Mr & Mrs J Dorval

Brookfield Residential Home

Inspection report

7-9 Hayes Road
Clacton on Sea
Essex
CO15 1TX
Tel: 01255 427993

Date of inspection visit: 13 November 2014
Date of publication: 18/02/2015

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 unannounced inspection took place on 13 November 2014. Brookfield Residential Home provides accommodation and personal care for up to eleven people. Two people had been admitted to hospital for care and treatment following serious concerns raised by healthcare professionals about how their needs were being met by the service. The majority of people living at Brookfield Residential Home were living with dementia and had varying levels of dementia related needs, some more advanced.

There was a registered manager in post at the service. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. In this instance the registered manager is also one of the partners in the partnership providing the service and is therefore also the registered provider.

Summary of findings

At our last inspection on 5 September 2014 we found the provider was failing to plan and deliver safe and appropriate care to people to meet their needs. We served a Warning Notice on the provider telling them where they were failing and requiring them to address the issues before 28 October 2014. We also asked the provider to make improvements to cleanliness and hygiene in the service, staffing levels and staff training, medication management, how the human rights of people who may lack capacity to take particular decisions are protected and how the quality of the service was monitored.

They sent us an action plan telling us the improvements they were making. During this inspection we looked to see if these improvements had been made. We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and that the provider had not responded effectively and promptly to our concerns; very little improvement had been made to ensure people received care that was safe, effective and protected them from harm.

People's safety was being compromised and they were at serious risk of harm because care was not being assessed and delivered which met their changing needs. There was no system to assess staffing levels and make changes when people's needs deteriorated, so that staff could care and support people safely. There were insufficient numbers of staff to meet people's needs at all times, particularly at night. There was poor medicine management and people were not always receiving their medication as prescribed.

Staff did not have the knowledge and skills they need to carry out their role and responsibilities effectively. They did not recognise poor practice which might put people at risk of injury, for example when supporting people to move and transfer. Risks, including nutritional needs were not identified, monitored or managed. People were not supported to have sufficient quantities to eat and drink and maintain a balanced and nutritious diet.

Care was based on routines rather than individual choice, for example the time people went to bed and the time they got up. People's interests or past hobbies were not explored; they were socially isolated and some were withdrawn. Staff were not provided with guidance on how to deliver the best possible care to people at the end stage of their life in a way that maintained their dignity and comfort.

Care was not personalised but delivered by a task led approach and people's choices and preferences were not respected. People had not been protected from the risks of receiving care that was unsafe or inappropriate. People had not been referred to healthcare professionals for treatment, support or advice to maintain their health and wellbeing.

Quality assurance systems had not been implemented and the provider was unable to recognise or independently identify where improvements were needed. There was a lack of proactive managerial oversight to ensure that risks to people's safety and welfare were being identified and managed. The culture of the service was not open and transparent with professionals who were trying to support and the service was not being run in the best interests of the residents.

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.

People were being put at risk through poor care. Risks to their health and welfare were not assessed or reviewed to ensure their needs were being met.

There was unsafe moving and handling practice.

There were insufficient numbers of skilled staff to meet people's needs effectively and medicines were not managed safely.

Inadequate

Is the service effective?
The service was not effective.

Staff did not have the knowledge and skills they need to carry out their role and responsibilities.

People were not supported to make decisions or choices for themselves.

The quality of food was poor with limited choice.

People's healthcare needs were not being met or suppported.

Inadequate

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

People were not supported to be as independent as possible or to express their views and be actively involved in making decisions about their care and support.

End of life care was not planned and delivered in a way that ensured people receive the best possible care at that time.

Inadequate

Is the service responsive?
The service was not responsive.

People did not receive personalised care that is responsive to their individual and diverse needs.

People were not supported to make choices about how they spend their time and pursue their interests.

Inadequate

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

The leadership of the service did not recognise poor practice or acknowledge improvements were needed.

The quality and safety of the service was not being adequately monitored or reviewed.

Inadequate

Brookfield Residential 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 13 November 2014 and was unannounced.

The inspection team consisted of two inspectors.

Prior to this inspection we reviewed information about this service. This included concern in relation to people's care and welfare from the local authority, Environmental Health Officers and the Medicines Safety and Governance Technician from a Clinical Commissioning Group.

We spoke with two people and one relative during our visit. Other people were unable to share their views and experiences with us because they were frail or unwell, so we gathered information through observation. We obtained views about the care being provided in the service from five health and social care professionals.

We spoke with three care staff and the registered manager. We reviewed a range of records about people's care and how the service was managed. These included the care records for six people, training records for all staff employed at the home, medication records, accident records and documents given to us by the registered manager that related to how they monitored the quality of the service.

Inadequate

Is the service safe?

Our findings

Our inspection of 5 September 2014 found that improvements were needed to ensure that people's health and welfare needs were met. We were so concerned that we served a Warning Notice for Regulation 9 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2010. We found that improvements had not been made during this inspection. We are currently considering what action to take under our enforcement powers. At the time of the inspection the local authority were so concerned about the safety and welfare of people they were making arrangements to move people to alternative services.

Health and social care professionals told us that the manager had not reported or referred people to them for support and treatment of pressure areas. This is where people's skin can break down and cause ulcers. However two people had multiple and severe acquired pressure ulcers. Their risk of developing a pressure ulcer had not been reviewed and reassessed despite their reduced mobility which increased their risk. Care staff and the manager were unable to explain any preventative measures they had taken to avoid this. Changes in their care needs of these two people had not been brought to the attention of relevant healthcare professionals for appropriate preventative equipment, for example pressure relieving mattresses.

People who were unable to move independently were supported by staff whose practice was unsafe. Four people needed to use the hoist and staff had no information about what size sling each should have been using. Staff could only show us one sling. People were being transported from one place to another in a small wheelchair. Their feet were dragging on the ground as care staff did not attach footrests to the wheelchair. This was unsafe and could have caused the person injury. Assessments and care plans did not reflect best practice guidance or individual moving and handling needs. They did not specify type and frequency of moving and handling in relation to daily activities, or address the environment and overall individual equipment the person needed, such as the type of hoist and hoisting sling to be used. People can experience discomfort or a fall if the wrong sized sling is used.

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

Two care staff told us that they had received moving and handling training and although we saw certificates to say that all staff had attended this training correct techniques were not being put into practice. Professionals told us they had witnessed poor moving and handling including moves that were not best practice as they put people at risk of injury. One staff member told us that they did not know how to use the hoist. The training was not effective because it was not being put into practice.

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

Care staff told us that they needed a new hoist and hoisting slings, they further explained that they could not get the hoist under the beds; two people who needed assistance to move slept on divan beds. We saw that this particular hoist was incompatible with divan beds and some people's chairs because it did not slide beneath them to allow for accurate positioning to enable a safe manoeuvre and protect people from risk of accident or injury.

The manager was unable to demonstrate that services and examination of the hoist met the requirements of the Lifting Operations and Lifting Equipment Regulations (LOLER) by someone with the relevant technical knowledge and the practical experience. There were no detailed wriiten reports of the examination as required by LOLER to identify risks associated with wear, deterioration and compatibility.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The manager was unable to demonstrate that they had taken appropriate action to ensure people were protected and safe from potential harm. For example one person had unexplained injuries which had not been reported to the local authority as required, or investigated to establish how the injuries had occurred. A record showed that another person who had raised concerns was told that if they continued to make allegations they would have to live elsewhere. A social care professional told us that this had caused the person anxiety and worry.

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

At our last visit in September 2014 we raised concerns that people were not being protected against the risks associated with medicines and that the provider did not

Inadequate

Is the service safe?

have appropriate arrangements in place to manage medicines safely. Following our visit, at the request of the local authority two medicine audits were undertaken at the service by a Medicines Safety and Governance Technician from the North East Essex Clinical Commissioning Group (NEECCG); one in September and one in October 2014. Despite support provided by the technician, there continued to be failings in the management and administration of people's prescribed medication, placing them at risk of harm. For example one person's admission to hospital would have been avoided if they had received their medication as prescribed.

Medication was not being managed safely and in accordance to National Institute Clinical Excellence (NICE) guidance recommendations and good practice for managing medicines in care homes. For example medication was not being given as prescribed. A person did not receive their medication on time which was important to help them control symptoms of a health condition. A staff member told us that they had been instructed by the manager that the medication would be given later, which was some time after the prescribed time. No reason or explanation was recorded or provided to us by the manager to explain why it was not given at the prescribed time. In addition we saw that the manager signed the records retrospectively to show that the medication was given. This was poor practice as records must be completed at the time of administering so there is information available about what has been given and when. There was not a full written medication policy and procedure to cover all aspects of the medicine management process that should also include appropriate record keeping. The manager and care staff had not received the relevant training in medicine administration neither had they been assessed as competent to handle and administer medicines.

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

At our inspection on 5 September 2014 we found there were not enough skilled and experienced staff to meet people's needs. At this inspection we found this had not improved. There were still not enough staff with the right experience and skills to meet the needs of the people living in the home. The manager was unable to demonstrate how they reviewed staffing levels to ensure there were sufficient numbers to meet people's needs at all times. Five people using the service had high dependency needs requiring two care staff to meet all their care needs. In addition people at the end of their life required hourly support throughout the day and night. At night there was only one staff member on duty and those people who were unable to move unaided required two staff to do this safely and to minimise their discomfort. The manager and staff were unable to explain how care was provided to the people at night where they required two care staff.

Care provided was linked to staff availability rather than to people's individual needs and choice. We received information that irrespective of choice people were "put to bed" after their tea at approximately 5pm and were assisted to get up early in the morning from as early as 6am, because this was when there was more than one member of staff working. Care staff also prepared and cooked all meals as well as their caring role. The local authority was so concerned about the quality of the care being provided that they supplied extra staff to support the provider and ensure that people were safe and their needs were being met. Despite this, visiting professionals and the temporary support staff reported continued poor practice in the service by existing staff and that there were not enough permanent members of care staff with the necessary skills to meet people's needs. As a result the local authority made arrangements to move people to alternative services.

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

Inadequate

Is the service effective?

Our findings

Our inspection of 5 September 2014 found that improvements were needed to ensure that people's health and welfare needs were met. We were so concerned that we served a Warning Notice for Regulation 9 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2010. The provider wrote to us and told us about how they were going to address this. We found that improvements had not been made during this inspection. We are currently considering what action to take under our enforcement powers.

During our visit a healthcare professional described one person's condition as dehydrated, malnourished and unresponsive, they were very frail and unwell. They were so concerned for this person's welfare that they arranged for their admission to hospital. A care staff member told us that they had reported their deteriorating condition to the manager but nothing was done about it. Fluid charts were inaccurate and did not reflect the person's condition or inability to drink without assistance. Records completed stated that the person had been drinking more than enough but this was not possible given their medical condition.

One person had significantly deteriorated since they were last seen by their GP three weeks prior to our inspection. A care plan was not in place to enable staff to deliver appropriate care and support including pain management or how to recognise and monitor further deterioration, when to seek further professional healthcare advice and follow up promptly.

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

People did not receive the care and support they needed because care staff and the manager did not have the knowledge and skills to carry out their role and responsibilities. Care staff told us that they had not received any training specific to people's needs and health conditions, for example, end of life care and dementia. They told us that they had one to one meetings with the deputy manager but they were not frequent and they did not address training needs. The training records did not show when staff attended training or when update training was due. Although staff told us that they had recently attended some training we found it was ineffective because our observations of care being provided, care planning, risk assessments, reporting to healthcare professionals, medicine management and end of life care did not reflect best practice. When speaking with staff they did not recognise poor practice or understand the impact this had for individuals they cared for such as possible injuries due to poor moving and handling techniques, pressure ulcer prevention and pain management.

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

At our last inspection we found that risks associated with people's nutritional needs were not being assessed. We found on this inspection that no further action had been taken and the service was still failing to identify people's needs in this area and how they should be addressed. Two people had diabetes and this was not being effectively managed or monitored to ensure they were receiving the appropriate care for the condition. One person told us that they found eating difficult, they had lost their dentures and these had not been replaced.

People's care plans did not contain any information in relation to their dietary needs and the level of support they needed. Where people were losing weight appropriate referrals to health care professionals had not been made to help support the service to manage this effectively..

Prior to our inspection we received information which raised concerns about the quality and nutritional value of the food provided. We found people were not receiving a balanced and nutritious diet and in some cases that they did not have access to enough to eat and drink. One relative told us that there was little, if any, choice or variety. One person bought in their own food because they did not like the food provided. We did not see any fresh produce of meat, vegetables or fruit in the service. One person working in the service told us they were asked by the manager to water down the milk to make it go further.

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

The majority of people living at Brookfield Residential Home had varying levels of dementia related needs, some more advanced. In addition they had limited mobility and were unable to manage stairs. The premises had not been adapted to meet their physical needs and improve their quality of life or promote their wellbeing. The passageways to the upstairs bedrooms were not wide enough to

Inadequate

Is the service effective?

manoeuvre a hoist. There was a lack of handrails to assist people to move independently. Attention had not been given to colour and signage to enable people living with dementia to orientate themselves. One person kept asking the way to their bedroom and became distressed. No action had been taken to help people recognise their room or the route to it. The outside area was cluttered with rubbish and was not adequately maintained to provide a safe accessible environment for people to go out into if they chose. The home was very cold and some people required blankets to keep them warm while they were seated in the lounge. One person who was unable to mobilise and remained constantly in their bedroom complained that their room was always very cold.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our last visit in September 2014 the manager had failed to take actions to protect two people where they were unable to make independent decisions about how their care was delivered. At this inspection we saw evidence that appropriate mental capacity assessments and a best interest decision had been undertaken by relevant professionals. This ensured that the decision was taken in accordance with the Mental Capacity Act (MCA) 2005, Deprivation of Liberty Safeguards (DoLS) and associated Codes of Practice. The Act, Safeguards and Codes of Practice are in place to protect the rights of adults by ensuring that if there is a need for restrictions on their freedom and liberty these are assessed and decided by appropriately trained professionals.

Despite the manager taking action to address the shortfall previously identified we found that the learning and principles of ensuring people's capacity to make their own choices had not been applied or considered within other assessments or care plans in relation to their day to day care and decisions. For example how they would like their care and support to be delivered and how they would like to spend their day.

Inadequate

Is the service caring?

Our findings

People said they liked the staff and we saw that staff expressed concern for people and their wellbeing. Despite this staff and the manager had failed to recognise their own poor practice and the impact this had on people through lack of action or escalation of concerns. Information from professionals and our own observations showed that the relationship staff had with those using the service were not positive as people's independence and choice were not promoted. People were not enabled to make their own choices and, in some cases, decisions about their lives.

One visitor told us that they had not been invited to be involved in their relatives care plan or a review since they had lived at the home. The manager was unable to tell us how people or their representatives had been involved in their care or support planning arrangements. The manager was unable to tell us how they ensured people's views and opinions were listened to and incorporated into the way their care was delivered. We saw that care was provided in a routine and task based way which left little opportunity for personal choice. For example daily routines were completed at the same time for all including going to bed, getting up and the provision of food.

The manager and care staff could not tell us how people with more complex needs were supported to express their views and experiences, or be involved in their care and support. Quality surveys had been completed for people using the service by a staff member. No consideration had been given as to whether people were able to understand or respond appropriately to what was being asked of them or if they felt able to provide an honest answer. There were no triggers or arrangements for independent advocates to support people with decisions. Without this staff were unable to ensure that as far as possible people's views were sought, listened to and acted on.

Care records showed that people needed support with personal care including washing and bathing. People looked unkempt, their hair required washing and combing and some people had very dirty finger nails. Their clothes were unclean. One relative told us that new clothes regularly went missing and on visits their relative was often dressed in clothes that were not their own.

Two people at the end stages of their life were not receiving appropriate care to meet their needs. They were both living with dementia and were unable to communicate their needs. A plan for the delivery of end of life care was not in place for either of them to guide staff on their mouth care, skin care, nutrition and hydration, repositioning and pain management. Staff were not provided with guidance on how to deliver the best possible care at this time that maintained people's dignity and comfort. As a result when healthcare professionals visited the service one was admitted to hospital in order to get the care they needed.

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

Inadequate

Is the service responsive?

Our findings

During our last inspection on 5 September 2014 we found that the provider was failing to plan and deliver safe and appropriate care to people. We served a warning notice telling them where they were failing and requiring them to address the issues by 28 October 2014. We also referred our concerns to the local authority safeguarding team who take the lead in investigating safeguarding concerns. The provider sent us a plan of how they were going to improve and also confirmed that the action had been completed. At this inspection we found that those improvements had not been sustained.

At this inspection people were not receiving personalised care that was responsive to their individual needs. Four people had difficulty communicating their needs and were totally dependent on staff to meet these needs. This meant they were vulnerable as they were unable to raise concerns independently or make more than basic decisions about their care and treatment. We saw staff struggle to interpret people's behaviours to understand and respond to their needs such as pain or if they were unwell. For example one person was cared for in a wheelchair. Staff failed to recognise that their distress was due to discomfort in the chair caused by pressure ulcers.

People spent much of their time sleeping or watching television with very little interaction from staff other than to respond to their personal care needs. One person told us that they never came out of their room and had only the television to keep them company; they were unable to mobilise and told us that no other options or opportunities to spend their time differently were offered. Another person told us that they liked to go to the town but this rarely happened. People's individual needs for social stimulation, leisure interests and hobbies had not been assessed and activities relevant to them and in accordance with their wishes and preferences were not provided to promote their wellbeing.

People did not receive personalised care. Care plans were either out of date or lacked detail to sufficiently guide staff on people's current care and support needs. There was no information on how people communicated to guide staff on how to interpret their needs and respond effectively. There was no information for staff on how people's dementia needs affected their day to day living and how they were to be supported. Individual daily records reported on people's mood negatively or positively such as good or bad and did not illustrate any triggers or reasons for a change in mood and how this was addressed and monitored to support a consistent approach to meeting their needs.

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

There were a lack of opportunities, encouragement and support in relation to promoting autonomy, independence and community involvement. One person did not like the choice of food provided at the home, and alternative options were not given. They were purchasing ready made meals from a supermarket out of their own money. This person also liked to go out into town but the opportunity to do so was not frequent and they said that they were often told by the manager and staff that it could not be supported because there were not enough staff or the weather was bad.

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

We looked at the information the service had on complaints and concerns to see how they listened and acted on feedback. They had no records of any issues being raised about the service except where the manager had advised someone they could leave the home if they were unhappy. In addition the local authority and other support services had provided guidance but this had not been used to improve the service.

Inadequate

Is the service well-led?

Our findings

At our last inspection on 5 September 2014 we found the provider did not have effective and robust systems in place to monitor and review the safety and quality of the service. The provider sent us an action plan telling us of the improvements they had made to ensure compliance. At this inspection the manager told us they felt they had done everything they needed to do to improve. However they were unable to show us evidence of how they had done this or how they monitored and measured the progress of their action plan.

Professionals involved with the service were concerned about the ability of the manager, to identify improvements, take action to address them and sustain them. For example despite having detailed reports and support provided to improve medication practice this had not been effectively monitored and sustained.

The manager did not acknowledge the concerns we and others had raised. They were defensive when we asked them for further information. They demonstrated a lack of understanding about the concerns we and others raised about the quality of the service. They had not taken the opportunity to learn from concerns, complaints and safeguarding investigations and improve the service. We observed that they did not engage positively with people who raised concerns, to find a way forward for resolution. This meant that the culture of the service was not focussed on improving for the benefit of those living there.

There were no systems in place to monitor the safety and quality of the service provided. The manager told us, “We haven’t anything written down.” Although records of medication checks had been completed they were ineffective because they failed to identify the shortfalls of staff practice. Improvement Notices had been served by an Environmental Health Officer and action had been taken to address the issues raised. However the manager could not tell us how they intended to monitor this in the future to avoid any reoccurrence. An environmental review system was ineffective and not robust enough because it did not include all aspects of the safety, cleanliness and hygiene of the service and identify where improvements were necessary. This failure to identify issues was demonstrated when the environmental health officer downgraded the service’s food hygiene rating from 5 (very good) to a 1 (major improvement necessary).

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

This section is primarily information for the provider

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered person did not take proper steps to ensure each service user received care that was appropriate and safe.**

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 registered person did not protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The registered person did not have suitable arrangements to ensure that service users were safeguarded from the risks neglect and acts of omission which cause harm or place them at risk of harm or response appropriately to any allegation of abuse.**

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 person did not protect service users against the risks associated with unsafe use and management of medcines**

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 registered person did not protect service users from the risks of inadequate nutrition and dehydration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The registered person did not take appropriate steps to ensure that at all times there were sufficient numbers of suitably qualified, skilled and experienced staff to safeguard the health, safety and welfare of service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person did not have suitable arrangements in place in order to ensure that staff were appropriately supported in relation to their responsibilities to enable them to deliver care to service users safely and to an appropriate standard.

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 registered person did not ensure that service users are protected by ensuring equipment provided was properly maintained, suitable for its purpose and used correctly to promote the safety, independence and comfort of service users.

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

This section is primarily information for the provider

Enforcement actions

The registered person did not ensure that service users are protected against the risks associated with unsafe or unsuitable premises.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services The registered person did not make suitable arrangements to ensure dignity and independence of service users, provide opportunities, encouragement and support to service users in relation to promoting community involvement or encourage them, or those acting on their behalf to express their views as to what is important to them in relation to their care and support, and, so far as appropriate and reasonably practicable, accommodate those views.