. Both relatives were unhappy with the response they received from the provider and did not feel their concerns had been listened to or addressed.

There had been three other complaints made in relation to staffing levels, people having to wait to receive care and staff attitude. Two had been investigated but there were no records to show an investigation had been carried out into the third. Records showed there had been a discussion between the provider and acting manager about lessons learned as a result of these complaints. However we found these concerns had not been resolved as our observations showed there were still concerns in relation to all three areas of concern raised.

People felt they could speak with staff or the acting manager and tell them if they had any concerns to raise. However we saw that one person had raised concerns twice and this had been recorded in their care records but had not been entered into the complaint log or acted on.

There was a procedure for staff to follow should a concern be raised, but this procedure did not contain contact details for the provider or external organisations such as the ombudsman. The procedures stated that complaints would be dealt with within 21 days. However our evidence showed this timescale was not being met in practice. The acting manager told us they had not discussed with people how they could raise concerns and we saw the complaints procedure was inaccessible to most people who used the service due to where it was positioned.

Staff we spoke with told us they knew how to respond to complaints if they arose and knew their responsibility to respond to the concerns and report them immediately to the acting manager.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Care plans we looked at contained some information about people's preferences in relation to how they wished to be cared for, however this was brief and focused on whether people would like a bath or a shower. There was no evidence that people had been involved in the care planning process. We spoke with the manager and they told us this was an area of improvement which had been recognised and there were plans to involve people in their care planning.

People were given the opportunity to participate in activities, however these were not centred on people's individual likes and dislikes. One person said, "My [relation] brings me books so I read most of the time." Another said "I've got my own radio so I listen to that." There had been some entertainers in the service such as a pantomime, a reminiscence class and arts and crafts. We saw there were forthcoming activities such as a watercolour arts class. The acting manager told us entertainers visited once a fortnight. However there was no evidence to show that people's individual hobbies and interests had been explored and steps taken to support people to follow these. The acting manager told us this was an area that needed improvement and there were plans to do this.

Inadequate

Is the service well-led?

Our findings

We found there was a lack of culture in shaping the service around the needs and desires of people that used it. There was a lack of appropriate governance and risk management framework and this resulted in us finding multiple breaches in regulation and negative outcomes for people who used the service. There were no systems in place to develop and improve the service, based on the needs of the people who used it, their families and staff.

People were clear about who the acting manager was and felt they could approach them if they wanted to discuss concerns. One relative told us, "[Acting manager] is always very busy but I discussed some issues with them and changes were made."

The acting manager told us they had been working to make improvements in the service but recognised there was still a lot of work to be done. They told us that complaints received had been looked at and trends identified in the concerns people were raising and they were working to provide guidance and training to staff in response to complaints received and had informed staff of the concerns raised. However our observations showed that this was not effective in relation to improving the attitude of some staff and poor practice taking place.

We saw there had been an infection control audit carried out by the local Clinical Commissioning group (CCG) in August 2014. They had found improvements needed to be made in relation to the cleanliness of the service and the systems in place to manage the risk of the spread of infection. Following the audit the provider had not taken steps to address the recommendations made nor had an action plan for improvement been implemented. During our visit we also had concerns about the cleanliness of the service and the risk of the spread of infection. We saw that some areas of the service were unclean and there were offensive odours in some bedrooms and communal areas. We observed the cleaning staff were not using a system for cleaning materials, such as mops. A lack of a system for infection control measures meant that there was a risk of the spread of infection posed as a result of the provider not acting on the recommendations.

There was an acting manager in post but they had not yet applied to register with us. A condition of the registration is that there should be a registered manager in post. We are discussing this with the provider and will monitor this. Records we looked at showed that the manager sent notifications to us within the required timescale.

During the morning of our visit we did not see staff being given direction and we observed staff having frequent breaks in the garden, leaving people in communal areas without any supervision. The nurse on duty in the morning had only been working in the service for a matter of days and the nurse was going to be in charge of the service once the acting manager finished their shift in the afternoon. The nurse had not been assessed as being competent to manage the medicines and so did not meet the criteria to be responsible for the service.

Systems to monitor the quality of the service provided were not in place. We found a number of failings which could have been identified and addressed prior to our visit had there been systems in place to assess and monitor the service, such as audits of medicines. The provider visited regularly but these visits were not effective in measuring or improving the quality of the service being provided.

There was a lack of oversight of the building maintenance and systems. Prior to our inspection we were alerted that the emergency call bell system was not always working. The provider and acting manager were also alerted to this. During our inspection we found a person in bed in an isolated part of the service who had been able to summon staff as their call bell was not working. The acting manager told us quotes were being obtained for a new system. However in the meantime systems had not been put in place to check if call bells were working on a daily basis and ensure there was a temporary system so people could have any assistance they needed. We had to ask the acting manager to do this.

We saw that the annual testing of electrical portable appliances in the service had lapsed and the equipment had not been tested since 2013. There were no monitoring systems in place to ensure people were protected from the risks of legionella, despite this being highlighted to the provider in 2014 by an external infection control nurse. We also saw a number of fire doors were wedged open with wooden blocks. This would prevent people from being protected by the fire safety systems if fire broke out.

People were not given the opportunity to give their views on the quality of the service provided. We asked a person

Inadequate

Is the service well-led?

who used the service if the acting manager or the provider ever asked them if they were happy with the service they received and they said, “No, I have not been asked that.” The acting manager told us that there were no systems in place for people to give their views on the service, the opportunity to complete satisfaction surveys or attend meetings.

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

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Regulation 9 2008 (Regulated Activities) Regulations 2010 Care and Welfare of people who use services. People who use services were not protected against the risks of receiving care or treatment that is inappropriate or unsafe because of a lack of assessing risk and response to changing health. Regulation 9 (1)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse. How the regulation was not being met: People who use services were not protected against the risk of abuse because incidents and allegations were not recognised or responded to. Regulation 11 (1)(a) and (b)

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 Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision. People who use services and others were not protected against the risks of inappropriate or unsafe care and treatment by means of effective systems to monitor and assess the quality of the service. Regulation 10(1) (a)(b)(2)(b)(i)(ii)(iii)(e)

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 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints. How the regulation was not being met: There was no effective complaints system to prevent or reduce the risk of people receiving inappropriate or unsafe care and treatment. This was because complaints were not responded to or handled appropriately. Regulation 19.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers. How the regulation was not being met: People were not protected from the risk of unsafe care or treatment because the recruitment procedure was not effective. Regulation 21 (1)(a)(i)(ii)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing. How the regulation was not being met: There were not sufficient numbers of suitably qualified and skilled persons employed to ensure people were safe and their health and welfare needs were met. Regulation 22.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff

This section is primarily information for the provider

Action we have told the provider to take

Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting workers.

How the regulation was not being met: People were at risk of receiving unsafe care because systems were not in place to make sure staff received training and supervision to enable them to support people appropriately. Regulation 23 (1)(a).

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 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines. How the regulation was not being met: People who use services were not protected against the risks associated with the unsafe use and management of medicines. This was because there was no effective system to ensure staff were administering and managing medicines safely. Regulation 13.

The enforcement action we took:
We have served a warning notice for this regulation.