Hexon Limited

Summer Court

Inspection report

Football Green
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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 14 November 2017 and was unannounced. At the last inspection in September 2015 the service was rated Good.

At this inspection we found breaches of Regulations 12 (Safe care and treatment), 18 (Staffing) and 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014. Staffing was insufficient to meet people's needs and staff were not adequately supported. People's medicines were not managed safely and there was a risk of infection because of a lack of cleanliness. The service was not consistently well led. Checks and audits had not identified some of the problems seen by inspectors. You can see what action we took at the end of the full report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Summer Court provides accommodation and personal care for 37 people who are living with a dementia related condition. It is a detached property set out over two floors. There were 28 people at the service when we inspected. The service was one of five services run by Hexon Limited. The provider had employed a general manager to oversee the running of these services on their behalf. The general manager provided support to the managers.

There was a registered manager employed at this service. They were supporting a new manager in post at the time of our inspection who was in the process of applying for registration. 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.

Risks to people had been identified but detailed guidance was not available for staff to ensure people received appropriate care and support in all cases.

Staff recruitment was robust.

Servicing and maintenance of the environment had been carried out in a timely manner.

People were not always supported to have maximum choice and control of their lives; the policies and systems in the service supported this practice but staff had not always followed the correct process for making best interest decisions.

People's nutritional needs were met although recording on food and fluid charts was inconsistent.

Staff were described by some people as being caring and we saw positive interactions between people and

staff.

There was a lack of appropriate and stimulating activities. Some people told us they were bored.

The environment did not reflect current good practice guidance for dementia friendly environments.

People knew how to make a complaint and we saw that where complaints had been made they were dealt with in line with company policy.

The quality assurance system was not effective. Audits had not identified failings identified at the inspection.

Documents were not always stored securely and in line with the Data Protection Act.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The premises were not consistently clean and this posed a risk of infection for people.

People were not always protected because risk management guidance was not always in place for staff to assist them to do the right thing.

Medicines were not managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had the right skills to provide care for people but their training was not up to date and so they were not always following current best practice.

Best Interest decision making was not always carried out in line with MCA guidance.

The environment had some elements which supported people living with dementia but this could be improved.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People gave good feedback about the care workers and the care they received from them. However, we observed some practices which did not support people's dignity.

Staff were task centred in their approach. Their interactions with people were respectful.

Relatives had been involved in helping to plan people's care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive to people's needs. Information about people's needs was gathered before they went to live at the service. However, care plans had a lack of information available for specific medical conditions.

Activities were not provided on a regular basis and people told us they felt bored at the service.

Staff recognised people's changing health care needs and they worked with other health care professionals.

People we spoke with told us they felt able to raise concerns and could make a complaint if they wished.

Is the service well-led?

Requires Improvement

The service was not always well led. There was a registered manager who was planning on deregistering and a replacement manager was in post.

Record keeping was not of a good standard.

Audits had not identified all areas for improvement.

People we spoke with did not always know who the manager was.

Summer Court

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 14 November 2017 and was unannounced.

The inspection team was made up of one adult care inspector, one bank inspector and an expert by experience who had experience of adult social care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the 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. We reviewed the information we held about the service, such as safeguarding information and notifications we had received from the provider. Statutory notifications are when providers send us information about certain changes, events or incidents that occur at the service. As part of the inspection planning process we contacted the local council commissioners and safeguarding team for their feedback; they had recently visited the service and had highlighted concerns about staffing levels and people's safety. They shared their findings with us.

During our inspection, we spoke with six people who used the service and three relatives who were visiting people. We spoke with the general manager, new manager, six members of staff and a visiting health care professional. 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.

We were shown around the building, looked at communal areas and some private bedrooms. We observed interactions between staff and people who used the service throughout the inspection.

We reviewed care records for five people who used the service. We also looked at medication administration records, recruitment and training records for four staff and other records relating to the management of the

service.

Requires Improvement

Is the service safe?

Our findings

People told us that they liked living at Summer Court and felt safe there. One person who used the service told us, "There is always someone around. I feel safe in my room" and a second person told us, "I have a nice room with a call bell that I can use [to summon assistance]." A relative told us, "They are kept very safe by the carers."

However, our observations showed a lack of staff on duty to meet people's needs and keep them safe. People told us, "Yesterday (call bell) was answered in less than five minutes but some days [answered in] half an hour" and, "They answer the call but come back much later, I don't use it at night." One care worker told us, "Most people need two staff. I have concerns because people are not bothering to call us and we are finding them [in need of support]." We observed during the inspection that one person in their bedroom had used a call bell which sounded for six and a half minutes before it was answered by staff. Other call bells sounded through the day that were not always answered promptly. We spent over two hours in a communal room. There were long periods of time when no care workers were present and one care worker told us they did not believe there were enough staff to care properly for all the people living in the service.

There was a manager on duty, one senior care worker and four care workers up to 2pm when the number of care workers reduced to three to support 28 people. Most people required two care workers to provide personal care. The manager was supernumerary and the senior care worker administered medicines and dealt with accessing GP's for two people, so was unable to provide support to care workers. This left four care workers supporting people with their care. One of those care workers had to become the cook/kitchen assistant for the evening meal. There was a cook on duty until 1.30pm and after that time care staff had to deal with requests for food and drink. Care workers also acted as cooks at the weekends with no food safety and hygiene training.

There was one person on duty to run the laundry and to clean the service on the day of inspection. A second person was employed by the service. In total, there were sixty domestic staff hours and no cover on Saturdays which meant that care workers also had to do the laundry. The care workers worked hard to avoid any impact upon people but we saw that some people were not able to get washed and dressed until late morning because they had to wait for assistance.

The service used a dependency tool and following the inspection the manager sent us an explanation of people's dependency and how that converted into staff hours. The manager had calculated that there were five hours available for staff to provide activities. However, on the day of inspection care workers had no time to provide activities. A staff member who told us they were the activities co-ordinator for the company said they had been asked to come to the service and provide an activity. They had not planned to be at Summer Court on the day of our inspection. They worked across the company which meant that they only visited Summer Court on one day a week.

Staff told us, "We have no time to speak to people. There are no activities." A second member of staff said, "They [service users] are bored out of their minds. I hear buzzers [call bells] all the time in my sleep. It is

constant." People who used the service confirmed that there were very few activities saying they were bored. The dependency tool did not accurately reflect the reality of the situation with no time available for activities to be carried out by staff. Taking care workers to work in the kitchen in the evening further reduced the staff available to people.

The building was large and spread over a large area and only one domestic staff was employed to maintain cleanliness. This was insufficient and resulted in poor standards of cleanliness in some areas which made it difficult to control the risks of infection.

In a recent survey, a relative had outlined areas they had noticed had declined, one of which was staffing. They identified a specific day when they visited and found only one senior care worker and two care staff on duty.

The failure to provide sufficient staff to meet people's needs effectively and make sure staff were supported was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We found areas of the service that were not clean with dust and debris around the edges of rooms, some of which were odorous. We saw in one room that there was a soiled pad left on the floor, there were marks on bed rail bumpers and food and drink left uncovered on a bedside table. In the shower room, there was dirty laundry spilling out of the laundry bin on to the floor. There were toilets that were dirty and stained. The carpet in one bedroom was stained and worn and another bedroom carpet was marked with brown stains. Corridor carpets upstairs were stained and the area was odorous, although the general manager told us there was a plan to replace these the next day. We saw one vanity unit chipped and another with the front missing. There was a lack of paper towels in some toilets for people to dry their hands.

When we spoke with the laundry/cleaning person they told us they completed a domestic cleaning record daily schedule. The last recorded entry was on the on the 13 October 2017 so they had not been completed for 30 days which meant the provider could not be sure that cleaning tasks had been completed.

Staff wore the same tunics in the kitchen that they had worn all day to provide care. These were covered with a plastic pinafore but still posed a risk of cross infection. We have asked the infection control specialist nurse to review the service.

We looked at the infection control audits and saw that on 10 May 2017 work was required in the kitchen; on 9 November 2017 that item was still on the list for action, so improvements were not completed in a timely manner.

Medicines were not administered safely. We found that one person had been prescribed a pain relieving gel to be applied topically. This had not been ordered in a timely way and was not in stock at the service. The empty box was labelled 17 October 2017. A topical applications chart had been last dated 23 October 2017 and a note said it had not been available then and more had been ordered. It was unclear exactly when it had last been applied as prescribed. This meant that a person may have suffered pain because staff had not followed up this prescription order. Auditing processes needed to be strengthened to ensure these types of incidents were identified quickly.

When people had been prescribed topical lotions and creams we saw a separate chart with a body map had been used, but these did not give information to help staff know why, when and how to use them. For example, one person had been prescribed cream 'to be applied when required morning and night.' A care worker told us it was used for itchy skin although this was not recorded on the chart; they said, "The carers

know when to use it."

When people had been prescribed 'as required' or PRN medicines, usually for pain relief, no further information was available for carers to know why, where or when a person might need pain relief or how they could communicate this. People living with dementia who may sometimes lack capacity cannot always communicate verbally and it is important for staff to know the needs of individual people relating to pain and how they communicate. When PRN pain relief was administered, there was no record of where the person had pain. This information would allow care workers to assess the effectiveness of any such medication.

Medicines were stored securely in a locked trolley fixed to a wall in a locked room. A medication fridge was also locked. The temperatures of the room and fridge had been checked each day and had consistently been within a safe temperature range. Staff had access to NICE guidelines to support safe administration of medicines but the British National Formulary (BNF) was four years out of date. The BNF contains information about medicines which, if it was up to date, would help staff understand the medicines they administered to people.

Risk assessments had been completed around people's health and safety. These included assessments of the risk of malnutrition, falls, mobilising, and developing pressure ulcers. In most cases when risks had been identified, a care plan with guidance was in place to minimise the risk. However, one person had an allergy to bee stings and although staff had contacted the doctor who decided not to prescribe an Epipen, no further plan was in place to help carers know what to do if the person was stung by a bee. An Epipen is an injection that contains medicines which can reverse the effect of an allergic reaction. This type of allergy can result in severe reactions and not having that information could result in harm to the person.

Another person had a risk of falls identified but their care plan had notconsidered sensory factors including hearing and visual disabilities that might increase the risk. Without this information, the person was at risk of inappropriate care which may result in them having a further fall.

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

Equipment had been serviced and maintained within timescales approved by the health and safety executive. There was a fire risk assessment and emergency plan so that people knew what to do in the event of a fire. Staff had received fire safety training. People had personal evacuation plans in place which helped to make sure they were evacuated safely in the event of an emergency. There had been a recent visit by Humberside fire service to audit the premises. They had asked for some improvements which had all been completed and approved by the fire service.

During this inspection we looked at the provider's recruitment procedures and found them to be robust. We checked the recruitment records for four staff employed at the service and we found appropriate procedures had been followed, including application forms with employment history, interviews and reference checks. Before staff were employed, the provider requested criminal records checks through the Disclosure and Barring Service (DBS). The DBS helps employers ensure that people they recruit are suitable to work with people who use care and support services. Staff who we spoke with confirmed that they were not allowed to start work until these recruitment checks were in place. One member of staff who had started working at the service early in 2017 told us, "I didn't start work until it [DBS] was received."

There were arrangements in place to deal with foreseeable emergencies. Personal emergency evacuation plans documented the support people required to evacuate the building safely. The risks associated with

the environment and equipment in use were assessed and reviewed. Safety checks were regularly carried out on hoists, installed fire alarms, gas and electrical equipment. The service had a contingency plan in place in the event of an emergency. For example, an unforeseen event such as flooding or a fire. The contingency plan explained how people would continue to receive care and support.

Requires Improvement

Is the service effective?

Our findings

Staff had the skills required to provide the care and support for people at the service but were not always up to date with current best practice because their training was not up to date. For example,19 staff had completed safeguarding training but only four staff had done any training in this subject in the last twelve months. This meant that people who used the service were not receiving care from staff with up to date knowledge. However, everyone we spoke with felt that the staff had the skills required to care for them. A community nurse told us that care workers effectively prevented people from getting pressure ulcers and when a person had developed an ulcer in hospital, it had healed when the person returned to the home due to effective pressure relief care. This meant that despite the training being out of date there was minimal impact on the care people received.

Staff received an induction when they started working at the service. They had undertaken training that the provider considered to be essential such as moving and handling, safeguarding, first aid, food safety and nutrition and pressure area care during their induction. One staff we spoke with told us that they had attended safeguarding training. We spoke to one staff member about working at this service. They told us, "It is alright but can be frustrating. It is very busy."

Staff told us they were well supported by the deputy manager and senior care workers. The new manager had only recently started at the service and staff told us they had been in the office a lot of the time so they did not know them well. Records confirmed that some staff had received supervision but this was not consistent for everyone. Supervision is a one to one meeting with a senior member of staff where work related matters and training and development needs can be discussed. One new member of staff had received more regular supervision in order to ensure they were supported in their first weeks working for the service.

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. There were four deprivation of liberty safeguard (DoLS) authorisations in place for people using this service. People were supported to make decisions as much as possible and where relatives had Lasting Power of Attorney they were consulted. However, one person was receiving their medicines covertly following a best interest decision by a doctor. This had not been recorded on their medicine administration record and a pharmacist had not been consulted about the safety of crushing tablets. This did not fully follow the MCA guidance around best interest decision making. This meant staff were not following good practice guidance showing a lack of understanding around the MCA.

We recommend that the service research Mental Capacity Act 2005 guidance.

People who used the service had their nutritional needs assessed where appropriate. Information about people's preferred foods and drinks, food allergies, likes and dislikes was recorded. If any needs were identified with eating or drinking people were referred to the appropriate health care professionals for advice and support.

When we asked people's opinion about the food provided they told us, "Adequate enough, no choice as a rule, just bring me a plate of food. I don't think we get enough to drink" and, "I used to get fruit juice regularly but not so much now." A third person said, "It is alright, not my taste; not keen on toasted teacakes for tea. I get given food and take it or leave it." A relative told us, "I can't say about food, his weight has stayed the same" and another said, "She has lost a bit of weight but she has no real appetite. I fetch her things in and they will do her anything."

We observed lunchtime and saw that there was no real choice offered, with every person except one given identical plates of food. However, the food looked and smelled appetising and was hot. People were offered specialist equipment to enable them to eat independently, such as plate guards. Some people had drinks of juice with their meal and people were offered hot drinks afterwards. The tea trolley had not been out in the morning as planned and people were not given regular drinks. There were jugs of juice available but some people were not able to help themselves. Some people had their food and fluid recorded on charts but these were not completed fully which made it difficult to determine what people had to eat or drink.

We saw evidence that there were health care professionals in regular contact with this service to support people. We saw evidence in people's records of visits by a community learning disability nurse, social workers and doctors.

The environment had not been adapted for people living with dementia. There was some signage on bathroom and toilet doors and these were painted in contrasting colours to highlight these areas. The service was very warm inside. We recorded a temperature of 24.5 degrees Celsius at 1045am which felt uncomfortable. The health and safety executive recommend keeping living rooms at around 21 degrees Celsius and bedrooms around 18 degrees Celsius. We pointed this out to the general manager who arranged for the heating to be turned down. There was access to a courtyard where people could sit but the garden area was overgrown which meant it was difficult for people to access safely.

We recommend that the provider research information about dementia friendly environments.

Requires Improvement

Is the service caring?

Our findings

All the people we spoke with told us the staff were caring and understood them. One person who used the service told us, "[Staff] are kind, caring and friendly" and, "Very good" others said, "Carers are gorgeous, they give me kisses and cuddles" and "On the whole they are alright, kind." A relative told us, "They [staff] seem nice and friendly" and second relative said, "Carers are caring and considerate." It was clear that people felt valued by care workers.

Staff were professional and respectful in their approach. However, they took a task centred approach to care in order to manage their workload which did not always promote people's dignity. An example of this was people queuing in wheelchairs outside a toilet before lunch. We observed two care workers assisting a person from wheelchair to chair. This was carried out gently and the staff chatted with the person. People sometimes had to wait for long periods when they used their call bells. We saw one person had to wait six minutes for a member of staff to answer their call bell. One person told us when asked if staff answered call bells promptly, "Sometimes not. Yesterday it took less than five minutes but some days it takes half an hour." A second person told us, "Staff are so busy, call bells vary from being answered straightaway up to half an hour and I get upset by waits." This did not support people's dignity.

A carer was able to answer questions about two people demonstrating their knowledge of them. Knowing people and their potential helped support people with personal care but staff had not been given time to provide compassionate support. The rotas were not organised so that staff were able to spend time chatting and listening to people. One person felt ill during the inspection and staff gave them a large bowl but left them sat at a table. They did not offer to take them to a more private place such as their room but did later help them move to a more comfortable chair.

When people had communication difficulties, such as deafness, we did not see carers talk to them in a way they could understand and people's care plans did not give care workers detailed guidance on how to support their sensory needs. We saw very little interaction between care workers and people living in the home during the day, apart from assisting with tasks and when a person was unwell. They seemed busy and did not have time to chat to people or support any activities during the morning. One person read a newspaper and a television was on in each large communal room.

We saw that professionals had commented in a recent survey that staff were always welcoming and relatives echoed that view when we spoke with them. Staff recognised people's needs because they knew them very well. Relatives and friends were encouraged to visit people as often as they wished. We saw evidence that relatives had been involved in planning care and in helping people to make decisions in care files. There was information about how people could access advocates in the entrance but most people were supported by their families.

People were not supported to develop and maintain friendships in the wider community unless their family supported them to do so. Staff told us they did not have the time to take people to use local clubs and amenities. However, we were told by the general manager that people went out on bus trips in the summer

months and could be taken by staff to access the local shops and banks.This meant that local contacts and friendships may be lost.

Requires Improvement

Is the service responsive?

Our findings

People at the service received care that was task focused but because care workers knew them well the impact of this was minimised. Care plans included information about needs and preferences but not always in detail. When people had hearing or visual disabilities we did not see care plans that specified how staff should communicate with them.

We saw people's next of kin details were recorded and when relatives had Power of Attorney for people's health and/or finances, the relevant documentation had been seen by the manager which meant that the correct people were involved in people's care. People told us that they thought their care plans reflected their preferences.

Care plans were developed following a person's admission to the service. They contained information about people's needs such as personal care, eating and drinking and communication.

There was no one receiving end of life care at the service but some people had been supported by the service for many years. When a person became unwell during the inspection we observed that one care worker acted with care and compassion. They held their hand and spoke to them gently. In addition, they asked for the senior care worker to review them

However, the management plans and guidance for some people was inconsistent. There was no specific guidance in some cases. For example, one person had a history of seizures but there was no guidance for staff to follow if this occurred. Another person had a history of falls and a falls risk assessment had been undertaken. However, the care plan did not include the fact the person had visual impairments and postural hypotension and how staff should take these factors into account to minimise their risk of falls. We saw evidence of reviews of people's care plans. People who represented their relative had sometimes, but not always, been involved in those reviews.

There was an activities organiser employed by the company. They visited six services and so they visited the service approximately one day a week. Because staff were busy they were unable to supplement those visits and so activities were not happening regularly. We did observe an activity on the day of the inspection. People told us, "I would like some [activities] to make it more interesting" and, "I played bingo once in a year." A third person said they did not take part in activities but it was their choice. Staff told us, "It is the same thing every day. There are no activities" and, "One person does have a vegetable plot and the cook uses the vegetable for meals. The activities organiser did organise a Halloween party but generally people are bored." people's specific and diverse needs were not taken into account when planning activities.

We saw that information was provided to people about the service complaints procedure when they came to live at the service. In addition, there were details on the noticeboard. There was a policy and procedure for staff to follow and complaints had been recorded and responded to. However, it was unclear how these complaints were used to make improvements at the service.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager employed but they were working as a deputy and planned to deregister. The new manager was in post and had held other management roles prior to this appointment. They had only recently started work at the service.

People who used the service told us they did not know the new manager. They said, "It [management] seems alright at the moment, I know her (manager) by sight but don't know her name". and "I don't think there is much organisation. I would put more staff on and do more activities." A third person told us the manager had changed but said they didn't know them. Relatives told us, "We have every confidence in the manager." One staff member told us, "The manager is open and transparent about things that are going on in the organisation and keeps the staff well informed of any changes that are going to happen."

The registered manager was supported by senior care workers who took some responsibility for the work carried out by care workers. One senior care worker told us that they supported care workers. Care was task led at the service which had become part of the service's culture. People were not involved in developing the service.

The registered manager told us they were committed to the continuous development and improvement of the service and they were supported by a general manager who oversaw the service. We saw some feedback had been sought from relatives and staff but this had not been collated into a report so that the responses could be discussed to make improvements.

The quality of the service was monitored through regular auditing. The audits had attached action plans but had not always identified all areas for improvement. We identified some failings which the provider had not addressed. Record keeping at the service was of a poor standard with forms and charts not consistently completed., staffing levels were insufficient for people's needs to be met appropriately, cleanliness and hygiene practices were not carefully monitored and training was not up to date.

Documents were not stored securely in line with the requirements of the Data Protection Act. We saw daily records on a table near the dining room when we arrived and later, were left opened on a table where a person and a visitor were sitting. Care plans were stored in a locked cupboard but these could be accessed by all staff which meant they were not secure.

The Care Quality Commission had received notifications about incidents that had occurred. The manager told us that any accidents and incidents were all investigated and acted upon and we saw evidence of this but there had been no analysis of incidents and learning was not taking place. In order to promote learning these incidents should be discussed in order for staff to learn from them.

The failure to develop systems to assess, monitor and improve the quality of the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for service users. The provider was not doing all that was reasonably practicable to mitigate risks because medicines were not managed properly or safely; The provider was not properly assessing the risk of, and preventing, detecting and controlling the spread of infections.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not in place to assess, monitor and improve the quality and safety of the services provided The provider did not maintain accurate, complete and contemporaneous records in respect of each service user.Records were not maintained securely in respect of the management of the regulated activity.

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 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed in order to meet the requirements of this Part. Staff did not receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

The enforcement action we took:

Warning notice issued.