Ferns Nursing Home Limited

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Inspection report

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Ratings

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

Overall summary

Ferns Nursing Home Limited is a care home that provides accommodation and nursing care and treatment for up to 33 adults who have nursing care needs. Accommodation is provided over three floors and the home is accessible to people who are physically disabled. Access to upper floors is via a staircase or passenger lift. The service is situated close to the centre of Southport, Merseyside.

During the inspection we met most of the people who lived at the home and we spoke with six people individually. We also spoke with a number of visiting relatives, three members of the care staff team, the cook, the deputy manager and the registered manager. We also spoke with the home owners.

We found that people living at the home were not protected from potential abuse because the provider did not have effective systems in place for responding to allegations of abuse. A procedure was in place for responding to allegations of abuse. However, this had not been reviewed for a number of years and included incorrect information about where to refer concerns to.

Summary of findings

Care staff told us they were confident about recognising and reporting suspected abuse and during discussions with the registered manager they told us they were aware of their responsibilities to report abuse to relevant agencies. However, during the course of our inspection we saw and heard of two different pieces of information which were safeguarding concerns. We found that these had been raised by care staff but no action had been taken by the registered manager in response.

We viewed the care plans for three people who lived at the home. Two of these provided sufficiently clear guidance on how to meet the person's needs. However, one of the care plans we viewed contained only basic information about the person's needs and some of this was inaccurate.

Staff worked well with health and social care professionals to make sure people received the care and support they needed. Staff referred to outside professionals promptly for advice and support.

Medication was in good supply and was stored safely and securely. We checked a sample of medication in stock against medication administration records. Our findings indicated that people had been administered their medicines as prescribed.

The manager had knowledge of the Mental Capacity Act 2005 and their roles and responsibilities linked to this. They were able to tell us how they would ensure a decision was made in a person's best interests if it was deemed that the person did not have the mental capacity to make a specific decision. At the time of our inspection the manager advised us that there was nobody living at the home who lacked the mental capacity to make decisions required of them.

During the course of our visit we saw that staff were caring towards people and treated people with warmth and respect. People who lived at the home gave us positive feedback about the staff team in general. However, they told us that not all members of the staff team had a caring attitude towards them.

There were not always sufficient numbers of staff on duty to meet people's needs. This was reported to us by people who lived at the home, relatives and members of the staff team. Staff rotas confirmed that staffing numbers were not always maintained at an appropriate level and at those deemed to be required by the provider.

Staff were only employed to work at the home when the provider had obtained satisfactory pre-employment checks.

Staff had been provided with the training they needed to carry out their roles and responsibilities. However, we found staff were not being provided with regular supervision or appraisal and team meetings were not taking place on a regular basis.

The premises were safe and well maintained and procedures were in place to protect people from hazards and to respond to emergencies. The home was clean and people were protected from the risk of cross infection because staff had been trained appropriately and followed good practice guidelines for the control of infection. The home was accessible and aids and adaptations were in place in to meet people's needs and promote their independence.

We found that the communal space was limited to one main lounge and one small quiet lounge. Together these contained enough seating for up to 15 people. There was no dining room and people therefore ate their meals in the main lounge or in their bedroom. We saw that during lunch time and when there were visitors to the home, the main lounge became cramped.

There was a registered manager at the service at the time of our inspection. 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.

The provider did not have effective systems in place to regularly check on the quality of the service. The views of people who lived at the home and their relatives were sought through surveys but we found that people's feedback had not been acted upon.

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?

Requires Improvement

The systems in place to protect people from the risk of abuse were inadequate. The registered manager had not taken appropriate action in response to safeguarding concerns. This failed to protect people from the risk of being subject to abuse.

People's medicines were stored safely and people were administered their medicines as prescribed.

Pre-employment checks were carried out on staff before they started working at the home to ensure they were deemed suitable to carry out their roles and responsibilities.

There were not always sufficient numbers of staff on duty to meet people's needs in a timely way.

Is the service effective?

Requires Improvement

Staff had been provided with the training they needed to support people effectively and they felt appropriately skilled and supported to meet people's needs effectively. However, we found that staff were not being supported through regular supervision, appraisal or attendance at team meetings.

The manager had some knowledge and understanding of the Mental Capacity Act 2005 and they told us they would work alongside family members and relevant professionals in making decisions in people's best interests if this was required.

Staff worked well with health and social care professionals to make sure people received the care and support they needed. Staff referred to outside professional for advice and support as required.

The home was accessible and aids and adaptations were in place to meet people's needs and promote their independence. However, we found that communal space across the home was minimal and did not allow for much room to accommodate people's moving and handling needs.

Is the service caring?

Requires Improvement

During the course of our visit we saw that staff were caring towards people and they treated people with warmth and respect. People who lived at the home told us that staff were generally good but they reported that a small number of staff did not always have a caring attitude towards them.

Relatives gave us good feedback about the staff team and told us that the manager was approachable.

Summary of findings

Is the service responsive?

Inadequate 

Each of the people who lived at the home had a care plan. However, we found people's individual needs were not always clearly reflected in their care plan.

Complaints had not been dealt with appropriately and the provider had not acted on feedback provided by relatives.

Is the service well-led?

Inadequate 

The systems in place to check on the quality of the service were ineffective and failed to identify the shortfalls we found.

People who lived at the home and their relatives were asked for their opinions of the service but their views and comments were not acted upon to ensure improvements were made.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Ferns Nursing Home Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2012 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2012.

The inspection was carried out on 17th and 18th December 2014 and was unannounced. The inspection team consisted of an adult social care inspector.

We reviewed the information we held about the service before we carried out the visit. Prior to our inspection we had asked the provider to complete a Provider Information Return (PIR) containing information about the operation of the home. This had not been returned to us.

Following our inspection we contacted one of the commissioners of the service to gain their feedback about the service.

During the inspection visit we spoke with six people who lived at the home and a number of visiting relatives. We also spoke with three care staff, a cook, the deputy manager, the registered manager and the registered provider.

We viewed a range of records including: the care records for three people who lived at the home, four staff files, records relating the running of the home and a small number of policies and procedures.

We carried out a tour of the premises and this included viewing communal areas such as the lounges and bathrooms and viewing a sample of bedrooms. We also viewed the kitchen, a food storage area and laundry facilities.

Requires Improvement

Is the service safe?

Our findings

People who lived at the home were not protected from the risk of abuse because the provider did not have robust procedures in place for responding to allegations of abuse. We looked at the provider's internal policy and procedure for safeguarding. This had not been reviewed for a number of years and included incorrect information about where to report suspected abuse to. The procedure also failed to provide any information or guidance for staff on what actions to take after reporting a safeguarding concern. We spoke with care staff about safeguarding and the steps they would take if they witnessed abuse. Staff gave us appropriate responses and told us that they would not hesitate to report any incidents to the manager. The manager was able to provide us with an overview of the action they would take in the event of an allegation of abuse, this included informing relevant authorities such as the local authority safeguarding team, the police and the Care Quality Commission (CQC). However, two safeguarding concerns came to our attention during the course of our inspection and we found that the manager had not taken appropriate action in response to these and had not reported them to the local authority in line with safeguarding protocols and procedures. The manager was not able to explain why they had not reported the concerns. We discussed our concerns with both the registered manager and the registered provider. We also contacted the host local authority to report our findings. Failing to ensure appropriate arrangements are in place to safeguard people against the risk of abuse is a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During the course of our visit we heard from people who lived at the home, relatives and members of the staff team that there were not sufficient numbers of staff on duty to meet people's needs in a timely way. People who lived at the home told us they sometimes had to wait too long if they asked for assistance or used their call bell. A number of relatives told us their family members often had to wait too long when they needed support with personal care. They also told us they sometimes had to ask staff to support their family member numerous times before support was provided. One relative told us their family member recently waited for an hour to be assisted to use the toilet and that this was undignified for the person concerned. People who lived at the home and relatives told us staff did not have any time to spend with them outside of providing personal care.

We saw that staff were very busy and their interactions with people were solely task orientated. We did not see staff having time to sit with people and have a conversation or to engage people in activities. Throughout our visit the call bell was ringing frequently and this created a loud, disruptive sound. Throughout the duration of our inspection we spent some time in the main lounge and we visited the lounge on numerous occasions. On most of these occasions there was no staff presence in the lounge.

Staff told us that they found it difficult to attend to people in a timely manner because they were often running at lower numbers than required and they supported people over three floors of the building. We found that the staffing level dropped from five in the mornings to four in the afternoons and evening. Staff told us that sometimes the numbers were three care staff all day. A member of staff was required to prepare a light tea for all of the people who lived at the home and we were told that this had a significant impact on the availability of care staff in the late afternoons and could result in only two members of care staff available to support all of the people who lived at the home. During discussions with staff they told us they found the staffing levels stressful and some staff presented as frustrated and stressed. Staff told us the home had been running on a shortage of staff for a number of weeks and that staff vacancies and absence was not being covered by agency staff.

We viewed the staff rosters for the four weeks prior to our visit. We saw there were occasions during this period of time when the home was not staffed in line with the numbers deemed to be required by the provider. On one occasion the home had been staffed by only two nurses and 1 carer.

The manager told us there had been some difficulties in recruiting new staff but that this would be resolved in the near future as new staff were in the process of starting. The manager also told us they found it difficult to secure agency staff at short notice. We asked the registered manager to send us with weekly updates on the staffing levels following our visit. These confirmed that the staffing levels were below the required level. Failing to ensure that

Requires Improvement

Is the service safe?

there are sufficient numbers of staff on duty to safeguard the health and welfare of people living at the home is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Medication was managed appropriately and safely. Medication was only administered by trained staff. The medication trolley and other storage areas were tidy and well organised and medicines were in good supply and were stored safely and securely. The majority of medicines were supplied in a pre-packed monitored dosage system. We checked a sample of medicines in stock against the medication administration records. Our findings indicated that people had been administered their medicines as prescribed. The registered manager told us that medication practices were audited on a regular basis and we saw confirmation of this.

We saw that risks to people's safety had been assessed and guidance on how to manage identified risks was generally incorporated into people's care plans. For example, if a person was at risk of developing a pressure wound then this had been identified as part of a risk assessment and information about how to support the person to prevent a pressure area was documented in their care plan. However, we did view one care plan which failed to adequately identify nutritional risks to a person and the information had not been reviewed or updated. We spoke with the manager about this and they agreed to ensure the care plan was reviewed and updated promptly so that it reflected the person's needs accurately.

We looked at staff recruitment records. We found that appropriate checks had been undertaken before staff began working at the home. We found application forms had been completed and applicants had been required to provide confirmation of their identity. We saw that references about people's previous employment had been obtained and Disclosure and Barring Service (DBS) checks had been carried out prior to new members of staff working at the home. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff.

Policies and procedures were in place to control the spread of infection and domestic staff were required to follow cleaning schedules to ensure people were provided with a safe and clean home environment. Staff told us they had the equipment they needed to carry out appropriate infection control practices and we saw examples of staff following the correct procedures during the course of our visit.

The manager informed us that the home had achieved a 5 star rating for food hygiene practices by the local council. During a tour of the building we viewed the kitchen and found it was clean and well organised.

Is the service effective?

Our findings

People who lived at the home were supported to maintain their health. The home provided nursing care and as such there was a registered nurse on duty at all times. People told us that the care provided at the home was good. One relative said "They are up to date with my mum's needs". People who lived at the home and relatives told us that staff responded quickly if they were feeling unwell and sought medical attention for them promptly.

We spoke with the manager about how they supported people to make decisions when there was a concern about their mental capacity to do so. The manager advised that nobody living at the home lacked the mental capacity to make their own decisions but that if there was they would refer for specialist advice to support the person. The manager told us they had been provided with training on the Mental capacity Act 2005. However, training records indicated that no other members of staff had been provided with this training to date. The manager also advised us that there was nobody living at the home who was subject to a Deprivation of Liberty Safeguard (DoLS). The Deprivation of Liberty Safeguards [DoLS] is a part of the Mental Capacity Act (2005) that aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests.

Staff told us they felt sufficiently trained and experienced to meet people's needs and to carry out all of their roles and responsibilities effectively. We viewed a sample of staff files. These included staff training records and training certificates. This information showed us that staff had been provided with training in a range of topics such as: safeguarding vulnerable adults, first aid, fire safety, infection control, health and safety, food hygiene and moving and handling.

We found from viewing staff files that staff had not been provided with supervision sessions with their line manager on a regular basis and for some staff we saw no evidence of any supervision having taken place. Staff appraisals were also not taking place on a regular basis. We saw no evidence of appraisal for some staff and for others the appraisal record had not been dated and therefore we were not able to tell when the appraisal had taken place. Staff team meetings took place on an occasional basis. The last meeting had been held in July 2014 and meetings prior to this were held in February 2013 and May 2012. We viewed the minutes of staff meetings but the record was poor and we could not gain any information as to the content and outcome of the meetings. This meant it was not possible for staff who were not able to attend team meetings to gain this information. Failing to ensure staff are appropriately supported to carry out their roles and responsibilities is a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

People who lived at the home generally told us the food was good. The cook was able to tell us how people's special dietary needs were catered for. The meals we saw provided to people looked well-presented and people told us they enjoyed them. One person we spoke with felt their dietary needs were not being well catered for and they had a lack of choice as a result of having a restricted diet. We spoke with the manager about this with the person's permission. The manager agreed to create a personalised menu with the person so as to accommodate their needs. People had a choice of a cooked breakfast every day and the main meal of the day was served at lunchtime. A lighter meal was provided at tea time and supper was offered to people in the evening. We visited people who were being nursed in bed as a result of their frailty. We found people had been supported to have regular meals and drinks and staff had kept a record of these. We spoke with people prior to their mealtimes and we asked them what they were having for their meal. We found that people did not know and they only found out when their meal was presented to them. Staff told us they sometimes asked people to make a choice of meals prior to mealtime but this was not consistent practice and depended upon which staff were on duty and how busy they were. During discussions with the cook they told us that they would ensure people were offered a choice on a daily basis.

We found that all areas of the home were clean and appropriately maintained. The home was accessible and aids and adaptations were in place to meet people's mobility needs, to ensure people were supported safely and to promote their independence.

The home had one main lounge area which could accommodate ten people. There was also a small lounge which could accommodate a further 5 people. These were the only communal areas for people who lived at the home to sit. At the time of our inspection there were 26 people living at the home. There was no dining area so people

Is the service effective?

were provided with their meals on small tables in the lounge. Once these were in place and visitors were occupying the lounge the space became very cramped. The small lounge offered some additional space but this was limited and provided little natural light. The manager told us that the provider had recognised the problems with the environment and lack of communal space and they were planning to have a conservatory built to the rear of the property to address this. They told us they also intended to make one of the larger ground floor bedrooms in to a lounge/dining area. They told us that this had provided a second lounge area prior to being turned into a bedroom.

Is the service caring?

Our findings

We observed the care provided by staff in order to try to understand people's experiences of care and to help us make judgements about this aspect of the service. We saw that staff were warm and respectful in their interactions with people. Staff spoke about the people they supported in a caring way and they told us they cared about people's wellbeing. However, we saw that the care provided was very task orientated. Staff did not have any time to spend with people outside of providing direct hands on care.

People who lived at the home told us that they felt staff were caring. However, every person we spoke with also said that a small number of staff did not present with a caring attitude towards them. One person told us "There are always one or two. I think you get that wherever you go". Another person said "They are nice but there are some that shouldn't be carers".

Relatives told us they felt the care staff were good and caring. They old us their family members were well cared for and that they had no concerns about the quality of care provided by the care staff. They did comment that staff were often too busy to provide support in a timely way. They told us that staff were frequently not available to assist people to access the toilet in a timely way.

During discussions with staff they showed concern for people's wellbeing and we heard that staff responded quickly to changes in people's needs to ensure they got the care and treatment they needed in a timely way. People who used the service, relatives and staff told us the manager and deputy manager were caring and approachable. Care staff we spoke with told us they were clear about their roles and responsibilities to promote people's independence and respect their choice, privacy and dignity. They were able to explain how they did this. For example, when supporting people with personal care they ensured people's privacy was maintained by making sure doors and curtains were closed and by speaking to people throughout, by asking people's permission and by explaining the care they were providing. However, feedback from people who used the service indicated that this was not always their experience of the care provided by all members of the staff team.

A lack of systems in place to support staff means that poor staff practice may go unchallenged. As reported under the effective domain we found that staff were not supported with regular supervision, appraisal and attendance at team meetings. These provide an opportunity for staff to receive feedback about their practice and to develop as workers. They also enable the provider to make explicit the expectations of staff in their role and to promote a healthy and open culture. We also saw from the provider's staff training matrix that staff had not been provided with training in topics such as equality and diversity or person centred care.

Inadequate

Is the service responsive?

Our findings

Care was not always planned appropriately. We viewed the care plans for three people who lived at the home. We found two of the three care plans were sufficiently detailed about people's support needs and provided guidance for staff on how to meet people's needs. The two care plans had been reviewed on a monthly basis and we found corresponding care plans were in place for any risks identified to people's welfare or safety. So for example, if a person was deemed to be at risk of developing pressure sores then information about how to prevent these was detailed in their care plan. However, one of the care plans we looked at included minimal information about the person's needs and we found some of the information to be inaccurate. We found that the person concerned had been assessed as being at risk of becoming nutritionally compromised. Their care plan detailed that they required a 'normal diet'. However, when we asked questions about the person's dietary needs we found they had diabetes and also required a pureed diet and assistance to eat their meals. This meant that the information recorded in their care plan was inaccurate and did not reflect the person's needs. We also found the person was not being weighed as regularly as required as documented in their care plan. We queried the person's weight record due to a fluctuation in the person's weight. The manager told us the fluctuation was because the scales were 2 stone out and had since been calibrated. Some sections of the person's care plan were blank, other sections were not dated and it had not been reviewed as regularly as the other care plans we viewed. For example a moving and handing assessment had been dated 'September' but with no year. This was scheduled to be reviewed monthly. However, we found it had not been reviewed. This was also the case for a bed rails risk assessment and a pressure sore risk assessment. Other risk assessment documents on the person's file were blank.

Our findings demonstrated an inconsistency in the quality of care planning. There was no indication that this had been picked up by the manager or the provider as part of the quality assurance checks on the home. People who live at the home are at risk of not receiving the care and support they need if their care is not planned effectively. Failing to ensure care is planned effectively is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The service worked well with other agencies to make sure people received the care and support they needed. We saw in records that staff referred to a range of health care professionals for specialist advice and support to ensure people's needs were appropriately met. For example, people had been referred for nutritional advice and support if they started to experience weight loss. This indicated to us that the manager ensured there was a multi-disciplinary approach to meeting people's needs. People who lived at the home and relatives we spoke with told us staff responded quickly if their relative was unwell or needed to attend a health appointment.

We found there was no activities co-ordinator employed to work at the home. Activities available for people to join included: a weekly music session (provided by a visiting relative), a monthly activity session and an entertainer visited monthly. We also found that a small number of people were provided with one to one support once per week to support them in accessing the community. At the time of our inspection we saw that a craft activity session had taken place. The person who was brought into the home to carry out this activity told us they visited once per month. People who lived at the home, relatives and staff all told us they felt there were not enough activities at the home and we saw that this had been fed back to the provider through surveys completed by relatives.

Complaints were not appropriately managed. The provider had a complaints procedure which included timescales for responding to complaints. We viewed the complaints' log. We found that the subject of complaints was not clearly documented and we found little evidence to indicate that people's complaints had been investigated and responded to. The manager was not able to provide a clear explanation as to what action had been taken in response to complaints. We found that one of the complaints that had been logged was a safeguarding concern. We asked the manager to tell us what action had been taken in response to this. We found no action had been taken. One relative told us about a complaint that they had submitted in writing. We found no evidence that this had been logged, investigated or responded to. The relative had not received a response to their complaint. The manager told us they were not aware of the complaint having been made. Not having an effective system in place to handle and respond to complaints is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service well-led?

Our findings

The systems in place for assessing and monitoring the quality of the service and making improvements were ineffective. We found that a number of areas of practice were being audited, for example medicines management, infection control and maintenance of the environment and equipment. However, most other areas of practice such as care planning, the management of complaints, the management of safeguarding, the monitoring of staffing levels and staff supervision were not being assessed and monitored. We have reported on shortfalls in these areas under the other domains of safe, effective, caring and responsive. We asked to view quality assurance reports carried out by or on behalf of the provider. The manager showed us just one report which was dated November 2014. This was completed following a provider check on the service. The check was not a detailed check and the report gave no indication that the shortfalls we found had been identified by the provider. The provider was failing to identify, assess and manage risks relating to health and welfare of people who used the service. This is a breach of Regulation 10 health and Social Care Act 2008(Regulated Activities) 2010.

Before we concluded the inspection visit the provider told us they intended to secure the services of a consultant to carry out quality assurance checks. They advised us that this would commence as soon as possible.

The service was managed by a person registered with CQC as the 'registered manager'. The registered manager had worked at the home for 22 years. They told us they were also the nurse on duty for a large part of their working work and that this had an impact on the time they had to carry out their management responsibilities. The manager was described as 'approachable' and people who lived at the home told us they felt confident to discuss any concerns they had with the manager. A deputy manager had recently commenced working at the home. We received positive feedback from people who lived at the home, relatives and staff about their impact on the service to date.

'Resident and relative' meetings were not held on a regular basis. The last meeting was held in February 2013. Surveys had been given to people who lived at the home and relatives for their feedback about the service. The results of these had not been acted upon despite the fact that some of the feedback was negative and had identified some of the shortfalls we saw during the course of our inspection. Feedback from people who lived at the home in surveys was mostly positive but we saw some negative feedback from relatives with regards to staffing levels and a lack of activities. However, we found people's feedback had not been explored and there had been no action taken to make improvements to the service. The provider was not aware of the negative feedback in the surveys until we brought it to their attention. The provider had therefore failed to have regard for comments and views made on behalf of people who lived at the home. This is in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During the course of our inspection we found that the provider had failed to notify the Care Quality Commission about a number of safeguarding concerns. This is in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Prior to our inspection we had asked the provider to complete a Provider Information Return (PIR) containing information about the operation of the home. This had not been returned and the provider did not have a satisfactory explanation for this. This is a breach of Regulation 10(3) of

the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The registered person had not made suitable arrangements to ensure service users were safeguarded against the risk of abuse. Regulation 11(1)(a)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The registered person had not taken appropriate steps to ensure that there were sufficient numbers of persons working at the home to safeguard the welfare of people who lived at the home. Regulation 22.

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 had not made suitable arrangements to ensure staff were appropriately supported in their roles and responsibilities. Regulation 23 (1)(a).

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 had not taken proper steps to ensure that each person who used the service was protected against receiving care or treatment that is inappropriate through the effective planning of care. Regulation 9 (1) (b).

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints The registered person did not have an effective system in place for receiving and handled complaints and comments made by people who used the service or persons acting on their behalf. Regulation 19 (1) (2) (c)(d).

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 People who used the service were not protected from unsafe or inappropriate care as the registered person did not regularly assess and monitor the quality of services provided or have regard to the comments and views of people who used the service or those acting on their behalf. The registered person had failed to submit a report to the Commission outlining how the operation of systems designed to assess and monitor the quality of the service was being adhered to. Regulation 10(1)(a) 2 (b)(i) (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person had failed to notify the Commission of abuse or allegations of abuse towards people who used the service. Regulation 18 (1) (2) (e).