Support for Living Limited

Support for Living Limited - 37 Barlby Road

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

We carried out an announced inspection on 13 November 2015. The provider was given 24 hours' notice because the location is a small home providing care to adults who may have been out during the day. We needed to be sure that someone would be in. Our previous inspection took place in January 2014 where we found the provider was meeting the regulations inspected.

Support for Living - 37 Barlby Road provides care and support for up to four people living with complex learning disabilities and physical disabilities. At the time of this inspection three adults were living in the home.

The service did not have a registered manager. 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 2008 and associated Regulations about how the service is run.

A service manager was responsible for the day to day running of this service and another nearby service run by the same provider.

People were not always protected from risks to their health and wellbeing because people's written risk assessments were not always up to date and had not always been reviewed in line with the provider's policies and procedures.

There were enough staff at the service but we could not be assured that all staff had received the appropriate training to equip them with the skills, knowledge and experience to carry out their duties effectively and with confidence.

We could not be assured that people were always protected from the risk of potential abuse because the provider did not have a robust system for recording these matters.

The service was not organised in a way that always promoted safe care through effective quality monitoring. The provider had not implemented or was not operating an effective system to audit different aspects of the service including care plans, medicines and safeguarding matters as per above.

During our visit we were unable to review people's proof of identity, right to work status and references as this information was not held at the service. We requested and received information from the provider relating to staff recruitment demonstrating that criminal record checks and other relevant checks are undertaken before staff commence working with people living in the home.

The home was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). CQC is required by law to monitor the operation of the Mental Capacity Act (MCA) 2005, Deprivation of Liberty Safeguards (DoLS) and to report upon our findings. DoLS are in place to protect people where they do not have capacity to make decisions and where it is regarded as necessary to restrict their freedom in some way, to protect themselves or others.

Some but not all staff had received training in mental health legislation which had covered aspects of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS). Senior staff understood when a DoLS application should be made and how to submit one. Following our inspection we contacted social workers to enquire as to whether DoLS applications had been received by the provider and processed by the relevant agencies. At the time of writing this report we are still waiting for this confirmation.

Staff developed caring relationships with people using the service but people were not always being supported to maintain their hobbies and interests and people's cultural preferences were not always being respected.

The provider conducted an annual survey for people using the service and their family members. However, we saw no evidence in the records or in the information we reviewed documenting that staff or advocates had supported people to provide feedback (where appropriate).

Our findings during our inspection of 13 November 2015 showed that the provider had failed to "…meet every regulation for each regulated activity they provide…", as required under the HSCA 2008 (Regulated Activities) Regulations 2014 (Part 3).

We found that the provider was in breach of five regulations. You can see the action we have told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

Summary of findings

terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

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.

Risks to people's health and wellbeing were not managed appropriately.

The provider was not following best practice around the storage, management and administration of medicines.

Not all staff were equipped with the skills and experience to support people whose behaviour challenged the service.

Inadequate

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

Staff did not receive the training necessary for their roles and were not always receiving adequate support and supervision.

People's nutritional needs and preferences were not being managed appropriately.

The service manager understood the legal requirements of the Mental Capacity Act 2005 but not all staff had completed appropriate training in this area.

Requires improvement

Is the service caring?
Not all aspects of the service were caring.

People's cultural identity, preferences and choices weren't always being respected.

Staff had developed caring relationships with people but not all staff were familiar with people's care and support needs and not all staff were able to provide adequate and safe support to people when out in the community.

Requires improvement

Is the service responsive?
The service was not responsive.

People were not always supported to maintain their health and wellbeing or partake in their preferred activities.

The service conducted an annual survey but it was not clear how people were supported to provide feedback about their care.

People's health action plans had been completed and gave details of the range of health care professionals involved in people's care.

Requires improvement

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

Inadequate

Summary of findings

The service was not organised in a way that promoted safe care through effective record keeping and quality monitoring. Shortfalls identified during our inspection had not been identified by the provider as areas to address.

The provider was inconsistent in monitoring the performance of staff and was not always providing support and guidance to staff members.

There were processes in place for reporting accidents and incidents.

Support for Living Limited - 37 Barlby Road

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 13 November 2015 and was announced. The provider was given 24 hours' notice because the location was a small service for adults who may have been out; we needed to be sure that someone would be in.

The inspection was carried out by a single inspector. Before the inspection we reviewed the information we held about the service and statutory notifications received. During the inspection we used a number of different methods to help us understand the experiences of people supported by the service. We observed staff interacting with people using the service, spoke with the service manager and two support staff on duty. We were not able to talk with people using the service as they were unable to express themselves verbally. We looked at people's care records, five staff files, as well as records relating to the management of the service.

Following the inspection we made telephone calls to a relative of one person living at the home, two health and social care professionals and a further four members of staff.

Inadequate

Is the service safe?

Our findings

People were not always protected against the risks associated with the unsafe storage, management and administration of medicines**.** Medicines were stored in a locked cupboard. However, the keys to the cupboard were not kept in a secure place and were visible and accessible to people within the home and/or others visiting the home. The light inside the cupboard was not working which may have led to difficulties for staff when managing people's medicines and could potentially have resulted in unnecessary errors in administration. We found opened boxes of eye drops that had passed their usable date and other unopened boxes of the same solution that should have been stored in a fridge. We also discovered surplus supplies of repeat prescription items and numerous medicines and topical creams dating back to May 2015 waiting to be returned to the pharmacy. First aid boxes were poorly stocked and guidelines as to what items should be contained within the boxes were missing.

Staff who had completed medicines training were responsible for administering people's medicines. The service manager told us people's medicines due at 8.00 pm would be administered by a staff member from a neighbouring service. This was because the staff on duty were not permanent employees and required support to administer medicines. This arrangement may have meant that people encountered delays in receiving their medicines, particularly emergency medicines and medicines that are taken 'as needed' known as PRN medicines.

Individual medicine administration records (MAR) for each person using the service were in place. MAR sheets were up to date, accurate and no gaps were evident. The service manager told us that auditing systems were in place in regards to these matters. We were unable to view medicines audits on the day of our visit as they had not been completed or were not accessible to staff members. Therefore we cannot be assured that regular auditing of medicines was taking place within the service.

The above issues indicate that people were not always protected against the risks associated with the unsafe storage, management and administration of medicines**.** This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service manager told us that risk assessments were completed upon the commencement of care provision and were updated on an annual basis and/or to reflect a change in the level of risk. We looked at people's written risk assessments and noted that reviews of people's care and support needs had been due in October 2015. Following the inspection we were informed by a senior staff member that reviews had taken place for two of the people using the service in May and June 2015. Information regarding these reviews was not available in people's records. This meant that staff and visiting health professional did not have access to the latest information regarding people's health and well-being.

We observed people coming in and out of the kitchen area when food was being prepared on a heated stove. Staff were not always providing adequate supervision to people who entered the kitchen area and we observed them repeatedly trying to prevent people from touching hot appliances and utensils by standing in their way. Neither were staff able to monitor and manage people who had a tendency to throw hot drinks, cups and other items when in this area. We found no evidence that these occurrences had been analysed for any potential risk of the harm they posed. Care plans and risk assessments did not contains information relating to these risks.

The above indicated that the provider was not always doing all that was possible to mitigate identified risks to people using the service and staff. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We read of six incidents where staff had been hit and/or bitten by people using the service. We asked the service manager if staff were provided with any training on how to manage and de-escalate these situations and what support was available to staff who had been involved in these incidents. We were told that staff were encouraged to discuss the matter, offered reassurance and further shadowing opportunities. The service manager told us, "If I felt there was a need for it [appropriate training], I'd push for it but I think it's all about approach. Perhaps staff aren't observing, listening or following guidelines." The service manager told us that people's behaviour that challenged the service and staff was monitored and reviewed by health care professionals from a local authority Learning Disability Team and the provider's communication and behaviour team.

Inadequate

Is the service safe?

The service manager told us that there were three full time permanent staff vacancies within the service. On the day of our inspection there were three members of support staff on duty and a team leader. Not all of these staff were equipped with the skills and experience to support people whose behaviour challenged the service.

When recruiting new staff, the service manager told us, "We don't necessarily look for paper qualifications" but applicants needed to be able to demonstrate "empathy, energy and enthusiasm". We reviewed five staff files that contained very little information about the person employed. During our visit we were unable to review people's proof of identity, right to work status and references as this information was not held at the service. We requested and have received further information from the provider relating to this matter demonstrating that criminal record checks and other relevant checks had been undertaken before staff commenced working with people living in the home.

Staff, had received training in safeguarding adults. They were able to describe the process for identifying and reporting concerns and were able to give examples of types of abuse that may occur. We saw a copy of the provider's safeguarding policies and procedures which were accessible to staff via their intranet system. Staff understood how to whistle blow and told us they would report any concerns they may have to their manager and other relevant agencies where appropriate.

The home was clean and we saw the home being cleaned during our visit. Infection control measures were in place and staff had access to disposable gloves and aprons. The building was secure and we were asked to identify ourselves on arrival and sign in and out of the building accordingly. We were also informed of the location of fire exits and assembly points. We saw evidence that health and safety checks on lighting systems, fire equipment and fire exits were completed. However these checks were not always carried out on a regular basis. We highlighted this lack of information to the service manager during feedback from our inspection.

Requires improvement

Is the service effective?

Our findings

People were not always protected from risks to their health and wellbeing because staff lacked the confidence, skills and experience necessary to support people with complex learning and physical disabilities. For example; one member of staff told us that after eight months of working in the service they still did not feel confident enough to support people when out and about in the local community. Other staff members told us that bank and agency staff often lacked the confidence and skills to support people to attend activities and appointments. Staff who were not permanent employees required support to administer people's medicines from staff members working in a nearby service run by the same provider. This may have resulted in unnecessary delays in people receiving their medicines.

The service manager told us that staff were supported to obtain the necessary skills and knowledge for their roles via a comprehensive induction and ongoing training. New staff were required to complete a 12 week induction and probation period. Staff were provided with a workbook and directed to complete e-learning, watch videos, access the provider's intranet for sources of information, observe, discuss and reflect on their learning experience. The service manager told us that staff attended one to one meetings with their manager on a monthly basis during their probation period.

We reviewed five staff files and documents relating to staff training and found no supporting evidence relating to the induction. Records demonstrated that some staff received supervision. However, these sessions were inconsistent and one member of staff had not been supervised at all according to the information held on file at the time of our visit. We saw no evidence of annual appraisals taking place for staff members and therefore there was no forum to discuss whether staff were meeting objectives and whether they were up to date with training requirements. Some staff told us they did not feel supported or confident in their roles.

The issues above related to a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always being supported to eat and drink what and when they wanted to. We noted that food and drink supplies were low due to a late supermarket delivery. This meant that one person was unable to have a cup of tea or coffee. We also observed staff preventing one person from accessing the drink of their choice when they requested it and telling them they should have it after their meal and not before. We noted another person being given tinned ravioli with no other choice offered when their care plan recorded that they 'particularly enjoy eating Caribbean foods' and where a diet high in fibre had been recommended by healthcare professionals.

Therefore we found that people's preferences and individual needs were not always met. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The service manager had a good working knowledge of current legislation and guidance. Some but not all staff had completed training in mental health legislation which had covered aspects of the MCA and DoLS. Staff were aware of the need to obtain consent where this was possible. We heard some staff explaining their actions and at times, using objects of reference to allow people to make choices (although this was not a consistent approach amongst staff members).

The service manager told us that referrals had been made to the local authority with regards to DoLS. Records demonstrated that the service had involved health and social care professionals and family members (where appropriate) to support people to make decisions about their care. The service manager told us they had submitted

Requires improvement

Is the service effective?

three DoLS applications in relation to leaving the home without staff support. However, staff were not aware that denying people access to the drinks of their choice could be perceived as restrictive practice. We notified the service manager of our observations who told us, "this shouldn't happen." We have contacted the relevant agencies in order to confirm that applications have been submitted and at the time of writing this report are awaiting a response.

There was evidence in people's care records that the provider worked collaboratively with healthcare professionals such as dietitians and social workers, and that staff contacted the person's GP and/or social worker if they had concerns with regard to people's health. Staff were aware of who to contact in a medical emergency. A family member told us, [Staff] always let me know what's going on, they phone me and let me know about my [relative's] appointments."

Requires improvement

Is the service caring?

Our findings

A relative we spoke with told us, “I’m happy with the service, the staff and how things are being run.”

People’s cultural identity, preferences and choices weren’t always being respected. One person’s care records noted that they ‘liked to embrace [their] cultural background and particularly liked eating Caribbean food.’ We saw no evidence that these choices were being incorporated into this person’s daily life.

Two people enjoyed going for long walks but one member of staff told us they did not feel confident enough to support certain individuals when out in the community. Three staff members informed us that people had previously enjoyed going to Church, taking part in music and dance sessions, attending local support groups and going on holiday but that none of these activities now took place due to funding issues.

We looked at people's care and support records which included their care planning documentation, risk assessments, healthcare documentation and other information. Care and support records contained brief life histories, and information about family relationships, hobbies, interests, likes and dislikes and daily routines. People’s weekly activity plans were inaccurate and/or out of date and it was unclear how this information was put into practice by staff caring for people living at the home in light of the information in the above two paragraphs.

We observed staff taking time to engage with those who used the service, whilst at the same time getting on with other essential tasks. Staff demonstrated a caring attitude and were patient with people in challenging situations. The service manager was able to provide detailed stories of the people living at the home. However, not all staff were as familiar with people’s care and support needs and care plans had not been read by all members of staff. For example; one member of staff was not able to tell us why a person using the service needed to use soya milk rather than dairy produced milk to avoid exacerbating a health condition.

Staff told us that respecting people’s privacy and dignity was an important part of their work and they always made sure they observed good practice such as asking people’s permission, telling them what they were going to do and making sure doors were shut whilst people attended to or were being supported with their personal care.

It was apparent that people were comfortable with the staff caring for them. We saw people moving around the home independently without restriction and they were able to spend time where they wanted to, for example; in their bedrooms, communal areas and in the kitchen. However, the home appeared void of personal touches, pictures and people’s belongings. A sensory room where people could ideally spend time in a calm environment was cluttered with papers and boxes and broken electrical equipment. We did not see anyone using this room for the purpose it was intended during our visit.

Requires improvement

Is the service responsive?

Our findings

People were not provided with opportunities and support in relation to promoting their autonomy, independence, home and community involvement as people living in the home did not always have the opportunity to go out or partake in activities in and around the local community.

The service manager told us they organised activities for people using the service. Some staff however, told us that no activities took place within the home. One member of staff said, "They [the management] have done nothing to bring meaning into people's lives. All the activities that people used to do have gone. The manager says it's funding. These people need a meaningful life. They can't get that." During our visit, we observed people completing household tasks such as laundry and tidying. Whilst we acknowledge that the completion of these daily tasks may be meaningful for people using the service we did not observe any other form of organised activity taking place within the home.

We noted in one person's care plan that they been diagnosed with depression. Health care professionals had recommended that staff support this person to increase their activity levels and to build relationships with others. Additional information stated that this individual responded well to being kept meaningfully occupied. These recommendations were not being put into practice.

We noted that care plans for two people indicated that they enjoyed going out for long walks. Staff told us they did not feel confident enough to provide support out in the community for two of the people using the service.

The above four paragraphs related to a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People were referred by social services and referral assessments were filed in people's care records. We noted that the provider involved social services in decisions about people's care based on correspondence we reviewed. Care plans included information and guidance to staff about how people's care and support needs should be met. They were retained safely and kept in individual files.

People's health action plans had been completed and gave details of the range of healthcare professionals involved in people's care. However, two members of staff told us that people using the service had missed health appointments because staff were unable to support people outside the home due to a lack of confidence and an inability to manage behaviour that challenges. Following our inspection we emailed the service manager regarding this matter. She told us she was unaware that appointments had not been attended. The service manager has since informed us that a GP appointment has been rescheduled. We are still waiting for information regarding another missed appointment at the time of writing this report. This meant that we could not be assured that people had access to healthcare specialists when they needed it.

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

The provider carried out an annual survey in order to gain feedback from people using the service, family members and/or representatives. However, analysis of the survey results did not indicate how many people using the service, if any, had responded. We asked the service manager how they sought feedback from people who were unable to verbalise their opinions about the care they received. She told us that two of the people living in the home had access to advocates. We saw no documented evidence of support from advocates during our inspection.

Inadequate

Is the service well-led?

Our findings

The service was not organised in a way that promoted safe care through effective record keeping and quality monitoring. We received five safeguarding notifications since our last inspection took place in January 2014. We were unable to confirm whether all allegations of abuse had been recorded, managed and responded to appropriately because records relating to this period were not available on the day of our visit. This indicates that systems and processes designed to monitor and record these types of incidents were either non-existent or inaccessible to those responsible for managing the service.

People were not always protected against the risk of inappropriate or unsafe care and treatment, by means of an effective operation of systems designed to regularly assess and monitor the quality of the service. We identified shortfalls during our visit relating to quality monitoring, risk assessments, safeguarding, record keeping and medicines management which had not been identified by a system of internal auditing. This and the above paragraph indicate that quality assurance procedures are failing to ensure people's health, safety and welfare is protected and promoted and that records in respect of each service user are being maintained and/or completed accurately.

The issues above related to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service manager told us of a recent incident involving a person living at the service who had fallen down the stairs and been admitted to hospital for treatment for their injuries. We asked the service manager why we had not been notified of this event and were told, "It completely slipped my mind."

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We have requested that in future all notifications are sent us in a timely fashion so that where needed, action can be taken.

Health and social care professionals told us the service suffered from poor staff retention, that communication between the provider, families and themselves could be improved and that staff didn't always seek support or follow guidance when it was given.

Team meetings took place every four to six weeks. Staff told us meetings were not always well attended and felt more like briefing sessions rather than a forum for staff to discuss concerns and make suggestions and/or recommendations about how to improve the service. We were told by some staff that they did not feel listened to and that an open and honest culture was not promoted by the management team. One staff member told us, "We don't feel valued and we are there 24/7 without any management. [Management] haven't done anything to improve the lives of the people we support." Other staff members told us that changes were not implemented when they needed to be and that, "If you complain, [management] don't do anything."

Information regarding how to make a complaint was available to people using the service, family members and staff. We were told that no complaints had been received since our last visit in January 2014 though it was unclear what measures the service had adopted to gain feedback from people who were unable to clearly verbalise their opinions.

The above two paragraphs indicate the provider was failing to assist people to express their views and, so far as appropriate and reasonably practicable, accommodate those views. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The service did not have a registered manager. 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.

A service manager was responsible for the day to day running of the service with support from a deputy manager. The deputy manager was absent from the service on the day of our visit. Staff told us the deputy manager was often absent from the service. The service manager was responsible for the overall management of this service and another nearby service run by the same provider. She acknowledged that she felt stretched in her ability to manage two services effectively particularly in the absence of full-time deputy management input.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 (RA) Regulations 2014 Person-centred care The provider was failing to ensure that care and treatment of services users was appropriate, met their needs and reflected their preferences. Regulation 9 (1) (a), (b), (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered provider had not notified the Commission without delay about serious incidents in relation to service users. Regulation 18 (1), (2) (a) (i) (ii) (b) (ii)

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not ensure that care and treatment was provided in a safe way as systems for the proper and safe management of medicines were not operated. Regulation 12 (1), (2) (g) The provider did not ensure that risks to the health and safety of service users were regularly assessed and that these risks were mitigated. Regulation 12 (1) (2) (a), (b) The provider did not ensure that service users were able to access healthcare in a timely manner. Regulation 12 (1), (2) (a), (b)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not operate effective systems to monitor and improve the quality and safety of the services provided, to monitor and mitigate the risks relating to health safety and welfare of service users, and did not maintain complete records in relation to safeguarding matters. Regulation 17 (1), (2) (a), (b), (c) The provider was failing to assist people to express their views and, so far as appropriate and reasonably practicable, accommodate those views. Regulation 17 (1), (2), (a)

This section is primarily information for the provider

Enforcement actions

The provider was failing to seek and act on feedback from relevant persons and others on the service provided for the purpose of continually evaluating and improving the service.

Regulation 17 (1), (2), (a), (e), (f)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider was failing to ensure staff received adequate training, supervision and support to enable them to carry out the duties they are employed to perform. Regulation 18 (1), (2), (a)

The enforcement action we took:
This will be reported upon at a later stage when our action has been completed.