Elysian Care Limited

Knoll House Care Home

Inspection report

The Avenue
Penn
Wolverhampton
WV4 5HW
Tel: There is no telephone service to this location.
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Date of inspection visit: 01 October 2014
Date of publication: 03/03/2015

Ratings

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

Overall summary

This inspection took place on 01 October 2014, and was unannounced. This meant the provider had no notice that we would be inspecting the home.

Knoll House was last inspected in February 2014 when we followed up on concerns about the condition of the building that we had first reported on in March 2013. In February 2014 we found that the provider had failed to meet the compliance action we issued to improve the safety and suitability of the building. During this inspection in October 2014 we found that the work to maintain and improve the premises that we said needed to be undertaken had still not been completed. Our inspection findings alongside information we had received from West Midlands Fire Service and a specialist Infection Prevention Nurse showed that there was a breach in the legal requirements that providers must meet.

Knoll House is registered to provide care and accommodation for up to 32 older people. At the time of our visit 16 people were resident at the home and two people were being treated in hospital. People all had their own bedrooms, some rooms had an ensuite

Summary of findings

bathroom, and there were shared toilets, bathrooms, dining rooms and lounges. The home should have a registered manager but this position had been vacant for over six months. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. There was no one in overall charge of the home.

We did not find that people using the service were safe. The registered provider had failed to keep the premises well maintained and clean. This placed people at risk of infection and people were not fully protected in the event of a fire breaking out in the building. The provider had failed to ensure that adequate numbers of staff were on duty. This meant staff were not always getting adequate rests between their shifts and that people were not always able to have their medicines at the correct time.

People were not benefitting from a service that was helping them live in the way they had chosen, or which would ensure they maintained good health. Talking to staff and looking at staff training records confirmed that staff had not been provided with the training they needed to update and develop their skills. At the time of our inspection the provider had failed to provide funds to purchase food. Stocks were running low with no finance available in the home to purchase more. We found evidence that staff had purchased items from their own money to ensure people always had adequate food and drinks and some staff had paid for snacks that people particularly enjoyed. People living in the home told us they were aware food stocks had sometimes run low and on occasions they had run out of basics such as tea to drink. People had been supported to see the doctor, dentist and optician. People with specialist health needs had been supported to attend clinics and appointments at the local hospital. We were particularly concerned for the safety and welfare of people with complex needs. We made the local authority aware of these concerns to ensure people were urgently reviewed and got the support they required.

The staff team ensured people were well cared for to the best of their ability with the resources they had available. The registered provider had not operated the service in a way that would ensure good care could be given. During our inspection we observed and listened to staff supporting people. We heard kind and friendly interactions and often staff and people living at the home enjoyed a laugh together. People we met had been supported to wash and dress in a style that suited their taste, gender and preferences. Staff we spoke with informed us they had not been paid their salaries for two months. Despite this they had continued to work at the home and provide care. Staff told us they had done this because of the relationships they had built up with people over time. People received care in the way that they needed and preferred.

Written records we saw contained information about people's life story and people important to them. This helped staff get to know people. Staff we spoke with were aware of people's specific needs and preferences and were able to tell us how they included this in their care.

People did not benefit from a well led service. The home had been without a registered manager for over six months. The registered provider had failed to make suitable arrangements for the day to day management of the home and we found that senior care staff were doing their best to lead the home on a shift to shift basis.

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.

The registered provider had failed to ensure that the premises, infection control practices, staffing, medicines and the management of health and safety were well managed to protect people from harm.

Inadequate

Is the service effective?
The service was not effective.

The registered provider had failed to put systems in place or to provide support or guidance for staff to assure that the service would always be effective. However care staff had provided effective care and support to the best of their ability when this was within their control.

Inadequate

Is the service caring?
The service was not caring

The registered provider had not put systems or resources in place for the effective running of the business which demonstrated an integral lack of compassion and care for people. However we observed individual staff members showing concern for people's well-being and providing care with compassion and kindness.

Inadequate

Is the service responsive?
The service was not responsive.

The service had not been organised in a way that would ensure people's needs would be met. However direct care staff had ensured that as far as possible people got the care they needed in the way they wished when this was within their control.

Inadequate

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

The service had no leadership, management or governance structures in place. This did not provide assurance that people would get the care they needed, when they needed it.

Inadequate

Knoll House Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

This inspection took place on 01 October 2014 and was unannounced.

The inspection was undertaken by two inspectors who were supported by a specialist advisor. The specialist advisor had knowledge about health and safety and infection control. Before the inspection we sent the provider a document to complete telling us about their service. We refer to this as a Provider Information Return (PIR). The registered provider failed to complete and return this. The law requires providers to notify us about certain events that take place in the home (Notifications). We had not received any recent notifications from the provider. Before the inspection we spoke to the staff who work at Wolverhampton Council with responsibility for placing people at Knoll House (Commissioner's). We reviewed information we had recently received from West Midlands Fire Service and from a nurse who was a specialist in infection prevention who worked for the local hospital. The information we received raised concerns about the safety and suitability of the service.

One day prior to our inspection staff working at Wolverhampton Council took the decision to stop paying for people to live at Knoll House and to find people an alternative home. People and their relatives had been informed of this decision shortly before our inspection started. The concerns identified during this inspection alongside concerns raised by other agencies resulted in everyone being offered alternative accommodation very quickly and the home closed on 03 October 2014.

During our inspection we met all of the 16 people living at the home, we spoke with four friends and relatives, and one health professional. People living at Knoll House, their relatives and staff had been informed on the day prior to our inspection that the home would be closing and people would be moving to other local care homes. This had been distressing news for people and the conversations we had concentrated on this rather than people's current experience of Knoll House.

During the inspection we spent time in the communal areas of the home, talking with people and watching the way staff supported people. With consent we undertook a full tour of the premises including people's bedrooms and the garden. We spoke with all the staff on duty and at length with the senior carer. We supported our observations with written records. We looked at eight records about care, nine medicine administration charts, seven staff files and a selection of records about health and safety.

Inadequate

Is the service safe?

Our findings

Before this inspection we had been made aware of concerns about the premises. We had received detailed reports from West Midlands Fire service (WMFS). The WMFS report stated that people were being put at risk as the registered provider had failed to take the action necessary to maintain the building in accordance with the law. We had identified shortfalls in the premises at our last two inspections and issued compliance actions requiring the provider to address these. At this inspection we identified that the work required had not been undertaken, this combined with the risks identified by the WMFS and infection control nurse meant the building presented an even greater risk to people's health and wellbeing. The provider had not ensured that people had been protected against the risks associated with unsafe or unsuitable premises. This is a breach of Regulation 15 (1) (b) (c) of the Health and Social Care Act 2008.

At the time of our inspection we found that there were inadequate numbers of staff on duty in the home to meet people's basic needs, and we were informed there had been times when the numbers of staff on duty had dropped far below a safe level and the registered provider had not provided any means of covering the shifts. Staff explained that local staff agencies would no longer provide staff as they had unpaid wage bills. We saw invoices requesting overdue payments to support this. We observed periods of time when there were no staff in the main communal lounge of the home. We saw people who lived at the home providing support for each other to move about the home and to go to the toilet when staff were not available within the room to provide this help. One of the people we observed moving without the supervision or support of staff had been recorded as having a high risk of falls, and as needing to be supported when moving around the home. Records showed this person had fallen five times in six months. Another person we observed to be at high risk of harm had care notes that stated, "[name of person] needs to be monitored at all times for her safety." The support available for these people was inadequate to ensure their safety within the home. The registered provider was not ensuring there were adequate numbers of suitably qualified or experienced staff and this is a breach of Regulation 22 of the Health and Social Care Act 2008.

We reviewed the management of medicines within the home. We found that the medicines people had been prescribed were available in the home, that they were securely stored and that records to underpin their administration were available. We observed senior staff administer medicines and saw them undertaking checks to ensure the right person received the right medicine. We saw that some people took responsibility for their own medicines and that they had been assessed as being competent to do so. Staff informed us that a safeguarding referral had been made about medicine administration as senior staff had altered the medicine administration times as a "work around" for the on-going shortage of senior staff. The local authority had identified that people may be have been at risk of receiving their medicines too close together, which may have had an impact on the person's welfare. This was under investigation at the time of our inspection. The registered provider had failed to protect people against the risks associated with medicine administration. This is a breach of Regulation 13 of the Health and Social Care Act 2008.

We looked at the arrangements in place to protect people from the risk of infection. Before our inspection we had received a copy of an audit undertaken by a specialist infection prevention nurse at the local hospital. They had inspected the home on 04 September 2014 and found significant and numerous concerns with the premises. The findings showed the home was not clean, which would be unpleasant for people and that the premises could place people at risk of infection. During our inspection we identified that action to address these concerns had not been undertaken and we observed further risks to people. Staff training records showed staff had not been provided with training to work hygienically or safely. We observed staff did not always wear aprons and gloves when caring for people in their rooms. Aprons and gloves were not always worn when carrying dirty linen and we did not always see staff cleaning their hands between tasks. This evidence meant people were not being protected against the risk of acquiring an infection or being protected from the spread of infection within the home. Two out-of-use clinical waste bins in the garden were partially full. The lids had not been secured and rain water had entered the bins and become contaminated with clinical waste. These bins were next to a broken fence and accessible by the public, as well to people living and working at Knoll House. Action had not been taken to protect people from the risk of exposure to

Inadequate

Is the service safe?

contaminated waste and the foul water contained within these bins, which would be unpleasant and a possible source of infection. This was a breach of Regulation 12 of the Health and Social Care Act 2008.

A maintenance person was employed at the home. We were informed that their responsibilities included checking the safety of the home, by testing appliances and auditing the premises. The person was not available to speak with during our inspection but records of their work showed that these checks and audits had not been undertaken effectively. Broken toilets, out of order emergency buzzers and damage to the premises that we observed during our inspection had not been identified in the most recent audits. This showed that the systems in place to identify and manage risks associated with health and safety were not being met. This is a breach of regulation 10(1) (b) of the Health and Social Care Act 2008.

We looked at the hoists used to lift people when they were unable to bear their own weight. One electric hoist that we observed being used was last recorded as being serviced in 2010. These appliances require service every six months to ensure they are safe to use. The bath temperature chart in one bathroom reported that the probe for testing the water temperature had not worked on several occasions. This broken probe combined with the lack of other safeguards to ensure people bathed in water that was a safe temperature could create a scalding risk. The public phone in the entry hallway was not working and staff said they were unable to remember when it had last worked. Failing to maintain this equipment is a breach of regulation 16 (1) (a) of the Health and Social Care Act 2008.

People we spoke with told us that they felt safe living at Knoll House. We observed people interacting with staff in a relaxed way, and as we listened to conversations it was apparent that people felt very comfortable with the staff team who supported them. The majority of staff we spoke with told us that they had worked at the home for many years and had established special relationships with people and their families over that time. The senior care staff we spoke with described how they responded quickly to concerns people shared with them. They were able to identify adult abuse and were aware of how to report this.

Inadequate

Is the service effective?

Our findings

We received information prior to our inspection that there were not always adequate stocks of food in the home. People we spoke with told us they were aware the home had run out of food and said, "We didn't even have any tea to drink." Other people told us they enjoyed the food and another person described it as "Boring". We looked at the stocks of food available in the home. We estimated there was enough food to last for about two days but there were no means to purchase any more. During our inspection we took action to ensure people had access to adequate food and drinks.

We looked in detail at the care needs of one person who needed their food made soft in a blender. There was no evidence to support that this person had been assessed by a Speech and Language Therapist, (SALT) who specialises in assessing and advising on the care and support of people with swallowing difficulties. There were no clear medical reasons explaining why soft food was needed. This person had not been weighed for a number of months, as the person's poor mobility meant that the weighing scales in the home were not suitable for them. Staff had not used another means of monitoring the person's weight. It was not possible to establish from the person themselves, from staff or from records if this person was receiving adequate nutrition or fluids. We raised our concerns about this person's health and wellbeing with the local authority to ensure the person was urgently reviewed and was able to access the services they required. Failing to ensure people have enough to eat and drink is a reach of Regulation 14 of the Health and Social Care Act 2008.

Staff we spoke with told us there had been no training provided recently. The 2014 training matrix we viewed showed that the majority of staff had not been provided with training that would help them work safely or with knowledge about the needs of the people living at the home. Staff we spoke with had worked at the home for many years and had undertaken a variety of training courses over their career; however they had not been provided with timely updates to ensure their practice remained safe or reflective of current good practice. The home had no registered manager and we found that staff had provided peer support to each other and that senior care staff had provided support on a day to day basis, however there was no established or effective system to ensure staff received the training, support or supervision they needed. Failure to provide staff with the training and support they require can place people using the service at risk from staff using unsafe practices. This is a breach of regulation 23(1) (a) (b) of the Health and Social Care Act 2008.

We had received no notifications informing us that the home had applied to restrict people's liberty. Staff we spoke with were not aware of any restrictions placed upon people. Care files we reviewed showed that consideration had been given as to how people made decisions and who helped them to do this. Staff we spoke with told us they had not received training about the Mental Capacity Act (MCA) since 2012. We did not explore this area any further due to the immediate and serious concerns we identified during the inspection. We looked at the needs of one person whose care notes stated they were not to be resuscitated in the event of them stopping breathing (DNAR).However there was no formal DNAR assessment, completed and signed by the doctor or the person if they were able. This could mean that the person may not be resuscitated when they should be, or that the person might be resuscitated when they do not want to be.

We found that over time the home had developed and maintained positive links with the local health care team. Staff were able to describe changes in people's condition or behaviour that would alert them that they needed to call the doctor or emergency services. Records we looked at showed that people had been able to see the doctor, dentist, and optician and to attend specialist appointments at local hospitals and clinics when this was required. Staff we spoke with were aware of people's health care needs however the written records we looked at did not reflect people's current state of health or needs accurately. In the event of usual carers not being available this could place people at risk of having their care needs omitted or delivered incorrectly.

Inadequate

Is the service caring?

Our findings

The registered provider had failed to ensure that people would be consistently well cared for. They had failed to ensure that adequate staff and resources were available to ensure people's individual care needs would be met and that their welfare and safety would be protected. The provider had also failed to follow published research and the findings of experts such as the infection control nurse. The provider had not made provision for emergencies, for example there was no senior management support for staff on a day to day basis or emergency cash float in the event of an urgent purchase being required. This meant that although staff treated people with kindness and compassion the staff were not supported to ensure that the care and welfare needs of people would always be met. This is a breach of regulation 9(1) (b) (2) of the Health and Social Care Act 2008.

During our inspection we heard staff supporting people with kindness and compassion. Most of the people we spoke told us they had great affection for the staff team and their comments included, "She's [staff member] ever so nice , but everyone is. They know how to treat us." A visitor told us, "The staff here are lovely. They really love these people" and staff we spoke with told us, "I have looked after this person for 14 years and it will be hard to leave him."

However two people told us "We are treated like children" and another person said they were lonely and some staff could be rude to them. We did see or hear any further evidence during our inspection to support these comments. Staff we met all showed concern for people's wellbeing, and had continued to provide care and support despite not being paid their wages. Staff we spoke with were aware of people's life history and who was important to each person, and we heard staff talking with people about this throughout the day.

We saw staff work in a way that protected people's dignity and privacy. Staff we observed spoke to people discreetly about their personal care and we observed people being moved using a hoist and this was done carefully to ensure the person was covered.

Inadequate

Is the service responsive?

Our findings

At the time of our inspection people had no formal way to share their experiences or raise their concerns with the registered provider. We found that individual staff did what they could to help people when elements of the service were not to their satisfaction. However staff had no resources or delegated authority from the registered provider to make changes. We looked at the systems in place for people to express their concerns or to make a complaint. The provider had failed to make any arrangements to ensure complaints would be listened to or acted upon. In the absence of a registered manager and without reliable contact with the provider the published complaints procedure would not have been effective. This meant people had very little control over the day-to-day running of the home. This is a breach of Regulation 10(2) (b) of the Health and Social Care Act 2008.

The registered provider had failed to organise the service in a way that would meet people's needs. However direct care staff had ensured that as far as possible people got the care they needed in the way they wished when this was within their control.

Staff we spoke with were able to describe the individual needs and preferences of each person. We saw that this was reflected in each person's plan of care. Each care plan we looked at was individual, and we saw that efforts had been made to record important people, events and things for each person. During the inspection we were unable to establish how much influence people had over their own care, treatment and support. Records we looked at showed that people and their relatives had in the past been involved in care plans and their reviews however reviews of care plans had not happened for some time.

We saw photos around the home and people told us that in the past a wide variety of activities had been offered. These included parties for special cultural and religious events, birthday's parties, entertainers, light exercise and music. Most people told us in the past they had enjoyed these activities and now missed them as they were currently not being provided due to staff and resource issues. We observed that the majority of people sat in the same chair, in the same position for the entire length of the day. We observed that the television was on all day. Some people were able to talk with visitors, to talk briefly with the staff on duty or with each other, however no interesting or stimulating events were provided for people. People had not been supported to maintain interests or hobbies that were important to them before they moved into Knoll House. We looked at the opportunities for people who were cared for in their room. We found that people were at risk of feeling isolated as they were disconnected from the majority of the daily activity within the home. We looked in detail during our inspection at the opportunities for one person and neither our observations nor records showed that this person received regular contact or stimulation unless they were receiving personal care.

We looked in detail at the care of one person who was distressed. We observed that this distressed behaviour was also upsetting the people sitting close to them. Staff described how they would sometimes move the person or other people from the main lounge and offer people an alternative activity and a break from each other. On the day of our inspection we did not observe this happen and we saw the person become increasingly distressed throughout the day. The care records we looked at did not provide any written guidance about how staff should manage situations such as this. This meant people were not always receiving care that met their needs or promoted a good quality of life for people at the home.

Inadequate

Is the service well-led?

Our findings

There was no evidence that the registered provider had played an active part in the running of the home. We were told," We have left messages but he never gets back to us" and "He [the owner] came to pick up his post but he never spoke to staff." We asked staff to inform the provider that we were undertaking an inspection on 01 October 2014 and that we requested his presence. The registered provider failed to visit the home during the inspection and did not respond to telephone calls or attend a meeting we later scheduled to discuss our concerns with him. Failing to provide effective management to the home is a breach of the homes condition of registration and a breach of Regulation 5 of the Health and Social Care Act Registration Regulations 2009.

There were inadequate systems in place to assess and monitor the quality of the service provided. In the absence of a registered manager the registered provide had not appointed a person or undertaken checks themself to provide assurance that the service was running in a safe or effective way. There was no evidence that checks to ensure staff remained suitable to work in care, audits on safety or infection control for example had been undertaken. This is a breach of Regulation 10 of the Health and Social Care Act 2008.

Our previous inspections, discussions with other agencies and information supplied directly to us by whistle blowers and concerned members of the public made us aware that the service had no leadership, management or governance structures in place. We had received information that suggested this had put the welfare, safety and comfort of people using the service at risk. People we spoke with during our inspection were very concerned about their future as the registered provider's poor leadership and management had resulted in a decision being made to close their home. People told us they had lived at the home for many years and did not wish to leave. Having to move had caused people anxiety about practical arrangements such as maintaining contact with their family and friends, maintaining the same doctor and safely moving precious personal items from one home to another.

There was no registered manager in post and one member of staff told us, "We've not had a manager since the end of January 2014". In the absence of a manager the registered provider had failed to make suitable or adequate arrangements for the leadership of the home. We found that senior care staff were running the home on a shift by shift basis. People and their relatives spoke highly of the senior care staff and their comments included, "She's such a nice person" and "The staff are all very good to us" however the senior staff had no delegated power from the registered provider and no access to resources to make changes or improve the service.

Staff informed us that they had not been paid their wages, and when we were in the home we observed unpaid bills and invoices from staff agencies and for food. The registered provider had not ensured that the financial management of the home was adequate to provide a secure service for the people who were dependent on it.

Before we undertake an inspection we ask the registered provider to complete and return a Provider Information Return. (PIR) When complete this contains information from the provider about the home under each of the five key areas we inspect. The document helps us to plan our inspection. The registered provider failed to complete and return this document which is a requirement under the Care Standards Act 2008. The provider is also required by law to notify the Commission about significant events that occur within the service. We call these notifications. The registered provider had failed to tell us about any notifiable events. Failure to communicate with the Commission suggests that the registered provider is uncooperative and raises questions about their fitness to run a care service.

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 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **The provider had not ensured that people had been protected against the risks associated with unsafe or unsuitable premises.**

The enforcement action we took:
The provider was not meeting regulations or the needs of people living at the home. We cancelled the registration of this provider and a service is no longer being provided at this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **The support available for people was inadequate to ensure their safety within the home. The registered provider was not ensuring there were adequate numbers of suitably qualified or experienced staff.**

The enforcement action we took:
The provider was not meeting regulations or the needs of people living at the home. We cancelled the registration of this provider and a service is no longer being provided at this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The registered provider had failed to protect people against the risks associated with medicine administration.**

The enforcement action we took:
The provider was not meeting regulations or the needs of people living at the home. We cancelled the registration of this provider and a service is no longer being provided at this location.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

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 providers Broken toilets, out of order emergency buzzers and damage to the premises that we observed during our inspection had not been identified in the most recent audits. This showed that the systems in place to identify and manage risks associated with health and safety were not being met.

The enforcement action we took:
The provider was not meeting regulations or the needs of people living at the home. We cancelled the registration of this provider and a service is no longer being provided at this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control Action had not been taken to protect people from the risk of exposure to contaminated waste and the foul water contained within clinical waste bins, which was unpleasant and a possible source of infection.

The enforcement action we took:
The provider was not meeting regulations or the needs of people living at the home. We cancelled the registration of this provider and a service is no longer being provided at this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment The provider had failed to maintain equipment within the home which could impact on people's safety and well-being.

The enforcement action we took:
The provider was not meeting regulations or the needs of people living at the home. We cancelled the registration of this provider and a service is no longer being provided at this location.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **The provider had failed to ensure people always had enough to eat and drink.**

The enforcement action we took:
The provider was not meeting regulations or the needs of people living at the home. We cancelled the registration of this provider and a service is no longer being provided at this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The provider had failed to provide staff with the training and support they required, which could have placed people using the service at risk from staff using unsafe practices.**

The enforcement action we took:
The provider was not meeting regulations or the needs of people living at the home. We cancelled the registration of this provider and a service is no longer being provided at this location.

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 providers **The provider had failed to make any arrangements to ensure complaints would be listened to or acted upon. This meant people had very little control over the day-to-day running of the home.**

The enforcement action we took:
The provider was not meeting regulations or the needs of people living at the home. We cancelled the registration of this provider and a service is no longer being provided at this location.

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

This section is primarily information for the provider

Enforcement actions

The staff were not supported to ensure that the care and welfare needs of people would always be met.

The enforcement action we took:
The provider was not meeting regulations or the needs of people living at the home. We cancelled the registration of this provider and a service is no longer being provided at this location.

Regulated activity	Regulation
	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered provide had not appointed a person or undertaken checks themselves to provide assurance that the service was running in a safe or effective way. There was no evidence that checks to ensure staff remained suitable to work in care, audits on safety or infection control for example had been undertaken.

The enforcement action we took:
The provider was not meeting regulations or the needs of people living at the home. We cancelled the registration of this provider and a service is no longer being provided at this location.