Holmdale House IOW Ltd

Holmdale House

Inspection report

Main Road, Havenstreet
Isle of Wight, PO33 4DP
Tel: 01983 882002

Date of inspection visit: 12 and 18 December 2014
Date of publication: 10/03/2015

Ratings

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

Overall summary

This inspection took place on 12 and 18 December 2014 and was unannounced. The service provides accommodation for up to 31 people, including people living with dementia. There were 30 people living at the service when we visited. This was the first inspection since the home was registered by the current provider in January 2014.

The home had a registered manager in place. 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.

People did not receive their medicines at the correct times or in a safe way placing them at risk. Records of medicines administration did not show people had received all their medicines as prescribed and when they needed them. There were not always appropriately trained staff available who could administer medication.

Guidance on the prevention and control of infections was not followed and the risks of cross infection were not managed effectively. Staff had not received infection control training and there were no plans for this to be undertaken.

Action was not taken when people had a fall or where they were noted to have bruising or injuries of unknown

Summary of findings

cause. Emergency and fire safety arrangements were inadequate. Staff had not undertaken fire awareness training and new staff were unsure what action they should take should the fire alarms sound.

Recruitment procedures were not safe as appropriate checks were not always completed before staff started work. There was insufficient staff with the necessary skills, knowledge and experience to meet people's needs. Staff had not completed other training necessary to enable them to provide safe, effective care.

People were satisfied with the care and support they received. People and relatives were positive about staff who they felt were kind and compassionate. They felt able to raise to raise concerns and complaints with the manager. However, concerns raised verbally were not recorded and patterns or trends could not be analysed to make improvements.

However we found not everyone had a care plan and others did not reflect people's current needs. People may not be receiving care in a consistent manner. Choice was available for meals and people felt they were of good quality but people's weights and nutritional intake were not monitored effectively.

The principles of the Mental Capacity Act 2005 were not being followed and Deprivation of Liberty Safeguards (DoLS) not implemented effectively.

People's privacy and dignity was not always respected and staff did not always ensure this whilst providing personal care.

Quality assurance systems were not effective. Audits had not been completed and incidents and accidents were not investigated to ensure learning was used to prevent further occurrences.

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

Inadequate

The service was not safe.

Staff had not received training in safeguarding adults and most were unaware how to report abuse outside the home. Emergency and fire safety arrangements were inadequate.

People did not receive their medicines at the correct times or when they required them.

Guidance on the prevention and control of infections was not followed and the risks of cross infection were not managed effectively. Staff had not received infection control training.

Appropriate recruitment procedures were not in place. There were insufficient staff with the necessary skills, knowledge and experience to meet people's needs.

Is the service effective?

Inadequate

The service was not effective

Care plans did not always reflect their current needs and how their health and personal care needs should be met.

Choice was available for meals and was of good quality. People's weights and nutritional intake were not monitored effectively to identify any changes in condition.

Staff were not receiving the induction training and supervision they required to give them the necessary skills to meet people's needs effectively.

The principles of the Mental Capacity Act 2005 were not being followed.

The design and decoration of the building did not meet the needs of people living with dementia.

Is the service caring?

Inadequate

The service was not caring.

Staff did not communicate effectively with people living with dementia. They had not undertaken training relating to communication and dementia awareness.

People's privacy and dignity were not always respected and staff did not always ensure this whilst providing personal care.

People and relatives were positive about staff who they felt were kind and compassionate.

Is the service responsive?

Inadequate

The service was not responsive.

Care and support was not planned or delivered in a way that met people's individual needs or responded to their changing needs.

Care plans and risk assessments were inadequate. People did not have their needs met.

Summary of findings

People and relatives felt able to raise concerns with the manager. However, patterns and trend were not be analysed to make improvements to the service.

Is the service well-led?

Inadequate

The service was not well led.

People had been asked for their views but the process was ineffective and improvements had not been made.

The provider did not have the necessary knowledge to monitor the quality of the service they were legally responsible for.

The staff team did not feel valued or listened too. They felt unable to raise issues as these would not be acted upon.

Quality assurance systems were ineffective. Audits had not been completed and incidents and accidents were not investigated to ensure learning was used to prevent further occurrences or make improvements.

Holmdale House

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 12 and 18 December 2014 and was unannounced. On the 12 December 2014 the inspection team consisted of an inspector and an expert by experience in dementia and care of older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second day of the inspection included a specialist advisor in the care of frail older people and in particular those living with dementia.

Before 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 used this information when planning and undertaking the inspection. We reviewed information we already held about the service including notifications. A notification is information about important events which the service is required to send us by law. Prior to the inspection we spoke with four health and social care professionals including district nurses and GP's who had regular contact with the home.

We spoke with nine people using the service and nine family members. We also spoke with the registered provider, the registered manager and ten staff members including care staff, housekeeping, kitchen and maintenance staff. We looked at records including care plans and associated records for nine people; staff training and supervision records; three staff recruitment files; records of accidents and incidents; policies and procedures; and quality assurance records. We observed care and support being delivered in communal areas including the lounge and the dining room over the lunch time period.

Inadequate

Is the service safe?

Our findings

Medicines were not managed safely. People prescribed regular medicines several times a day; the interval between each administration was not adequately spaced. Some people received paracetamol with a gap of two and a half hours between administrations instead of four to six hours. At night time the gap between administrations was too long. At night there was not always a member of staff available who could administer medicines as they had not been trained. People were at risk of receiving inadequate pain control and being left in pain for long periods. Some medicines which should not be given with food were given with meals. This reduced the effectiveness of the medicine.

Care plans did not contain guidance for staff as to when 'as required' medicines should be administered. No pain assessment tool was used to determine when 'as required' medicines should be given. One person's pain medicine could not be administered as it had not been recorded on their Medicines Administration Record (MAR). This left the person in unnecessary pain. People would not be able to receive pain relief or other 'as required' medicines when needed.

The systems used to manage stock levels of medicines were not effective, which meant not all medicines were available for people. Prior to the inspection the registered manager had notified us of an incident when there had been a delay in obtaining antibiotics for a person for over two weeks. Another person, who had been on a medication for many years, was placed at risk of sudden withdrawal when this ran out over a weekend.

There were no procedures or records in place to inform staff where and which prescribed topical creams should be applied. One person had been prescribed a topical pain relief cream. There was no record to show this had been applied since February 2014. The prescribed cream was not available in the person's bedroom and care staff were unaware of the need for this to be applied. The failure to ensure prescribed topical creams were correctly applied meant people did not receive effective treatment.

The above concerns were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Care and cleaning staff had not received infection control training. No infection control training was planned. People were therefore at risk that staff would not have the necessary knowledge and skills to prevent and control the risk of infection.

Providers are required to take account of the Department of Health's publication, 'Code of Practice on the prevention and control of infections'. This provides guidance about measures that need to be taken to reduce the risk of infection. Measures had not been taken in relation to the environment and staff practices and the provider was unable to demonstrate how they reduced the risks to people acquiring an infection.

The systems for managing soiled and used clothing and linens were inadequate to prevent the risk of cross contamination. There was no process in place to prevent clean items being contaminated by dirty items entering the laundry. Laundry was being taken through the dining room at one meal time. The sluice room doubled as a laundry room. The failure to have adequate systems in place to manage soiled laundry placed people at risk of infection.

The sluice/laundry room was being used to store boxes of Personal Protective Equipment (PPE) and clinical items such as stoma supplies. Liquid soap and paper hand towels were not available in areas such as bedrooms where people were receiving care.

Cleaning schedules were not available. There was no record of the cleaning of equipment. The care and cleaning staff were unsure whose responsibility it was to clean equipment. Although the home appeared clean the lack of systems and procedures was not ensuring all areas of the home were cleaned effectively.

The above concerns were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider did not respond appropriately to incidents of potential abuse. The provider had failed to take action in a timely way to ensure the safety of a person who had made a safeguarding report. No action was taken in respect of safeguarding the person or appropriate referral made to the local authority. The provider did not follow their own safeguarding procedures.

Staff had not received safeguarding training. Staff would report concerns to the manager however, they were unsure

Inadequate

Is the service safe?

what action they would take if the manager failed to act on the concerns they raised. Staff may not recognise some forms of abuse or take action if abuse occurs, placing people at risk.

Action was not being taken when people had a fall or where they were noted to have bruising or injuries of unknown cause. There was no procedure to follow up or monitor incidents to reduce the risk of subsequent events. Medical advice had not been sought when a person suffered a head injury. A first aid trained member of staff was not available on every shift.

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

Fire safety arrangements were not adequate. Staff had not undertaken fire awareness training and new staff were unsure what action to take should the fire alarms sound. No fire drills had been undertaken. The fire risk assessment was undated and there was no evidence that this was being kept under review.

Care plans contained personal evacuation plans however: these had not been updated when people's needs had changed and other care plans did not have evacuation plans. In an emergency staff did not have had sufficient knowledge as to what to do which could place people at risk.

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

Recruitment procedures were not safe as appropriate checks were not always completed before staff were employed. There was no evidence to confirm staff members identify or other information required in Schedule 3 of the Health and Social Care Act 2008 had been applied for or obtained. References for one staff member had been received after they started work and their DBS check was received two months after they had commenced work. There was insufficient evidence that at least three of the staff were suitable to work with older people. The provider was not operating an effective recruitment process to ensure staff employed were fit to carry out their roles and did not pose a risk to people.

This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There was insufficient staff to meet the needs of the 30 people at the home. The staffing numbers had remained the same since the provider had purchased the home in January 2014. They were no formal assessment tools to determine the number of staff required. Staff and external health professionals felt the level of people's needs had increased. Observations showed long periods of time when staff were not present in the communal areas and people's needs were not being met. People were not receiving the help they needed and when they required it, placing them at risk of increased falls.

During lunch there were insufficient staff to support people with their meals. We saw one staff member assisting three people at the same time to eat. They also had to interrupt this to support another person who was unsafe and moving across the dining room unaided. The lack of sufficient staff meant people received very little interaction and did not have their needs met in a timely way.

Staff felt there were insufficient staff to meet people's needs effectively especially at night. Some people required two staff for care. As there were only two staff on duty, there were long periods of time when they were not able to monitor other people in communal rooms.

Arrangements to cover staff absence were not robust and did not always ensure staff were replaced at short notice.

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

Inadequate

Is the service effective?

Our findings

People did not receive effective care. We observed instances when staff failed to provide appropriate care with moving and handling placing the person at risk. Senior care staff were nearby but neither intervened to ensure the person received effective support. We heard the provider talking to a person in their office. The person was not able to articulate their concerns/anxieties and the conversation was ineffective in ensuring the person received the support they required. We observed other instances when staff failed to effectively communicate with people meaning their needs were not identified and met.

Healthcare advice was not always sought when required. Care records did not always show when medical advice had been sought or what the advice or guidance from medical practitioners had been. This meant medical advice could not be carried out.

The above issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw profiling beds and airflow mattresses in use; however staff were unsure about the care and maintenance of these. One person had an airflow mattress but was sat in a chair with no pressure relief cushion. Staff said "one has not been asked for, they are provided by the (district) nurses". Daily records noted the person had a sore area on their sacrum but no action had been taken to obtain the necessary pressure relieving cushion. The lack of correct equipment or knowledge as to how to use some equipment places people at risk that equipment will not be used effectively.

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

Care plans did not provide sufficient information about people's nutritional needs. The care plan for one person who was receiving a pureed diet and thickened fluids did not contain any information about their nutritional needs or how thick drinks should be. Staff were unsure, and gave us conflicting information. Other care plans also lacked information about people's nutritional needs and how these should be met. There were no malnutrition risk assessments (MUST). Care plans did not specify the support people required with food or drinks or information about preferences but directed staff to "offer food and fluid [the person] enjoys". We could not be sure people always received appropriate meals, prepared in a consistent way, with appropriate support.

People's weights were not monitored effectively. Records for one person stated they had not been eating properly for at least six weeks prior to our inspection. There was no food and fluid chart and the person had been intermittently vomiting. There was no record that their weight was being monitored. Another person was identified as having a low body mass index (BMI) in September 2014. However, their weight or BMI had not been recorded since. With the exception of one person, we were unable to identify weight records for the other eight people whose care plans we viewed. Systems were not in place to protect people against the risk of inadequate nutrition and weight loss.

The above issues were a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People and relatives were positive about the meals provided. One person and their relative said "there is always fresh fruit, vegetables and cake, they make great birthday cakes and celebrate birthdays". Another visitor said "I am happy with the home, the food is excellent although hot lunches are served on a cold plate". One person told us "the food is reasonable and there is some choice". We saw the chef had a positive relationship with people in the dining room and that they were able to provide variations to the main menu as requested by people. Where people were able to express an opinion, choices were available.

Seven staff had been trained in the Mental Capacity Act 2005 (MCA). Other staff had not received this training and there were no plans for this training to be provided. Care records showed that MCA principles were not followed and people were not supported to make decisions and their legal rights were not being upheld. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. No-one living at the home was subject to DoLS. However, following the inspection, the local authority safeguarding team visited the home and identified DoLs referrals were required for several people. People maybe unlawfully deprived of their liberty.

Inadequate

Is the service effective?

One person was being restrained without the proper assessments being conducted. We observed them sat in a chair with a table pulled close to them. Staff stated that it helps [the person] not to fall out of their chair or try to get up. They claimed it kept the person safe and prevented them from falling out of their chair. The person's care plan did not contain any risk assessment or a DoLS consent for them to be restrained in this way.

The above issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The above issues were a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

The home is an old building and it was difficult for people to move around safely. Some bedrooms were unsuitable for the person using the room as they had difficulty getting moving and handling equipment into some bedrooms. The home had a main passenger lift. People then had to transfer to stair lifts to reach bedrooms. In one person's daily notes we saw they had fallen whilst being transferred onto a chair lift. The failure to consider fully the needs of people and how the environment may be a risk to them has placed people at risk of injury.

The majority of people living at Holmdale House had dementia. However, the provider and staff were not aware of guidance about creating environments that were dementia-friendly. Consequently, the design and decoration of the building did not meet the needs of people with dementia. The lack of adequate lighting reduced people's desire to move around the home and placed others at risk of falls when they did move about independently.

The above issues were a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff were not receiving the induction and training they required to give them the necessary skills to meet people's needs safely. The registered manager was unable to provide evidence detailing what training each staff member had undertaken and when updates may be due or a training programme detailing what training was planned. There had been no training needs analysis completed to determine what training was required for each staff member. The registered manager had completed a 'train the trainer' course for moving and handling and safeguarding and had provided moving and handling training for eight staff. External professionals had provided end of life care training to three staff and mental capacity awareness to nine staff. Otherwise no training had been provided.

None of the three new staff whose records we viewed had a qualification in care and they had not completed a formal induction. There were no records of tasks undertaken during the shadow shifts or that they had been deemed competent to provide care. Night staff told us they had not undertaken medication, glucose monitoring or stoma care training and therefore could not meet these care needs. The lack of training meant people were placed at risk and could not have their health and personal care needs met at all times.

There was no supervision plan and staff were not receiving regular supervision. The manager had supervised a small number of staff when there had been concerns raised. We were told staff meetings had occurred however the minutes were not available. The Provider Information Return (PIR) stated that staff received regular supervision and training in infection control which was not the case.

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

Inadequate

Is the service caring?

Our findings

Care staff were kind and caring towards people. Staff explained to people what they were doing before providing care or support. At lunch time staff were busy but still responded in a calm and caring way when a person needed assistance. People were positive about the care staff. One person spoke of a "good attitude of people all around". Another person said "everyone is so friendly". They added "everyone is so nice and come to your aid". One person told us "most of the girls (care staff) are alright; sometimes we get spoken to like little children". However, observed staff not allowing people the time they needed to communicate and at times people were being ignored who were showing signs of anxiety and pain.

Care plans contained inadequate information about people's preferences and individual wishes as to how they would like to be supported. Some contained information about people's life histories but most did not have this information. Staff did not know or understand what may be important to individual people who may not have been able to express this. People may not have been receiving care and treatment in the way they wished to receive it.

Staff lacked the communication skills to support people to make decisions and did not have equipment, such as visual aids, to assist people. Staff told us they had not undertaken any communication training related to the needs of people living with dementia. They did not have the skills to communicate effectively with people living in the home.

People's privacy and dignity was not always being maintained. Doors were being left open when people were being supported or when they were receiving personal care. Some care records and the handover report were written in an inappropriate and disrespectful way. Words such as "grumpy" were being used when referring to people's mood. People's privacy and dignity was not being respected.

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

Inadequate

Is the service responsive?

Our findings

Care and support was not planned or delivered in a way that met people's individual needs or responded to their changing needs. Not everyone had a care plan. Over a week after a person had moved into the home there was not a care plan in place. The manager had completed an assessment of the person's needs before they moved in but this did not detail all their care needs. There were no further information or risk assessments as to how the person should be cared for. Care staff were unaware of key information that they should have known in order to provide care for the person. Within the daily notes we saw that care staff had identified new concerns indicating pressure damage. There was no evidence that assessments had been completed and action was being taken to reduce the risk of further skin damage. The person was not receiving care which met their needs and they were at continuing risk of further health deterioration.

Where people had care plans these were no longer representative of people's needs as they had not been updated when needs had changed. None of the care plans seen were representative of the care people were now receiving. Some stated they had been reviewed however; they had not been updated with the current information. One person had returned from hospital and the discharge information stated the person should be on bed rest. The care plan had not been updated and a daily record for the following day recorded the person was sat in a chair. Systems were not in place to monitor people for changing needs. Staff were unaware one person's bowel chart recorded they had not had their bowels open for ten days. No action had been taken and the person had not received the medical care required placing them at increased risk.

Care plans and risk assessments were inadequate to direct and inform staff as to how people should be cared for and did not have their needs met. Where people had infections, such as urinary tract infections (UTI) care plans did not contain risk assessments or guidance as to how the risk of repeat infections should be managed or prevented. We found people were experiencing repeated UTIs.

Daily records and body maps identified bruises and marks on people. However, there was no evidence that these were then followed up and changes made to the way the person was cared for. For example, in one file we saw that it was noted "sacrum broken down and very sore and red". There were no further action noted and no reference to this in the person's notes. A body map showed a person had sustained a large bruise on their hip, right ankle and left ankle. The map did not show measurements. The bruises were recorded as unexplained injuries. There was no investigation and no review of how the person should be supported. Similar concerns were found in other care plans viewed. The failure to investigate unexplained injuries means no action was being taken to reduce the risk of future harm.

People were not receiving adequate mental or physical stimulation. The activities recorded were group activities such as "watching the music man". On the two days of the inspection there was one organised activity. Otherwise entertainment was either the television in the lounge or music in the dining room. Some people were taken to a nearby garden centre recently and one person said "we had a lovely ride out to (name of garden centre)". Musicians visited weekly and in the summer people were supported to sit out in the garden. However, people living with dementia require regular varied activities which aid stimulation. Activities did not take account of people's past experiences or interests because these had not been obtained as part of the admissions process. The type and level of activities provided insufficient stimulation for people living with dementia.

The above issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People and relatives felt able to raise concerns or complaints with the registered manager. One said "the manager is very approachable about any complaints as are the staff". Another said "I sort out any issues with the staff. Sometimes my relative has the wrong slippers, I know because I buy a particular make". People who were paying privately for care received information within their contracts as to how to complain. People who were funded by the local social services were not provided with this information although it was available on the wall in the entrance hall. The registered manager had not received any formal written complaints. They did not record concerns which were raised verbally as complaints. There was no record of these or the action which had been taken to address the concern. Patterns or trends in concerns or complaints could not be analysed and action taken to improve the lives of all people living in the home.

Inadequate

Is the service responsive?

The above issues were 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 provider for Holmdale House is registered as a limited company and registered with the Care Quality Commission (CQC) in January 2014. The nominated individual (NI) was at the home most days overseeing the running of the service along with the registered manager. Due to the changes made by the provider the services statement of purpose had not been updated and people did not have up to date information about the service and how this should be provided.

Since registration the NI, registered manager and the majority of the staff did not have the knowledge, skills and training to care for people living in the home. The NI had not completed any training and was therefore not able to understand or assess the quality of the care provided. The registered manager and NI did not have clearly defined roles and responsibilities. Staff gave examples when the NI had changed decisions made by the manager. This was resulting in confusion of who was responsible for what within the service. There was a failure to develop and train the staff team to display the correct values and behaviours such as in the way they referred to people.

The staff team did not feel valued or listened too when they raised issues with the NI. Staff had raised issues about the staffing levels and about the type of cleaning products provided. However, neither issue had been addressed so staff felt there was little point raising issues. Staff were not clear about their roles and responsibilities such as with cleaning equipment resulting in some tasks not being completed.

When concerns were identified, such as with medication or care plans, individuals took no responsibility for rectifying the issues and blamed each other. External professionals such as district nurses, care managers, pharmacists and GP's were also blamed for some areas of concern. The culture of blame meant nobody was taking responsibility for the areas of concern and no action was being taken to address these.

There was a lack of systems for monitoring the quality of service provided. The NI had not picked up the concerns identified during the inspection. There was a lack of audits and reviews with no learning from events or evidence that improvements were being made. There was no record or analysis of accidents or incidents and no action was being identified and taken to reduce incidents and harm to people.

Surveys or questionnaires had not been used to seek the views of people, relatives or external professionals. Resident meetings had been held and the minutes of the meeting held in July 2014 were viewed. These showed people had been provided with information about the service and activities and menus had been discussed. However, it did not demonstrate that people could raise concerns or issues or that these had been addressed.

The above issues were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There was inadequate record keeping relating to all aspects of the service including care panning, the care people had received and records relating to staffing and the management of the service. Records were not well maintained. The care staff office was disorganised and records were not stored in a way which meant they were readily accessible when required. Although the office was secure personal information, such as prescriptions, was left on desktops or on notice boards.

The above issues were a breach of Regulation 20 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 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The registered person has not protected service users against the risks of inappropriate or unsafe care and treatments by means of the effective operation of systems designed to regularly asses and monitor the quality of services provided. Regulation 10(1)(a)&(b) and 10(2)(b)(i)(iii)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **The registered person has not ensured service users and others are protected against the identifiable risks of infection.Regulation 12(1), 12(2)(a)&(b) and 12(2)(c).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **The registered person has not ensured that service users receive adequate nutrition and hydration which meets their individual needs or that they have the necessary support with meals and drinks. Regulation 14(1)(a)&(c).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises

This section is primarily information for the provider

Action we have told the provider to take

	The registered person has not protected people against the risks associated with the environment or ensured that the environment meets their needs. Regulation 15(1)(a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment The registered person has not protected people from the unsafe use of equipment or ensured that staff are aware of how to use and maintain equipment. Regulation 16(1)(b) and 16(2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services The registered person has not ensured the dignity of service users. Regulation 17(1)(a)&(b) and 17(2)(a),(b)&(c)(ii).

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 does not have suitable arrangements in place for obtaining and acting in accordance with the consent of service users. People's legal rights have not been upheld. Regulation 18.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	The registered person does not have an effective system for identifying, receiving, handling and responding to complaints and comments made by service users or persons acting on their behalf. Regulation 19(1) and 19(2)(a)&(c).
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The registered person has not ensured proper information and records were maintained. Regulation 20(1)(a)&(b).
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The registered person has not ensured effective safe recruitment procedures are followed. Information as specified in Schedule 3 was not held for all staff. Regulation 21(a)(i),(ii)&(iii) and 21(b).
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The registered person has not ensured that at all times there are sufficient numbers of suitably qualified, skilled and experienced persons employed. Regulation 22.
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person has not put suitable arrangements in place to ensure staff receive appropriate training and supervision. Regulation 23(1)(a).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person had not taken proper steps to ensure service users were protected against the risks of receiving care and treatment that is inappropriate or unsafe by means of the planning and delivery of care to meet service users' individual needs. Procedures were not in place for dealing with emergencies which the provider could reasonably expect to arise. Regulation 9(1)(a), 9(1)(b)(i),(ii)&(iii) and 9(2).

The enforcement action we took:
We issued a warning notice which the provider must comply with by 26 January 2015.

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 has failed to make suitable arrangements to ensure service users are safeguarded against the risks of abuse. Regulation 11(1)(a)&(b).

The enforcement action we took:
We issued a warning notice which the provider must comply with by 26 January 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person had not protected service against the risks associated with unsafe management of medicines. Regulation 13.

The enforcement action we took:
We issued a warning notice which the provider must comply with by 26 January 2015.