P & C Care Limited

Ivy House

Inspection report

6 Hollingwood Close
Moorhead Lane
Shipley
BD18 4LG
Tel:01274 591476
Website:

Date of inspection visit: 5 November 2014
Date of publication: 11/02/2015

Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
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

We inspected Ivy House Nursing Home on 5 November 2014 and the visit was unannounced.

Our last inspection took place on 23 April 2014. At that time, we found breaches of legal requirements relating to privacy and dignity, care and welfare, safeguarding, staffing and the statement of purpose. We asked the provider to make improvements and they sent us an action plan telling us they would be fully compliant in all areas by 1 October 2014. On this visit we found insufficient improvements had been made.

Ivy House Nursing Home is a 40-bed service and is registered to provide accommodation and personal care for older people, younger adults, and people living with dementia or mental health conditions. Nursing care is provided. At the time of our visit there were 23 people using the service. The number of people using the service had reduced as following our last inspection placements were stopped by the organisations who commission and pay for the service.

The accommodation for people is arranged over two floors. There are single and double bedrooms and some

Summary of findings

rooms have en-suite toilet facilities. There are communal bathrooms and toilets throughout the home. The communal rooms are on the ground floor and there is a separate dining room.

The home has a registered manager who is also one of the owners. 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.

We found the service was not well led. The registered manager did not have a good understanding of governance and the quality systems that were in place were not effective. There were no 'lessons learnt' from accidents, incidents and complaints to demonstrate what action had been taken to try and prevent them from reoccurring.

We found people's safety was being compromised. Procedures to keep people safe were not being followed. We were concerned about fire procedures in the home and following our visit we asked the fire officer to visit.

The home smelt strongly of stale urine and faeces and some areas of the home were poorly maintained.

There were not always enough staff on duty to make sure people received the care and support they needed. Not all of the staff had received the training they needed and staff were not always following people's care plans.

We found the service was meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS).

People were receiving the healthcare they needed from a range of health care professionals, who told us they felt the staff were providing good care and support. This information contradicted our findings on the day of the visit.

We found there were people who had lost weight and staff were not monitoring their weights to see if the food supplements they were being given were effective.

We saw staff were patient and respectful in their direct dealings with people, however, not everyone was being supported to live their life in a dignified way.

We found on-going 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 the 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 did not always follow safeguarding procedures and there were incidents that should have been reported to the local safeguarding authority that had not been.

There were not always enough staff on duty to make sure people received the support they needed.

The home smelt strongly of faeces and stale urine and there were areas of the home that were not well maintained and were posing risks to people who lived there.

Is the service effective?

Requires Improvement

The service was not effective.

Not all of the staff had received all of the training they needed to care for people effectively.

We found the service was meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS).

People's health care needs were being met by a number of health care professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always being supported to lead their life with dignity.

We saw people looked relaxed in the company of staff and responded to them in a positive way. Staff in their direct dealings with people showed respect and patience.

Is the service responsive?

Inadequate

The service was not responsive.

Action had not always been taken to reduce individual risks to people using the service, which had resulted in injuries.

We saw people had lost weight and staff were not checking their weights frequently enough to establish if the additional food supplements they were receiving were effective.

Care plans were not always up to date and care workers were not always following these plans.

Summary of findings

Some activities were on offer, but there were times when people were unsupervised and unoccupied.

There was a complaints procedure in place but no evidence that there were 'lessons learnt' from these.

Is the service well-led?

Inadequate 

The service is not well led.

The manager lacked understanding about governance and quality systems.

Although there were some systems in place to look at the quality of the service these were ineffective and had not identified many of the areas for improvement that were identified during our visit.

Ivy 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 checked 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 5 November 2014 and was unannounced.

The inspection team consisted of one inspector, a bank inspector an inspector manager, a specialist advisor in quality assurance and governance and an expert by experience in nursing care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the home. This included information from the provider and speaking with the local authority contracts and safeguarding teams. Before the inspection, the provider 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.

On the day of our inspection we spoke with eight people who lived at Ivy House Nursing Home, one relative who was visiting the home, seven members of staff, the registered manager, service manager, a general practitioner, a community psychiatric nurse and psychiatrist. Prior to the inspection we spoke with another psychiatrist.

We spent time observing care in the lounge and dining room and used the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not express their views to us. We looked around some areas of the building including bedrooms, bathrooms and communal areas. We also spent time looking at records, which included five people's care records, four staff recruitment records and records relating to the management of the service.

Is the service safe?

Our findings

When we visited in April 2014 we were concerned people using the service were not always being protected from the risk of abuse and asked the provider to make improvements. In the action plan the provider sent to us told us they would be compliant with the regulation by 1 August 2014.

We asked one person if they felt safe and they told us, "Not all the time, some of them might hit and I have to watch out." We spoke with two senior members of staff who demonstrated a thorough understanding of safeguarding and could competently describe the circumstances when they would take action and what that action would be. However, we found there had been nine incidents between people that had not been reported to the safeguarding team or ourselves. If safeguarding referrals were not being made this meant external agencies were unable to consider the issues raised in order to decide if a plan to keep people safe was required. Following our visit we made eight individual safeguarding referrals to the Local Authority.

This breached Regulation 11of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at the recruitment records for four staff members. We found that recruitment practices were safe and relevant checks had been completed before staff worked unsupervised. We spoke with a new member of staff who confirmed a Disclosure and Barring Service check and references had been completed before they started work. This meant people who used the service were protected from individuals who had been identified as unsuitable to work with vulnerable adults.

When we arrived at 7:00am the night nurse did not know the digital codes to the two front doors so they let us in through the back door. This meant in an emergency they would not have been able to open the front doors to let ambulance personnel into the building.

We asked the night nurse how many people were using the service and they told us there were 20. A night care assistant told us there were 22, when there were in fact 23 people using the service. We asked the night care assistant what they would do in the event of a fire and they were unable to give us an account of the evacuation procedures. This meant in the event of an emergency arising there was no assurance staff would take the correct action.

This breached Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Most medication was administered via a monitored dosage system supplied directly from a pharmacy. This meant that the medicines for each person for each time of day had been dispensed by the pharmacist into individual trays in separate compartments. The staff maintained records for medication which was not taken and the reasons why, for example, if the person had refused to take it, or had dropped it on the floor. A record was kept to show medicines which had been destroyed.

When medicines were dispensed in individual boxes the total number of tablets received was recorded on the medication administration record (MAR) sheets. On two occasions we found that medicines administered from individual boxes had not been signed for on the MAR sheet. Checking of remaining quantities suggested that the medicine had been given but not recorded.

Inspection of the medicine fridge revealed eye drops which were out of date. The nurse immediately took the preparation out of use.

We looked around the building and saw some redecoration and refurbishment had taken place and some of the bedroom accommodation had been improved since our last visit.

Upstairs windows all had opening restrictors in place to comply with the Health and Safety Executive guidance in relation to falls from windows. However, we found some of the restrictors to be defective allowing windows to fully open.

We saw the carpet on the first floor landing was poorly fitted and showed signs of wear which posed a trip hazard. We were told that carpets were included within a refurbishment programme which would be actioned within the next few weeks following our visit.

We also saw a number of fire doors which were not closing securely into the door frames. This meant the effectiveness of these doors to hold back smoke in the event of a fire had been reduced. We raised our concerns in relation to fire safety with the West Yorkshire Fire Service.

Is the service safe?

The concerns we raised in relation to the property breached Regulation 15 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

When we visited in April 2014 we were concerned there were not always enough staff on duty and asked the provider to make improvements. In the action plan they sent to us told us they would be compliant with the regulation by 1 October 2014.

We spoke with two care workers about the staffing levels at the home. They told us they felt there were enough staff on duty to meet people's needs. They also told us there were bank staff available to cover if someone called in sick. However, one person said, "We are all working extra all the time. It's like you don't have a life of your own" and, "It's hard when there aren't enough staff on." Another member of staff told us they worked an additional day each week to cover the rota.

We looked at the duty rotas for a two week period and saw staffing levels were not being maintained consistently. For example, the numbers of care workers on duty in the mornings ranged from four to seven.

We spent time observing the communal areas of the home and saw there were not always staff available to offer people support. For example, in one person's care plan we saw they were supposed to have 1:1 observations by staff when they were awake. One of the senior care staff explained this meant within 'eyesight' of staff. We saw this person sitting in the lounge with other people who lived at the home and no staff were present.

We spoke with the domestic staff on duty who told us of unfilled vacancies which were having an impact on their ability to carry out all cleaning and domestic duties. They told us their substantive job entailed the weekly checking of mattresses but this task was largely not undertaken at the time of our visit. We spoke with the management team who acknowledged the shortage of cleaning staff but said recruitment was underway. They said that in the meantime mattress checking would be given a high priority.

This breached Regulation 22 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Prior to our visit we had received feedback from a visiting professional that the home smelt of stale urine. On arrival at the service each one of the inspection team commented on the smell of faeces and urine that was prevalent throughout the ground floor. This meant there were no effective systems in place to ensure odours were kept to a minimum.

We found that some areas of the home were in need of repair or refurbishment which meant that cleaning those areas was difficult. We found areas of engrained dirt on some painted surfaces but noted that these areas were to be repainted thus improving the ability to maintain a clean and hygienic environment.

This breached Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw the provider had instituted a recognised system of colour coding cleaning cloths, mops and buckets. We observed areas of the home being cleaned with the correct cloths. We spoke with the cleaner who demonstrated a thorough understanding of the need to maintain separation of cleaning equipment. We saw that all cleaning materials and chemicals were safely stored in a locked room.

We observed staff regularly washing hands after participating in direct care. We saw signage adjacent to hand-wash basins reminding staff to wash their hands. All soap dispensers were found to be in use and disinfectant gel dispensers were placed around the home. Bins for the use of disposing of paper towels were foot operated and paper towel dispensers were full.

Is the service effective?

Our findings

There was no information on display about what meals were on offer on the day of our visit. Staff told us they had photographs of various meals to help people to make an informed choice about what meal they would like. However, we did not see these being used.

When we arrived at the home at 7:00am there were six people up sitting or walking around in the lounge areas. No one had a drink. We saw the night care staff give two people a drink and biscuits but the others had to wait until breakfast. They did not get a drink until 8:30am.

At breakfast we saw the tables were set with cloths, cutlery, serviettes, cups and saucers, plastic glasses and condiments. We saw people who were in the dining room were offered a choice of cereals and cooked breakfast. Meals were well presented and we saw people enjoying the food. The meal time was relaxed and staff offered assistance when people needed it.

When we looked in people's care plans we found very little information about people's preferences in relation to food and drink. We did find information about people who needed special diets, for example, soft and diabetic diets. When we spoke with the chef and kitchen assistant we found they had a good knowledge of people's preferences and of special diets that were required.

We talked to staff about training and found their experiences were varied. For example, two senior staff with whom we spoke had received training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). When we asked four other care workers they told us they had not. One of the care workers told us they spent most of their time giving care to one person who required six hour periods of one-to-one care. When asked if they knew of people at the home who were subject to a deprivation of their liberties they said they had no knowledge of anyone, yet the person they spent a considerable amount of time caring for was subject to DoLS. The manager confirmed that whilst the care worker had more wider-ranging duties they did spend some part of each day delivering one-to-one care to someone subject to DoLS. As such the provider was not ensuring that staff had the necessary knowledge to care for vulnerable people whose care was influenced by a legal framework imposed through a DoLS authorisation.

On the provider information return we were told all of the staff had completed training in relation to dignity and respect. However, one care worker told us they had not completed any training about dignity in care. When we spoke with one of the night care workers we asked them about the fire procedures in the home. They told us they were shown the fire procedures when they attended the service for an interview but had not done any training since. This member of staff did not have a clear idea about what they should do in the event of a fire. We looked at this person's training records and saw they had completed nine different courses on the same day on 'e-learning.' There was no evidence the computer based learning had been followed up to assess their understanding of the training they had completed.

The provider information return showed only eight members of staff had completed training in dementia care. When we looked at the training records we saw only seven members of staff had received training in relation to managing challenging behaviour and only one person had completed training regarding nutrition and diet.

We looked at the training records and saw not all of the staff had received safeguarding training. We spoke to two care workers who showed some understanding of how to keep people safe but did not know about the West Yorkshire multi-agency safeguarding procedures.

Two senior staff with whom we spoke had received training in the MCA and DoLS. They were able to give examples of instances when Best Interest Decisions had been made with the involvement of relevant professionals. When we looked at the training records these only evidenced one person, who was a non-carer, had completed DoLS training. This meant the training records were not up to date and indicated the vast majority of staff had received no training in this area.

This breached Regulation 23 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We were told that 5 people using the service were subject to authorised deprivation of liberty and a further application had recently been made.

Is the service effective?

Our scrutiny of people's care records demonstrated that all relevant information was clearly filed. The care planning system also prompted when authorised DoLS were to be reviewed.

Care plans evidenced information regarding people's capacity to make decisions. This ensured that people were protected against the risk of excessive and unlawful control or restraint. We saw that all people at the home had been assessed as to their capacity to make decisions.

We saw from people's care files they had been supported to access other services, such as speech and language therapy and dieticians when they required them. Records we saw confirmed that care and treatment prescribed by other providers had been included in the individual's plan of care.

We spoke with two psychiatrists, a community psychiatric nurse and a GP. They all told us staff at the home worked well with them and followed any instructions they were given. One health professional said, "The staff are available and approachable and I am pleased with the care at Ivy House."

Is the service caring?

Our findings

When we visited in April 2014 we were concerned people's dignity was not being maintained and asked the provider to make improvements. In the action plan the provider sent to us told us they would be compliant with the regulation by 1 August 2014. During this visit we found staff were not supporting people to live a dignified life.

When we arrived two people were sitting in the small lounge area next to the dining room. The TV was on, with no sound, showing a shopping channel. It was 45 minutes before care staff changed the channel and turned the volume on. There was also no light on in this room.

When one care worker came on duty they walked through the conservatory and small lounge and did not speak to anyone. This showed a lack of respect to those people who see Ivy House as their home.

The bathroom on the ground floor did not have a lock. This meant anyone using this room was at risk of someone else walking in. We also noted the 'visitors' toilet was kept locked and was of a superior standard to the toilets people using the service had access to. This showed a lack of respect for people living at Ivy House.

People did not look well cared for or well groomed. We saw people wearing stained clothing, clothing with buttons missing and clothing with holes in them. Again, we saw people with long and dirty fingernails and men who had not been shaved.

We looked around the bedrooms and found many of the mattresses smelt of stale urine. We saw one bed had been made but the bottom sheet had faeces on it. The service manager agreed this was unacceptable.

Many of the people using the service required support to meet their continence needs and use pads and special pants to keep these in place. We found no-one had their own supply of 'net' pants but these were used communally. The laundry assistant confirmed this was the case. The service manager agreed this was unacceptable.

We saw one person being nursed in bed. Their bedroom smelt of stale urine and the TV had been left on showing a 'Jeremy Kyle' programme. We took the service manager to this room who agreed the television programme was inappropriate.

When we looked in people's bedrooms we saw some had been personalised with pictures, ornaments and furnishings. However, other rooms were very sparse and had not been personalised. We also noticed clocks in people's bedrooms that had not been changed when the clocks went back on 26 October 2014.

This breached Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There was very little information in people's care files about people's life histories or their personal preferences and interests. This meant there was no written information for staff to refer to. We found staff who had worked at the service for some time were aware of individuals preferences but newer staff were dependent upon getting this information verbally.

Some people who had complex needs were unable to tell us about their experiences in the home. So we spent time observing the interactions between the staff and the people they cared for. We saw in their direct dealings with people staff approached them with respect and support was offered in a sensitive way. People responded positively to staff and were relaxed in their company.

We looked at a care plan for someone for whom there was no person, other than care staff, to take an interest in their welfare. We found the provider was ensuring that the Mental Capacity Act 2005 requirement to arrange advocacy for people who have little or no network of support was being met. Furthermore we saw from records that the advocate was being formally consulted in the decision-making process in particular care plan reviews.

Is the service responsive?

Our findings

When we visited in April 2014 we were concerned people's care and welfare needs were not being met and asked the provider to make improvements. In the action plan the provider sent to us told us they would be compliant with the regulation by 1 August 2014.

We saw in one person's care file that they were visually impaired and had fallen seven times since or last visit in April 2014. A falls risk assessment completed by one of the nurses in June 2014 stated there was no risk of falls. Five of these falls had resulted in an injury, for example, a laceration to the person's forehead. We saw this person in the lounge wearing only one slipper with just a sock on the other foot. No staff were present in the lounge and this individual nearly fell over the coffee table. No care plan or additional safety measures had been put in place to reduce the risk of this person falling.

In another care file we saw the instructions to staff were, "Staff must ensure person X is wearing close fitting footwear that is in good condition." We saw this person wearing slippers which were in a poor condition. This meant there could have been an increased risk of this person falling because they were wearing inappropriate footwear.

We saw one person had been prescribed medication to help prevent or treat deep vein thrombosis and pulmonary embolism. We checked remaining stock levels with the registered nurse and found that nine doses should remain whereas ten were in stock. We further checked this with the registered manager. In the absence of a suitable explanation it was concluded that one administration of the medicine had been signed for but not given. This meant they had not received the medication they had been prescribed.

We looked at five care plans and saw two people had lost weight. We saw the first person, over a 5 month period, had lost 5.9kgs in weight. The last weight recorded was on12 August 2014 and was 48kg. The nutritional risk assessment identified they were at high risk. We spoke with the GP who confirmed they had increased the prescribed Complan drinks to two per day. However, this person's weight was not being monitored. This meant it was not possible to establish if the increase in Complan drinks, together with their meals was helping them to put on weight.

In the second person's care plan we saw from their weight records they had lost 12.2 kgs in weight between February 2014 and 2 October 2014. It was not clear from the care plan what measures staff had put in place to address this weight loss.

At 4:45pm we went to see one person who was being nursed in bed. Their mouth and lips looked dry. We looked at the record sheet and saw only two drinks had been recorded as being given at breakfast and lunchtime. We also found past records of their fluid intake in the top drawer of their chest of drawers. We took the service manager to see this person and they agreed their mouth and lips looked dry, but said they were sure the person would have received more to drink than the 400mls recorded. They told us at the end of the inspection staff had given more drinks but had not got a pen to record on the sheet. This meant no one had been checking to see if they had been getting enough to drink.

We noticed one person had a strong body odour when we arrived. We looked at their care plan and saw they were dependent upon staff to meet their personal hygiene needs. The hard soap in their bedroom was dry and we could not find any details in the daily reports about how their hygiene needs had been met that morning.

We saw care plans were in place and reviews were being completed monthly. However, we found some of the information was out of date. For example, one care plan stated the person liked to sit in a quiet area by the nursing office. This area had been made into an area for staff with a desk and computer. We spoke with the service manager who told us they had tried to audit the care plans but said it was, "A futile exercise as they all needed a complete review."

This breached Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered manager told us they had appointed an activities co-ordinator to work three days per week. They had started work the week prior to our visit, but were not on duty on the day of inspection. We noted there was a Halloween themed display in the conservatory. We saw one person who appeared shocked each time they walked past a life-size picture of a skeleton in a costume that had been put up on display. This made us question how appropriate this display was for people living with dementia.

Is the service responsive?

In one person's care file we saw recorded that they did not watch television because they were partially blind. We saw this person sitting in front of the TV during the morning.

During the morning there were no activities on offer for people. During the afternoon a film was put on and staff served popcorn to people in the lounge. We saw staff spending time with people and people were clearly enjoying their company.

One person told us, "I would like some new clothes and a nurse was going to take me out but she went on maternity leave and no-one has taken me since she went." We looked in this person's care plan and there was nothing documented about their wish to go shopping or how staff would support this.

We saw there was information about how to make a complaint in the entrance lobby. We saw one complaint on file that was about the laundering of clothing. We saw the complaint had been responded to, however, the formal written response to complainants did not offer a course of action that could be taken if the complainants remained unhappy with the response from the home. We also found there were no 'lessons learnt' from this complaint. When we looked around the home we found two very shrunken thermal vests in one person's drawer. The vests could not have been worn as they were so badly damaged. When we took the service manager to this bedroom and showed them the vests they told us it was very unfortunate as it was this person's laundry the original complaint had been about.

Is the service well-led?

Our findings

The registered manager is also one of the directors of the company. A number of family members work at the service in a variety of roles. The registered manager is supported by a service manager.

We spoke with three members of staff about our findings on the morning of the inspection. They told us the experience of people who used the service was dependant on the nursing staff leading the shift. Staff told us if one nurse had been on duty we would have found the service to be fresh and clean and people would have been offered breakfast and drinks. This showed us the leadership within the service was inconsistent and the provider was not monitoring the standard of care provided to ensure people received an acceptable standard of care at all times.

We spoke with the registered manager and found they lacked understanding of governance and assurance processes. We asked them about the incident reporting system and asked them what organisations needed to be informed of incidents. They could not answer these questions and left the room. They returned with a Senior Care Assistant who informed us that some incidents should be reported to the Clinical Commissioning Group, Safeguarding and CQC.

We saw the basic systems and processes for governance were in place but were in need of further development. The service manager told us, “A lot of work needs to be done to bring this service to the standard I would like to see.” They also told us there was, “A lack of systems” and that, “Every level I have looked at needs work.”

We asked for a copy of the business plan that set out the mission, visions and values in a structured and systematic manner that could easily be understood by staff, people using the service and relatives. This could not be produced.

Incidents were reported on the computer system but this was not well used. The process for investigating serious incidents was inadequate and needed to improve. We reviewed two serious incident reports relating to two people who had fallen and sustained fractures. There were common themes of not reporting these falls to Nursing staff and failure to seek a medical opinion and assistance in a timely manner; which in turn resulted in delayed admission to hospital for treatment and pain relief. We could not ascertain how the manager had reviewed these incidents using robust Root Cause Analysis (RCA) methodologies. We could not see how systems and processes had been reviewed to try and reduce the risk of occurrence of similar incidents in the future.

The Operations Manager had developed the Continuous Quality Improvement System (CQIS). If completed this would have been a good system. However, the lack of information being put into the system made it ineffective.

During the inspection we found issues in a number of areas such as with the premises, infection prevention, medication, planning and delivery of care, staff training and safeguarding. If there were effective systems in place all of the issues should have been identified by the provider and measures put in place to ensure they were rectified.

This breached Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **People were not safeguarded against the risk of abuse. Regulation 11 (1) (a) and (b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **People who used services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. Regulation 15 (1) (c).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **There were not enough staff on duty at all times to safeguard the health, safety and welfare of people living there. Regulation 22**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **Staff had not received appropriate training to enable them to deliver care safely and to an appropriate standard. Regulation 23.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services

This section is primarily information for the provider

Enforcement actions

Treatment of disease, disorder or injury	Suitable arrangements had not been made to ensure people were treated with dignity and respect. Regulation 17 (1) (a) and (2) 9a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People who used the service were at risk from not receiving care that met their individual needs and lack of emergency procedures. Regulation 9 (1) (b) (i) and (2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers People using the service were not protected against the risk of inappropriate or unsafe care and treatment because the quality systems were not effective and risks were not being identified or managed. Regulation 10 (1) (a) and (b).