Cavendish Close Limited

The Close Care Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on 11 November 2014 and was unannounced.

The Close Care Home is situated in Burcot, near Abingdon in Oxfordshire. The home is registered to provide accommodation, nursing and personal care for up to 90 people. The home is divided in to four units. River View unit supports 20 people living with dementia, Willow unit supports 33 people with nursing and care needs, Dorchester unit supports 29 people with nursing and care needs and Clifton unit supports eight people with acquired brain injuries. On the day of our visit there were 74 people using the service.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

At our inspection on 30 May 2014 we found breaches of regulations relating to how people's care and welfare needs were met. We also found breaches relating to staffing and systems relating to assessing and monitoring the quality of service. Following that inspection the provider sent us an action plan to tell us what improvements they were going to make. They told us these improvements would be made by 16 July 2014.

During our inspection on 11 November 2014 we looked to see if improvements had been made. We could see that some action had been taken but further improvement was needed in the level of staffing, the way care was delivered to people to promote their welfare and the quality assurance systems. We also found additional areas of concern in relation to the services ability to safeguard people from harm, how staff were supported in their roles and how people were respected and involved in their care. We have also made a recommendation in relation to The Mental Capacity Act 2005.

Although people told us they felt safe we found staff did not always report concerns and the provider did not always respond appropriately to concerns when they were raised. We found that staffing levels were not always sufficient to meet people's needs. Staff did not have time to spend with people which put them at risk of social isolation.

We observed some interactions where staff showed kindness and understanding; however some people were not supported in a way that respected them. People were not always given choices. When people were given choices, staff did not always respect their choice.

Although the home had taken steps to provide social interaction, people told us they were not always able to take part in activities that interested them. Some people wanted to go out into the grounds of the home but told us this did not often happen.

Staff told us they were not supported through a system of regular supervision and appraisal. Several staff had not had training in dementia care.

The service had systems in place to monitor the quality of the service but did not use the results to look for trends and to improve the quality of care.

People, relatives and staff reported concerns over the management and leadership within the home. The culture did not promote openness and transparency. Staff described morale as low and relatives told us this was impacting on care the provided.

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?

Inadequate

The service was not safe. Although people told us they felt safe we found this service was not providing safe care.

We found there were insufficient numbers of staff to keep people safe.

Some staff could not identify the signs of potential abuse. Staff were not clear about their responsibilities to report concerns and the registered manager did not always follow local policies and procedures when reporting abuse.

Staff recruitment processes were safe.

Is the service effective?

Requires Improvement

The service was not always effective. Some staff had not received training relevant to people's health conditions, for example dementia training. This meant people were not supported by staff who understood the impact of conditions on people's lives.

Staff did not consistently follow people's care plans to ensure their heath needs were met. This put people at risk of deteriorating health.

People enjoyed their meals and had a choice of food. Staff were not always aware of people whose food and fluid intake was being monitored.

People had access to appropriate health care professionals when required.

Is the service caring?

Requires Improvement

People were not always supported by staff who were caring. Some staff treated people with dignity and respect whilst others did not show kindness and compassion.

Staff did not always respect people's choices.

Staff appeared task focussed although we did observe some staff had a good rapport with people.

Is the service responsive?

Requires Improvement

People did not always receive a service that was responsive to their individual needs. Some people's call bells were not within easy reach.

Some people did not have access to activities that interested them. Staff did not spend time talking with people which put them at risk of social isolation.

There were mixed views about how the service responded to concerns. Some people and their families felt concerns would be responded to promptly whilst others did not feel they were listened to.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well led. Systems were in place to check the quality of service, however this information was not used to look for trends and improve the service.

Relatives, visitors and staff told us that conflict in the management team was impacting on the leadership in the home. This resulted in a culture that was not open and transparent.

The service did not provide CQC with information requested before the inspection.

The Close 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 11 November 2014 and was unannounced.

The inspection team consisted of three inspectors and two experts by experience who had experience of older people's care services. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Prior to our inspection we reviewed the information we held about the home and contacted the commissioners of the service to obtain their views. We asked the provider to complete 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. The provider did not return a PIR and we took this into account when we made the judgements in this report.

During the inspection we spoke with 16 people who used the service, 11 relatives, four housekeepers, the chef, nine care workers, three registered nurses, the deputy manager, the registered manager and the managing director. We looked at the care records of seven people who used the service, the staffing rotas from 1 November 2014 to14 November 2014. 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. Following the inspection we spoke to three social and health care professionals.

After the inspection we asked the registered manager to provide us with the information relating to staffing levels in the home.

Is the service safe?

Our findings

At our inspection on 30 May 2014 we found that people's health safety and welfare were not always safeguarded because the provider had not taken appropriate steps to ensure that, at all times there were sufficient staff to meet people's needs. We saw at this visit there were no improvements and the same issues highlighted in May 2013 were repeated.

People we spoke to told us there were not enough staff. Comments included; "There is never anyone about. They leave me all alone here. What am I supposed to do"? "They are so short of staff" and "I think they've got too much to do".

People told us staff were always busy and sometimes took a while to respond to their call bells. A relative told us, "If staff are very busy we do have to wait to get a response but I will go and find a member of staff if necessary". We saw on one unit that when call bells rang the nurse in charge checked the room number and prompted staff to answer them. We found that call bells were responded to promptly in some areas of the home, on some units the response was variable.

On the day of our visit the registered manager told us the required staffing levels for the home. The rota for the day of our visit showed us that these staffing levels had not been achieved. The rotas for a two week period showed that on eleven out of thirteen days required staff numbers were not achieved.

Relatives also spoke of concerns about staffing levels. One relative said, "There is a lack of staff, especially at weekends". Another relative told us "They are always understaffed." Relatives were concerned at the length of time people spent alone, particularly when in their rooms.

All staff told us there were often not enough staff, particularly at weekends. Comments included, "A lot of carers want to do more but our hands are tied from a time perspective". Another care worker told us there was no time to talk to people.

During our visit staff were busy supporting people with care tasks but had no time to spend talking to people. Two people were still in bed and had not received personal care at 12:20pm. When we asked staff they explained that this was due to staffing levels. One person was in bed and told us they were waiting to get up, they explained that staff supported them to get up, washed and dressed "when they can".

The home employed two people to support with drinks and snacks on two units in the home. Staff told us on one of the units that they did not have this additional resource and people did not always receive drinks and snacks during the morning and afternoon due to staffing levels. During our visit several additional staff member supported people at lunchtime on this unit, this included members of the management team. Staff told us they did not normally have this additional help.

We asked the registered manager to provide us with the details of how they calculated the number of staff required to meet the needs of people who used the service. We also asked for details of the number of staff (in hours) who had left the company and the number of staff (in hours) who had started with the company since our last inspection. We received details of the assessment of people's needs but the provider was not able to provide information regarding the way this information was used to determine staffing levels for the home. We did not receive details in relation to the number of staff who had left or started employment.

We found that the arrangements for staffing did not safeguard the health safety and welfare of people who used the service. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Some relatives felt people in the home were safe. Comments included "[My relative] is well cared for and seems very safe here". However other relatives had concerns about safety due to lack of staff time to support people who had behaviours relatives described as 'challenging'. One person described finding a situation 'upsetting' when someone entered their room uninvited. Another person told us, "There is a mixture of residential and dementia residents and there is not enough staff to ensure they do not come into other resident's rooms". We have since been told by the managing director that there are no areas of the home that supports people with this combination of needs.

Some staff had received safeguarding training, however one care worker had no understanding of what safeguarding was and had not received any training.

Is the service safe?

Several staff were unsure of their responsibilities to report concerns. One member of staff told us they had reported concerns but as they had not been updated as to whether this had been followed up, they did not feel confident to raise any further concerns.

We asked the registered manager about these concerns; they were aware of the incidents but had not reported them all to the local authority safeguarding team. We advised them to raise two safeguarding alerts, which they did. We were not assured that the registered manager responded to allegations of abuse in line with local authority agreement on safeguarding adults.

We found the registered person had not made suitable arrangements to ensure people were safeguarded against the risk of abuse. This was a breach of Regulation 11 of Health and Social Care act 2008 (Regulated Activities) Regulations.

Appropriate arrangements were in place for the obtaining, recording, administration and storage of medicines. We saw administration records were completed when medicines were administered. A nurse told us people's medicines were only administered by qualified nurses who wore tabards when administering medicines to minimise interruptions and the potential for errors. We saw the nurse administered medicines in a safe and friendly way, staying with each person until they had taken their medication.

Records relating to the recruitment of new staff showed that relevant checks had been completed before staff worked unsupervised at the home. These included employment references and disclosure and barring checks to ensure staff were of good character.

Is the service effective?

Our findings

Staff were not always effectively supported to carry out their roles and responsibilities. Several staff we spoke with had received no supervision or appraisals. Only one of the staff files we looked at contained supervision notes and these were dated September 2013. The registered manager showed us the supervision schedule which showed most staff had not received supervision since May 2014. Staff told us they did not always feel supported by the management team. Some staff felt they were supported in their role by the qualified nurses and felt able to go to them with any concerns. Comments included, "I have huge respect for the nurses", "If I need any clarification I know I can ask".

Staff told us they had received training in moving and handling, food hygiene and infection control. Staff completed an induction period where they shadowed more experienced staff and attended training. One member of staff felt they were not given enough guidance or time to observe care delivery during the induction and that they were "Expected to get on with it straight away".

Several of the care workers working in areas of the home that supported people living with dementia had not received any training in supporting people with dementia. Nursing staff told us that some staff would benefit from training in dementia. We saw some staff did not follow good practice guidance when supporting people living with dementia, for example we saw staff pass by people without interaction, despite the person calling out.

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

People's needs had been assessed and care plans were in place. Assessments identified that some people were at risk of pressure damage. One persons' care plan stated that the person should be repositioned 'regularly'. We were advised by a nurse that the person would be repositioned when their continence needs were checked. The care plan stated that continence checks would be made every three to four hours. We looked at the repositioning chart for this person, which did not show they were being supported in line with their care plan. For example on 7 November the person had not been repositioned nor had their continence needs met between 12:00pm and 12:00am. We spoke with the nurse who was unable to confirm whether the person had been supported to reposition between the times recorded. This put people at risk of skin break down.

People were monitored for weight loss. Where people were assessed as being at risk of weight loss they were referred to appropriate health professionals. One nurse told us they were responsible for monitoring people's weights and ensured that all nurses and the catering manager were made aware of any nutritional concerns. However we saw one person had lost weight each month since June 2014. The care plan stated the action care staff should take; 'Encourage with Complan' for two months, followed by encouraging the person to have smoothies and for a fluid chart to be completed. There was no detail about how the person should be encouraged and no fluid chart had been completed by staff to enable them to assess whether the person was receiving sufficient fluids to maintain their health.

We asked staff on one unit if they were supporting anyone who had weight loss or nutritional concerns. Two staff stated that there was no one on the unit where they were working who was being monitored. When we spoke to the nurse in charge of the unit we were told there was one person who was being monitored due to weight loss. This meant that staff were not aware of the needs of a person they were caring. This increased the risk of weight loss for the person as monitoring was not taking place.

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

Some staff told us they had received training in the Mental Capacity Act 2005 (MCA). The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack capacity to make decisions are protected. Staff were able to describe how they supported people to make decisions in relation to their daily lives. One member of staff described that decisions must be made in a person's best interest, adding "We have to take into account their integrity and dignity and continue to explain to them".

Care plans contained mental capacity assessments. Some had been completed by appropriate health professionals involved in the persons care. However we saw that some

Is the service effective?

capacity assessments were a general statement in relation to the person lacking capacity and did not follow the principles of the Mental Capacity Act 2005 which requires capacity assessments to be 'decision and time specific'.

The service was complying with the legal requirements of the Deprivation of Liberty Safeguards (DoLS). DoLS provide a lawful way to deprive someone of their liberty, provided it is in their best interests or is necessary to keep them safe from harm. The registered manager told us they were aware of the recent Supreme Court judgement and were reviewing people in the home to ensure appropriate referrals for DoLS had been made.

People gave us positive comments about the food. Both people who used the service and relatives told us that food had improved in recent months. One relative said, "[My relative] has started to eat more now. She did lose weight but is having supplements. The chef comes round and talks to her when he's passing". Catering staff had good knowledge of people's likes and dislikes and special dietary requirements.

The food at lunchtime was well presented. There was a choice of two meals and where people did not like the choices on offer they were offered additional options. In one unit there was a member of staff serving the food who showed us a record of people's specific dietary requirements, including soft and pureed diets. We saw that staff knew people's specific needs and supported them appropriately.

People had access to health professionals when required. One person told us they had recently been assessed for new hearing aids and had new glasses from a visiting optician. Care records showed that people had been referred to their general practitioner (G.P.) when there had been changes in the person's health condition.

The home employed a physiotherapist who works closely with a visiting health professionals. People were positive about this; one person told us "I get wonderful treatment here. They've taught me to walk again".

We recommend the provider considers Chapter 2 and Chapter 6 of the Mental Capacity Act 2005 Code of Practice for guidance.

Is the service caring?

Our findings

People were generally positive about the staff who supported them. Comments included; “They are kind to me”, and “I am well looked after and the staff take care of me”. However, some people’s comments were not so positive. “They get me up when they want. I’d like the choice but it doesn’t happen”, and “They are pretty good but one or two are new and say ‘you’ve got to get up now’”. This person went on to say “They don’t know what they’re doing so I have to tell them”. The person felt this was because the staff member did not know about their preferences, rather than they did not have the skills to provide their care.

We asked staff how they ensured people were treated with dignity and respect. Most were able to give examples of how they would achieve this. Comments included, “If someone doesn’t want a bath or shower, I would offer a wash”. However our observations showed that staff did not always treat people with dignity and respect.

A care worker approached a person who was talking to us and asked them if they would like a wash or a shower, the person requested a wash. Two other carers approached the person telling them it was their “shower day”. They did not respect the person’s choice to have a wash and the person had to be supported by us to confirm they wished to have a wash.

We observed interactions that were kind and caring and involved people in their care. However we observed one person living with dementia being supported to sit in a lounge area where a television was on. The care worker supported them to sit down and asked if they wanted to watch television. The person said, “No”. The care worker walked away without waiting for the the person’s response. Staff were supporting another person living with dementia. This person was banging the table. Staff responded by telling the person to “be quiet”.

During lunch time we saw some people being supported in a dignified and respectful manner, however we saw that some care workers were not caring in their approach to people. We observed a care worker supporting a person with their meal. They did not engage with the person and stood beside them leaning over them to support them to eat. Another care worker was sat with a person supporting them to eat their meal. They engaged with the person for some of the time but broke off regularly and spoke loudly across the room to other care workers. We observed little interaction between people and care workers, as most interaction was between care workers.

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

Two people told us they were having difficulty understanding some issues relating to their care and support. One person had found an advocacy service by researching on the intranet; the other person was not aware of advocacy services but thought it would be helpful. We brought this to the attention of the registered manager who advised us that advocacy services were available and they would ensure people were aware of them.

Is the service responsive?

Our findings

Most people had call bells within reach to enable them to call for help when they needed it. One person's call bell was on the floor; we spoke to a member of staff who advised the call bell had fallen to the floor and promptly gave it back to the person. The relative of one person told us they had found the person distressed the previous evening as they had been unable to reach their call bell. The person was sat in the dark and required support with personal care. The call bell had fallen on the floor. The relative told us they had reported the broken clip on the call bell several weeks before but nothing had been done. We checked the person's call bell and found that it was in reach; however the clip was still broken.

Health and social care professionals advised us that the service was not always responsive to advice and guidance. Examples given referred to guidance given to nurses and care staff relating to communication when responding to behaviours of people living with dementia. The professionals told us this impacted on the consistency of care people received.

Relatives felt they were consulted about their relatives care, however some told us they did not feel they were listened to. Some care plans included information about people's life history and individual preferences and showed people and their relatives had been involved in developing the plans. These were comprehensive and had a personalised approach which enabled staff to deliver individualised care. However others were focused on people's physical care needs and lacked information regarding people's life history and interests. There were some entries relating to activities, for example one person had attended and enjoyed a Halloween party. However in one person's care file there were only seven entries from January 2014 to November 2014 relating to activities. Nurses told us this person needed support to participate in activities that interested them but this rarely happened.

Activities were organised in the home by two life skills support worker. There was a calendar of events displayed in the home. On the day of our visit there was a remembrance day service taking place in the home. We saw care staff supported people to attend. However people did not always have access to the activities of their choice. Comments included; "I would like to go out but they haven't got the time to take me and I am fed up, they say they will do something and don't". Another person told us they wanted to access the library within the home as they enjoyed reading but staff had not had time to take them.

There were particular concerns regarding activities in the unit supporting people with acquired brain injuries. Staff, relatives and visiting health professionals all told us that people living in this unit did not have access to sufficient activities that interested them. One visitor commented that 'nice things' were going on in the rest of the home but not for this particular group of people.

People wanted staff to have the time to sit and talk to them. One person said, "It would be nice if they (care workers) could spend more time". Staff were task focused, interacting with people when providing support to meet a physical care need. Staff did not sit and talk with people. Where people remained in their rooms they had little social contact unless staff were responding to an identified health or care need, this left people at risk of being socially isolated.

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

We looked at the complaints received by the service. They had all been dealt with in line with the service's complaints policy. All complaints had been logged and there was evidence of the response to the complaint and actions taken.

Relatives gave examples of issues that had been resolved as a result of raising a concern. Comments included; "I had a problem with [relatives] lost clothes but the laundry manager dealt with the problem very quickly". And "Anything I have noticed that I am not happy about had been dealt with straight away by the carers".

Some people felt confident to raise concerns with management however people did not feel that action was always taken as a result. Relatives told us they had raised complaints and were aware of the home's complaints policy. However some relatives told us issues had not been resolved despite making complaints; some relatives said there had been repeated concerns raised regarding the staffing levels and inconsistency of staff but that nothing had been done to resolve the issue.

Is the service well-led?

Our findings

Communication methods were not always effective and information was not shared with people using the service, staff or relatives. The registered manager told us there were monthly meetings organised for people who used the service. The meetings were led by a well-being counsellor to enable people to discuss any aspects of their lives. People we spoke with were aware of the meetings but had not attended. The management team did not attend the meetings and there were no records relating to any issues that may have been raised. There were no other meetings held for people to discuss concerns with the management team in the home. The registered manager spent time in the home and we saw her speak with one person who wanted to raise a concern; however other people told us they would talk to care staff or nurses and would not approach the registered manager.

The management team told us that weekly staff meetings were held on each unit. Staff we spoke with said staff meetings were not held frequently. The last staff record of a staff meeting was 4 April 2014. Some staff felt able to approach the registered manager to discuss issues and that they were available. However others felt they were not listened to and would not 'bother' to speak with management. One staff member told us they had attended regular meetings in the past, where issues were discussed openly with management, however following changes in the management team, meetings no longer took place and there was no dialogue with management. Staff and the management team did not have an effective way to communicate and share information.

The registered manager held weekly 'surgeries'. The registered manager explained these were an opportunity for relatives to meet with them informally and discuss any issues relating to the home. The registered manager told us these had been poorly attended. Relatives we spoke with said there had been meetings for relatives in the past but these had stopped with the change in management in the home. When we spoke to the management team they told us the meetings had not always been constructive and continuing them had not been considered helpful. Relatives told us they had approached the management team to hold a relatives meeting in the home but this had been declined as it was felt there might be a negative impact on people's well-being due to meetings taking place in a communal area of the home.

People, relatives and staff had raised issues in relation to the impact on people's care due to insufficient staff. Several complaints seen in the complaints log raised concerns about staffing levels. A questionnaire had been sent out to people and their relatives in October 2014. Replies received identified areas of concern which included people's care needs not being met due to shortages of staff. The management team were not using information gathered to improve the service.

Audit records showed that systems were in place to monitor the quality of the service. These included; medication, care plans and falls. However it was not clear what action was taken as a result of the audits in order to improve the service. The falls audit identified records relating to people who had fallen, however there was no system to identify patterns or trends in relation to the whole service with a view to risks of falls being reduced. Care plan audits identified areas for improvement; it was not clear how this was communicated to staff responsible for completing care plans.

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

There was a conflicting leadership approach in the management team which impacted on the culture and morale in the home. Staff told us that members of the management team did not work together. Comments included; "They [management team] are not singing from the same script", staff added that it would be difficult to improve things until they work together. Staff did not feel listened to and described feeling "Bullied and harassed by management".

Some staff told us morale was low in the home, others felt it was starting to improve. Staff felt supported by nursing staff but some felt the support was not provided from the management team. Staff were reluctant to raise concerns with management as they felt they would not be responded to.

Relatives spoke of staff appearing uncomfortable with management, which they felt was transferring to the

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residents. They felt staff were defensive and not as willing to speak with relatives. One relative told us the management team talked about being open and transparent but that was not the culture in the home.

Health and social care professionals who visited the home told us that there had been increased tension in the home which had resulted in some defensiveness from senior staff. This impacted on working relationships.

Before this inspection we asked the provider to complete 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. The provider did not return a PIR and we took this into account when we made the judgements in this report

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 Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met: People were not protected against the risk of receiving care or treatment that was inappropriate by means of carrying out an assessment of the needs of the person and planning and delivering care and treatment that met individual needs and ensured the welfare and safety of people. Regulation 9 (1) (a) (b) (i) (ii).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers How the regulation was not being met: People who used the service were not protected against the risks associated with an ineffective operation of systems to regularly assess and monitor the quality of the services and to identify, assess and manage risks relating to the health, welfare and safety of people and others who may be at risk from the carrying on of the regulated activity in the home. The registered person did not regularly seek the views of people using the service, persons acting on their behalf and staff. Regulation 10 (1) (a) (b) 2 (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse How the regulation was not being met: People who used the service were not safeguarded against the risks of abuse by means of taking reasonable steps to identify the possibility of abuse and prevent it before it occurs and by responding appropriately to any allegation of abuse. Regulation 11 (1) (a) (b).

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 Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services How the regulation was not being met: There were not suitable arrangements in place to ensure the dignity and privacy of people, or to ensure that people were enabled to make, or participate in decisions relating to their care or treatment. People were not always treated with consideration and respect. Regulation 17 1 (a) (b) 2 (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff How the regulation was not being met: The registered people did not ensure that people employed by the home were appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to people using the service safely and to an appropriate standard by receiving appropriate training, supervision and appraisal. 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 Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing How the regulation was not being met: There were not sufficient numbers of suitable qualified, skilled and experienced persons employed for the purpose of carrying on the regulated activity. Regulation 22

The enforcement action we took:
A warning notice was issued. To comply with Regulation 22 by 31 January 2015