Barchester Healthcare Homes Limited

Latimer Court

Inspection report

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Ratings

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

Overall summary

The inspection took place on 23 and 24 November 2015 and was unannounced.

The home provides accommodation for a maximum of 80 people requiring nursing and personal care. The home is also registered to provide nursing care for people who require some additional support. There were 61 people living at the home when we visited. A registered manager was in post when we inspected the service but was not available. 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 and associated Regulations about how the service is run.

People at the home resided in one of four units. People's experience of care varied depending on where they lived within the home. People's experience was also affected by the level of care they required. People who were more independent , were more likely to receive a better experience of care. People requiring more support, were less likely to receive this.

Summary of findings

People did not always feel safe because there were insufficient staff to care for them. Of the staff that were available to them, many were agency staff who people felt did not always understand or know their needs.

People did not always receive their medication on time because the medication round took longer than necessary. Agency staff were unfamiliar with people's needs which caused the delay and people requiring gaps between medicines did not always receive these.

Staff were not supported. Staff described an absence of supervision meetings that would have enabled them to raise issues of concerns. Although the interim manager discussed issues they needed staff to be certain of, there was no evidence to demonstrate staff could participate in two way discussions.

People's consent was obtained by staff. People who could not make decisions for themselves were supported by staff within the requirements of the law. However, people and their families had not always been involved in the discussion making process.

People enjoyed the food and were able to choose from a menu. Although people received support to have their meals, this impacted on when people ate. Some people experienced delays in receiving their meals as they waited their turn for staff to support them with their meal.

People's health needs had not always been assessed regularly but the interim manager described a new system of working with the GP and clinical lead which would mean people's needs would be better understood by staff caring for them.

People liked the staff who cared for them, however people felt the inconsistency of care staff made it difficult for staff to understand their care needs. People's privacy and dignity was not respected and people were not involved or supported to make choices about their care

Staff we spoke with told us they raised concerns that were not responded to and a formal mechanism for allowing staff to raise issues or discuss concerns did not exist.

The registered provider had not made adequate provision to ensure that they monitored how the registered manager managed the home. Staff changes meant that regular checks of the home did not happen and concerns were only raised when an interim manager took over the day to day running of the service. Gaps in monitoring the continuity of people's care meant that people did not receive person centred care and people's needs were not fully understood by either the registered manager or the staff.

Systems in place to assess and monitor the quality of the service provided were not effective. We found multiple breaches of the regulations. The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This

will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of

inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe. People's access to staff was limited because there were not enough staff to respond to people's needs. People's health and risks to their health were not fully understood by staff and there was a reliance on agency staff. People did not receive their medicines as prescribed as staff were unfamiliar with their needs.

Inadequate

Is the service effective?
The service was not always effective. People were cared for by staff that were not supported and supervised regularly. People were not included in discussions about their care and were not always supported to make choices.

Requires improvement

Is the service caring?
The service was not caring. People were cared for by staff they liked. However, the large turnover in staff made it difficult for people to establish relationships with care staff. People were not always treated with dignity.

Inadequate

Is the service responsive?
The service was not always responsive. People were not involved in influencing their care and deciding how their care needs should be met. People did not receive support to participate in activities or to pursue their interests.

Requires improvement

Is the service well-led?
The service was not well led. People's care and the quality of care had not been reviewed and updated regularly. People's choices were not adequately sought and responded to ensure people received what they had anticipated. The registered provider did not have adequate systems to ensure people's care was consistently monitored.

Inadequate

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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 23 and 24 November 2015 and was unannounced. There were four inspectors and one specialist advisor who was a registered nurse.

We reviewed the information we held about the home and looked at the notifications they had sent us. Notifications are reports that the provider is required to send to us to inform us about incidents that took place at the service, such as an accident or a serious injury. The provider also completed 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 also spoke with the Local Authority and requested information about the service from the clinical commissioning group (CCG). They have responsibility for funding people who used the service and monitoring its quality.

As part of the inspection we spoke to six people living at the service. We also spoke with seven relatives, six staff, the interim manager and the regional manager. The registered manager was not available at the time of the inspection and had been absent from the home since September 2015. An Interim Manager from one of the Registered Provider's other location and was overseeing the service at the time of the inspection.

We observed care and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We reviewed five care records, the complaints folder, recruitment processes, minutes of meetings, internal audits of the service as well as questionnaire results.

Inadequate

Is the service safe?

Our findings

People told us there were not enough staff to care for them. One person said, "A few more staff and it would make all the difference in the world." Another person told us, "There are so few people to help us." One relative told us, "They're constantly short of staff."

We spoke to both the interim manager and the regional manager to understand how staffing levels were determined. They showed us how they calculated staffing levels based on people's individual needs. The interim manager told us staffing levels were already higher than the dependency tool suggested. However, what we saw and heard from people was in contrast to this.

We heard the call bell ring constantly and there were often long delays until which the bell was turned off. One person told us, "I only call when I have to…you have to wait. You have to wait a long time." One person told us they had used the call bell and when staff had failed to answer, they used their mobile phone to call the home and summon the help they needed. Other people we spoke with talked about having to wait their turn. One person we spoke with spoke of their frustration because they felt people with more pressing needs received a greater proportion of the care staff teams' time and so their needs were overlooked.

Staff we spoke with told us they were understaffed and they struggled to cope with the people they cared for. For example, one staff member told us, "If you're doing pads and the call bell rings – what do you do?" We discussed the dependency tool with staff. One staff member told us, "If the unit lead doesn't fill in the care plan, how can they tell how many staff we need?" We spoke to the interim manager about how people were admitted to the different units and whether people's needs had been fully reflected in staffing levels. The interim manager confirmed that all people "Were in the process of being re-assessed". This confirmed that people were not being cared for based on an accurate assessment of their current individual need and that corresponding staffing levels would therefore also be inaccurate.

People's access to support was varied. Whilst we saw that people enjoyed their food when they received it, we saw that people's experience was affected by their access to support. For example, in the Avalon Unit, 11 people required support to have their meals, but only two staff were available to support. This meant that some people waited a significant amount of time before they received their meal. One staff member we spoke with confirmed that meal times could be delayed for some people because there were a large number of people requiring support. We saw one person seated for 40 minutes before they received their meal. The person sat and waited watching whilst others received their meals and became increasingly anxious.

People's health and risks to their health were not consistently understood by staff caring for them. We observed a staff handover in order to understand how people's health concerns were cascaded to staff taking over from the next shift. The handover was carried out by two agency staff, one of whom who had worked at the service for the second time. Staff knowledge of people and their health conditions was vague. We asked people about the care staff that supported them, one person told us, "Sometimes I'm not confident. They've all had different training."

People's access to medicines was mixed. Although people told us they received support to take their medicines, it was not always at the time that had been prescribed for them. For example, we saw a morning medication round was not completed until 11:45 which meant that people requiring time specific medicine were not receiving their medicines on time. One person also told us that they required pain relief before they went to sleep at 10:00pm. They told us it was not unusual to receive this at 1:00am. The person's relative told us "Most of the time, she's not sure she's getting the right medicines. The nurses don't know the medicines, the people or where the medicines are kept." Staff told us there had been a reliance on agency staff for some time. The interim manager told us that staff competency for administering medicines had all been reviewed and updated based on a recent review.

The registered manager and provider did not ensure sufficient numbers of suitably qualified, competent, skilled staff were deployed. This was a breach of Regulation 18(1) HSCA 2008 (Regulated Activities) Regulations 2014.

Staff were able to describe their understanding of safeguarding and keeping people safe. Staff described to us training they had received on the subject and could also describe to us what it meant to safeguard people who used the service. A number of staff we spoke to during the inspection raised their concerns around staffing levels and

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Is the service safe?

their concerns for people's safety. We also noted from our records that some staff had also contacted the Care Quality Commission prior to the inspection to further raise their concerns around safe staffing levels.

We reviewed how staff were recruited. A number of staff had been recruited and vetted through a recruitment agency and staff told us they submitted the relevant paperwork to the agency to prove it was safe for them to work at the home. The provider had a system in place for ensuring all Disclosure and Barring Service (DBS) checks were made. This check is carried out as part of a legal requirement to ensure care staff were able to work with people and any potential risk of harm can be reduced. The registered provider was taking steps to recruit a number of new staff. Recent events had meant a number of staff had left. The registered provider's information returned to the Care Quality Commission also highlighted a high number of staff had left recently.

Requires improvement

Is the service effective?

Our findings

Staff told us they did not receive regular support and supervision. We asked staff about opportunities they had to have two way discussions and to raise their concerns. Staff we spoke to said many of the people in senior positions such as unit leaders had left and that supervisions had not been prioritised. An internal audit by the provider confirmed only one or two supervisions had taken place to support staff within the last 12 months. Although the interim manager showed us minutes of meetings that took place, many of the meeting minutes were to confirm staff had been informed of individual issues such as changes in the legal requirements around the Mental Capacity Act or where a staff member had been asked to discuss particular issue with the interim manager.

Staff we spoke with confirmed they had plenty of access to training and could ask for further training if they required it. For example, one staff member said, "Yes. We get plenty of training." The interim manager also confirmed that training had been prioritised and a number of permanent staff had all had their training updated. For example, we saw that all permanent staff had completed medication competency training as well as training to understand the Mental Capacity Act. When we spoke with staff, staff demonstrated their understanding of the Mental Capacity Act. Staff were able to describe to us the importance of obtaining someone's consent when caring for them. Staff told us they would speak to a senior member of staff if they were unsure of any aspect of care. Care staff were seen to offer people support but also respect their refusal of care if they did not want something. For example, one person was seen asleep on the sofa and staff respected they did not want to be moved.

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

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

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We reviewed how the registered and interim manager had ensured people's freedom was not restricted. We found that a number of DoLS applications had been submitted to the local authority on a retrospective basis by the interim manager, although none of these had been submitted by involving the person or the family in the decision making process. We also reviewed how the registered manager had made a decision about the person's capacity to make decision. Although we saw in people's care records some decisions had been made in a person's best interests, people, their relatives or advocates had not been involved in the decision making process. When we raised this with the interim manager, they agreed and confirmed this had already been prioritised for them to undertake.

People's wider health needs were now being overseen by a clinical lead for the home who would be supporting the local GP. The interim manager told us that some people's needs had not always being met and so a new system was being introduced following feedback from the GP to provide greater accuracy of information provided for the management of non-urgent GP calls. People we spoke with told us that they saw the GP regularly and people were also able to tell us about the hospital appointments they had been supported to attend. During our inspection we also saw that a Tissue Viability Nurse supported staff to care for people who required additional support.

People told us they liked the food. We saw that people were offered a variety of choices to select from. People told us that if they didn't like the food on offer, an alternative would be offered. One relative told us their family member liked soft fruit and that they were always given a selection to choose from. Staff preparing meals understood which people required special diets and which did not. We saw the chef help direct staff as to which people should receive which meals. We also saw people were offered a choice of

Requires improvement

Is the service effective?

drinks and where appropriate, people were offered thickeners if they were needed. People whose intake of fluids and food needed to be monitored also had these details recorded to ensure people received the correct diet.

Inadequate

Is the service caring?

Our findings

People's experience of how they were supported and cared for varied across the different units. Where staff had worked at the home for a long time, people spoke affectionately about them, but this was not consistent for everyone. One person told us, "It feels like the people in the other units get better care." People we saw with more acute or complex needs were less likely to have the care they needed because care staff were struggling to cope.

People who were more independent were more likely to have built a relationship with care staff and for staff to understand their needs. Within the Beaufort Unit, where people were more able to support themselves, we saw people laugh and chat with care staff. Staff knew people's names and we saw people completing jigsaws and craft activities to keep themselves occupied. People living in the Grosvenor Unit required greater support as many of the people were living with Dementia and some had difficulty communicating verbally. There were lots of examples that we saw throughout the day that showed staff did not always engage with people in a way which had a positive impact on them. Care staff were not able to spend any other time with people than the time needed to complete the task they were required to perform. For example, a number of staff were witnessed walking through the lounge and connecting dining hall without acknowledging people sitting there because they were busy completing the task they were focussed on. Care staff at times walked past without engaging with people or trying to initiate any conversation, especially as people were not occupied in any other activity. We saw people were left for long periods in the lounge without any staff support. During these times, people were unable to occupy themselves. During one period we saw a person lash out and hit another person and a staff member had to called by the inspection team to provide support. It was only at the insistence of the Inspection team that the incident was recorded and the interim manager notified.

We saw one example of a person who had reached a significant birthday milestone. During mid-afternoon we noticed that cards sent to them lay unopened in the nurse's office. Although one staff member gave the person a gift from the home, no other effort was made to recognise the person's birthday and share their experience.

We saw three people in the Grosvenor unit sitting in the lounge with no socks or footwear. One person had not received foot care. They had not had their toe nails cut and their feet were swollen and skin was dry. When we reviewed the complaints process, people's access to foot care had already been identified as an issue by another relative of a person within the home and so the interim manager would have been aware of issues with people's foot care. When we raised this with the interim manager agreed that this was not acceptable.

For another person, we saw that their dignity was compromised. They were sitting in the lounge in their underwear which could be clearly seen by other people. When we raised the issue that we were concerned for the person's dignity, a staff member later proceeded to get the person dressed in the lounge and not take the person somewhere discreet to get changed.

We spoke to people about their experiences of care at the service and how staff supported them. People told us that staff worked hard but staff did not always have time to fulfil everybody's needs. One person told us, "We wish we had a little more times to spend (with staff)". One person also described how they had called for staff to support them to use the bathroom. The person was being visited by a family member and by the time staff arrived the person had inadvertently become incontinent. A relative also described this incident to us as well as their family member's embarrassment.

Within the Avalon Unit, we observed staff rushing from one task to another and not able to spend time getting to know people or their needs. For example, we saw hot drinks being served by an agency staff member. A drink was served to a person without asking what they wanted. When the person was served a hot drink, the person had found the drink too hot to hold and the person struggled with the drink but the staff member had moved on to the next person. One relative of a person living within the Avalon Unit told us, "They just don't know the residents. They don't know their routines."

The registered manager and provider did not ensure people were treated with dignity and respect. This was a breach of Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2014.

People were supported to maintain relationships with people who were important to them. We saw relatives visit

Inadequate

Is the service caring?

their family members. Relatives told us that they were able to visit whenever they chose but were also kept informed of their relative's conditions via telephone if there were any changes. One relative told us, "I come in every day."

Requires improvement

Is the service responsive?

Our findings

People we spoke with told us they did not receive an opportunity to further their interests. One person told us they liked to go out, but they had only been out with family members since they moved to the home, over a year ago. We spoke with the activity co-ordinator about how people's interests were pursued. Although, the activity co-ordinator recognised people's interests, it was not possible for them to offer the individual support that some people required to be able to participate in activities. This was because the activities team had been reduced due to staff sickness. They told us they planned activities but relied on care staff to fulfil the activities with people. The activities co-ordinator described how some people required more individual support to engage them. For example, one person she described became involved with activities once they were able to relate the activity to their occupation, which they had enjoyed for a long period of their work life. However, it was not possible to offer the person the dedicated individual support they needed. People were seen lying on the sofas in the lounge, slumped in arm chairs or staring ahead with a vacant look. Other people chose to remain in their bedrooms. Although a planned singing session took place, we were not able to observe any other activity taking place during the inspection for people requiring support.

Relatives we spoke with told us their family member's did not receive the individual support they had anticipated to pursue interests. One person told us, "Most of the time I spend in my room. I find it really depressing. There aren't any films." One family member told us "They tend to just plonk them in front of the TV." The relative was not able to describe any interests their family member had been involved with since moving to the home. We observed people sitting around in the lounge bored, withdrawn and uninterested. Although the home had a home cinema system, a piano and a well-stocked activities room, these were not being used. We asked staff about whether they were able to support people in their interests, staff told there was not enough time. For example, one staff member told us, "There just isn't the time to do that sort of thing." When we raised this with the Interim Manager, they confirmed that due to staff sickness, activities had not taken place with regularity.

We spoke to people to understand whether their needs were being met. One person told us they liked to have a bath once a week but had not been able to do recently because staff were not available. They told us, "I do it at staff convenience." One person described to us the importance of maintaining their religious beliefs. However, they could not tell us about any occasions when they were supported to do so within the home. When we spoke to the interim manager they confirmed that people's individual needs had not always been recorded or were known to staff. We spoke to staff to understand what they knew about people's individual care and preferences. One staff member told us, "I have worked here for two years and I've never given anybody a bath."

When we spoke to some staff they could not tell us about people because they were agency staff and unfamiliar with people. For example, we saw care staff being unsure of people's names, what sort of meal they required and how people liked to be cared for.

The registered manager and provider did not ensure people received care and treatment that reflected their preferences. This was a breach of Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014.

People had completed a questionnaire between September and October 2014 which asked them a variety of questions about their care and their perceptions about their care. Nine people completed the questionnaire and were positive about their experience. However, people highlighted that they didn't think staff had enough time to spend with them as an area of dissatisfaction. When we spoke with people and asked the same question, people told us staff did not have enough time to spend with them. As the registered manager was not available, we could not verify what had been put in place to reassure people or to respond to their concerns.

We asked about other ways in which people's feelings about the service they received were understood. People we spoke with told us they were not always consulted about their care. We saw that residents' meeting had only very recently been reintroduced since the interim manager had taken over, but evidence for other meetings before this period could not be seen.

People told us they knew how to complain but they preferred to speak to staff about any issues that they thought they might be able to help with. For example, one

Requires improvement

Is the service responsive?

relative told us about how they had asked staff to be mindful of their family member's hair and that staff had supported their family member as requested. Another relative told us their complaints were "well documented."

Although the registered provider had a system for recording complaints, we were not able to review how the complaints were received, acknowledged or responded to. The interim manager told us complaints ought to have been logged onto an online system for the regional manager to review. However, these had not been completed adequately. We spoke to relatives and saw examples regarding issues they felt had not been responded to. For example, one relative had had a complaint upheld by the Health Ombudsman during the inspection period because their concerns had not been adequately responded to. Another relative told us they had been concerned about their family member's health and did not feel their concerns were listened to. When we asked the Interim Manager about the system for responding to complaints they acknowledged that complaints system had not always been followed although the system had been corrected now.

The registered manager and provider did not investigate and take the necessary action in response to complaints. This was a breach of Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

We reviewed the registered provider's governance structure and how the quality of care was monitored. We also noted that between approximately May 2015 and August 2015 the registered manager was not supported by a regional manager as the post had become vacant. During this period no review of the registered manager's performance took place to ensure that people received the quality of care expected by the registered provider. Additionally, the provider had taken no further checks to assure themselves of the quality of care being delivered. The registered manager at the home had also become absent from the home from September 2015 and a registered manager from one of the registered provider's other locations was covering the day to day running of the service in the interim. Systems established by the registered provider had not been followed and no effective mechanism was in place to raise concerns about safety or the quality of people's care at the home.

We were told that the provider had last conducted an audit of the home in September 2015 which identified a number of concerns. For example, inadequate levels and deployment of staff, competency of the staff administering medicines as well as how the home was being run had all been identified as of concern. However, the internal audit also identified that internal processes for monitoring people's care had not been followed and people's care had not been adequately monitored. For example, monthly checks by the registered manager were last completed in May 2015 which included people's skin condition and people's medication. The lack of performance reviewing of the registered manager meant this had not been flagged up to the registered provider. Although, people were not harmed, people were exposed to risk because they had not received the care they had expected.

We reviewed how complaints were being investigated and reported. Despite the systems the provider had in place, these had not been followed thoroughly and evidence to confirm complaints had been handled correctly could not be located. The interim manager had instigated a system whereby complaints would be investigated and a copy sent to the provider. However, the interim manager could not be certain that people were satisfied with the care they were receiving especially as no in depth satisfaction survey had been completed since September 2014.

Although care planning records had all recently been reviewed by the interim manager, people's records were not accurate and up to date as people's needs and wishes were not central to the care planning process. Many of the systems and processes to ensure the quality of care could be monitored had been re-established within the last few weeks. The interim manager could not therefore be certain that the systems were robust as these could not yet be tested. We also noted that although care plans had been updated to reflect risk assessments and people's histories, without the involvement of people in the care planning process, care records could not adequately reflect people's individual preferences.

Staff we spoke with described issues they raised that had not been taken further and that they had not had a chance to raise concerns formally through regular supervisions. Staff described repeatedly raising their concerns about staffing levels. One staff member we spoke to described their job as "Horrendous." Other staff described the environment where they felt under pressure constantly because of the pressures of staffing. For example, one staff member told us, "You can get agency nurses, but at the end of the day, some just want to do the meds and nothing else." Although staff were aware that new staff were about to join, the effects had not yet allayed the concerns of staff. Staff did not feel able to raise their concerns. When we asked about what prevented staff discussing issues, staff told us they didn't think it made a difference.

The registered manager and provider did not make regular checks of the service and had not ensured high quality care had been delivered. This was a breach of Regulation 17(2)(a) HSCA 2008 (Regulated Activities) Regulations 2014.

People we spoke to were familiar with the registered manager and knew who they were. For example, people were able to recall their name and described them. People did not always understand what was happening at the home in terms of recent management changes. For example, people knew that some staff have changed or had moved but were uncertain which staff would be covering their units.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The registered provider did have systems in place that ensured people received person centred care.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The registered provider did not ensure people were treated with dignity and respect.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **The registered provider did not ensure systems were in place to acknowledge, respond and investigate people's complaints.**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered provider did not make regular checks of the service.**

The enforcement action we took:
We issued a warning notice on 23 December 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered manager and provider did not ensure sufficient numbers of suitably qualified, competent, skilled staff were deployed.**

The enforcement action we took:
We issued a warning notice on 23 December 2015.