Apex Care Homes Limited

Alicia Nursing Home

Inspection report

105-115 and 33-35 Marsh Road,
Luton
Bedfordshire
LU3 2QG
Tel: 01582 560 500
Website: www.apexcare.co.uk

Date of inspection visit: 5 and 14 November 2014
Date of publication: 30/03/2015

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

We carried out an unannounced inspection at Alicia Nursing Home on 5 November and 14 November 2014.

At our last inspection on 08 April 2013 we found the service was meeting all the expected standards of care.

Alicia Nursing home provides accommodation with nursing and personal care for up to 68 people with physical and mental health care needs including dementia, learning disabilities and ongoing mental health needs. At the time of our inspection there were 62 people living at the service. The home is divided into five units, four of which are on one site, and the fifth unit, Atwell House, is located a five minute walk away.

There was 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.

Summary of findings

People were not protected against the risks of receiving care that was inappropriate or unsafe and care was not planned or delivered to meet people's individual needs. Medicines were not administered safely.

There were sufficient numbers of staff on duty but they did not all have the skills and experience to support people's needs well.

People were not protected from abuse because staff failed to recognise and report concerns appropriately. Risk assessments failed to provide information on how to reduce the risks and promote people's independence.

The induction process was not effective, staff training was not all kept up to date, and many staff lacked the skills and knowledge to support people's complex needs.

People's nutritional needs were not met. Sufficient quantities and choice of suitable food was not always available. Staff did not consistently provide dignified, appropriate assistance to people during meal times.

People's dignity and confidentiality were not upheld and they were not asked for their consent before care was provided. Many staff did not demonstrate respect for people. People's individual needs were not always recognised and met. This was particularly the case for people who had complex needs or who were unable to communicate their wishes verbally.

The manager understood the requirements of the Mental Capacity Act (2005) and the associated Deprivation of Liberties Safeguards.

Systems to assess and monitor the quality of the service were not effective and leadership in the home was not effective. People's records were not held securely.

During this inspection we found the service to be in breach of several 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.

Medicines were not administered or stored safely.

Risks were not managed appropriately.

There was not always sufficient staff with the skills and experience to support people safely.

Is the service effective?

Inadequate

The service was not effective

Staff training, including induction, was insufficient to ensure that people were supported by staff that had the right knowledge to meet their needs.

People were not offered a choice of food and did not receive appropriate assistance to eat their meals.

The manager understood the requirements of the Mental Capacity Act 2005 and the related Deprivation of Liberty Safeguards.

Is the service caring?

Inadequate

The service was not caring.

There was a task led approach to care and did not take into account people's individual needs.

People's privacy and dignity were not respected and they were not treated as if they mattered.

People were not included in making decisions about their care.

Is the service responsive?

Inadequate

The service was not responsive.

People were not involved in the planning of their care and care plans did not consistently reflect people's individual wishes and preferences.

There was insufficient guidance for staff on how to care for people in a way that promoted their mental wellbeing

People were not supported to pursue their interests and hobbies.

Is the service well-led?

Inadequate

The service was not well led.

The quality monitoring systems in place were not effective.

Records were not held securely.

The leadership did not promote an open and person centred culture.

Alicia Nursing Home

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 5 and 14 November 2014 and was unannounced. The inspection team was made up of four inspectors.

Before our inspection we reviewed the information we held about the service. We reviewed the 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 what improvements they plan to make.

We looked at the notifications that the provider had sent us. A notification is information about important events that the provider is required to send us by law. We looked at the report from the previous inspection held on 08 April 2013.

We carried out observations and used the short observation framework for inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who were not able to talk with us due to their complex needs.

During the inspection we spoke with eight people using the service, two people's relatives and a visiting health care professional. We also spoke with the registered manager, three senior managers, a kitchen manager, two administrative staff, four nurses and seven care staff. Following the inspection, we spoke with five health and social care professionals who visit the service.

We reviewed records for 10 people who used the service. We also reviewed staff rotas and management records relating to complaints, incidents and accidents, training and quality monitoring.

Inadequate

Is the service safe?

Our findings

We found that people were not always protected from the risks of harm and neglect. Although one person told us they felt safe at the home, another person told us they were not confident that staff knew how to keep them safe. Many of the people who lived at this home were not able to tell us about their experience due to their complex needs so we spoke with some relatives and observed the delivery of care to help us understand their experiences. One person's relative told us that they had not had any cause to believe their family member was not safe. However another visitor told us they believed their relative was, "reasonably safe" but that this depended on which staff were on duty.

We found throughout the inspection that there was a significant lack of engagement and interaction for people which left them bored and sometimes isolated. We observed that some people calling out in distress were ignored and that many staff supported people in silence without giving eye contact or acknowledging them in any way. People were left with food over their clothes and faces after eating. This contributed to a culture of neglect throughout the home. Staff had failed to recognise this as neglect, and had consequently failed to take any action to report the matter. Discussions with staff and a review of records showed that staff had received training in safeguarding. Staff we spoke with demonstrated an understanding of the safeguarding process, and were able to explain their responsibilities to report suspected abuse. However, their failure to recognise the practices of neglect we observed, demonstrated that they had limited understanding of what matters they should report. Although the manager had reported safeguarding concerns to the local authority, they had not always notified the Care Quality Commission of these matters as required.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Although risk assessments were in place for individual people, we found they did not contain sufficient information on how to reduce the risk and support people's independence. One assessment identified how someone's behaviour could put themselves or others at risk. However it did not outline how this should be managed to prevent or minimise the risks. The risk of eating inappropriate food had been assessed for one person who was reluctant to follow a soft diet and was at high risk of not eating and drinking enough. There was insufficient guidance to tell staff how to support the person with this safely, particularly given the high use of agency staff, many of whom were unfamiliar with the service and the people they were caring for. Although assessments were in place, people were not protected from the risk of developing pressure areas. We visited three people who were nursed on bed rest in one unit and found that the pressure relieving mattresses for all three people had been set incorrectly. We spoke with staff who told us they did not understand how to set the mattresses. This increased the risk of pressure areas developing. The records showed that one person had developed a pressure area in October 2014; however staff were unable to confirm if this was correct.

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

We found that people's medicine was not always administered as it had been prescribed. Records contained unexplained gaps, and administration practices were unsafe. We observed the nurse administering medicines, and noted they were frequently distracted by answering the telephone and talking to colleagues. This increased the likelihood of mistakes being made. We found errors on medication administration records (MAR) for 19 of the 62 people who lived at the home. There was no consideration given to individual prescriptions where medicine should be given at set times. A member of the management team told us, "We do the meds after we've done the personal care and people have had their breakfasts." Therefore people did not always receive their medicine as prescribed. Protocols to guide staff about the correct administration of medicine prescribed on an 'as required' basis (PRN) were not available within the medicines records, and staff who were administering people's medicines could not tell us where these were held. Two staff we spoke with gave inconsistent explanations of when they would give one particular person PRN medicine. One staff said, "[Name] is like a baby sometimes. They seek attention. If you can't deal with them you have to give them meds". Another member of staff said that they would not give the medicine. This did not protect the person from the risk of inappropriate administration of medicine because staff did not have access to clear guidance about when it was required.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service safe?

Medicines were stored appropriately with dates of opening recorded. This protected people from the risks associated with taking out of date medicines. Stock checks were made and were up to date in most cases we looked at. We saw that there was a photograph and allergy information at the front of all but one person's medicine records that we looked at.

The manager was unable to tell us how decisions were made about the numbers of staff required and how they were allocated to meet people's needs safely. Although we found there were sufficient numbers of staff on duty, we identified that some lacked the skills needed to care for people who were living with learning disabilities, poor mental health or dementia. From our discussions with staff and from looking at records, we found that both care and nursing staff were frequently covered by agency staff that were not familiar with the service. Agency nurses that we spoke with were leading shifts but not all had the skills, knowledge or experience to safely care for people who lived at the home. One agency nurse told us they had no previous experience of this type of nursing, although they were leading shifts across two units on their second day at the home. This resulted in a lack of consistent, safe and appropriate care for people who lived at the home. The provider told us they were continually trying to recruit suitable staff. They demonstrated the use of a robust recruitment process whereby staff did not commence work until all appropriate pre-employment checks and processes were completed.

There was a system for staff to record accidents and incidents. The management team told us that they analysed the frequency and pattern of incidents to learn from them and to improve the care provided to people.

Inadequate

Is the service effective?

Our findings

Due to people's complex needs most were not able to tell us their views about the skills of the staff. Of those we spoke with, one person said, "Some of the staff are okay"". However, one visitor commented that staff did not talk enough to people, and they were not confident that all the staff had the skills and knowledge to meet their relative's needs.

We looked at the training records for the home and found that much of the training that the provider considered mandatory for their staff was out of date. For example, the training to manage behaviours that could put people at risk of harm or injury was out of date for 31 of the 63 staff. The lack of skills in this area was evident in our discussions with staff and our observations. We saw that staff avoided people who were known to display behaviours that had a negative impact on others, and subsequently some people were isolated.

Although the home had an induction procedure in place it was not used effectively to train new staff. Staff told us that their induction was not sufficient. New staff, including an agency nurse who was in charge of two units, told us that their induction consisted of being shown around the building and introduced to staff. One of these members of staff told us that they did not have previous experience of working with people with mental health needs and that they "just copy what other staff do." Staff also told us they were not trained and did not know how to set pressure relieving mattresses correctly. One health care professional who worked with the home told us that despite staff being trained to use a nutrition assessment tool, some had not used it correctly. This had resulted in them failing to identify the risk of a person not eating and drinking enough and not referring them to a dietician. This placed people at an increased risk of poor or inappropriate care because staff did not have the skills and knowledge to support them.

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

Consent to care and treatment was not always sought. We observed that staff did not ask people for their consent before providing support. At lunchtime, we saw staff put a person's hair into a ponytail without speaking to them first, put clothing protectors on people without any communication and served meals without asking people what they wanted or explaining what was on their plate. We saw staff move people in their wheelchairs without speaking to them or asking them if they wanted to move. Care plans we looked at were not signed to show that people or (where appropriate) their representatives had agreed with or consented to the plan of care. This approach to caring for people did not protect their rights to make decisions about their own lives and about the care that was offered to them.

This was a breach in Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2010.

CQC is required by law to monitor compliance with the Deprivation of Liberty Safeguards (DoLS) requirements of the Mental Capacity Act 2005 (MCA). The MCA sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected. Records showed that staff had received training on MCA and DoLS, and basic mental capacity assessments had been completed for people when it was believed that they did not have capacity to make informed decisions. We saw two people had a DoLS authorisation in place and that this was held within their care records. The management team were aware of their responsibilities under the MCA. Where people lacked capacity, we saw that best interests decisions were made on their behalf by their relatives and, where appropriate, professionals involved in their care.

One person told us, "The food is awful. It is stone cold. I don't eat it". Another person said, "They just take a guess at what I want. They don't ask me." Although one person's relative said they did believe their relative had enough to eat, another visitor told us that they frequently made tea for people when they arrived because staff had not done so.

We saw that people were not offered a choice of suitable and nutritious food and drink and people did not get appropriate support to eat. At lunchtime, some people waited over twenty minutes to receive assistance to eat their meal so by the time they were eating, their meal was cold. The choice in the main course was limited and we saw that no alternative other than another pudding was offered to one person who did not want the food provided. Snacks were not freely available between meals. Although staff told us that they would provide a snack if people asked, many people living at the home were not able to do

Inadequate

Is the service effective?

this and were not offered. We also observed two occasions where people did request food and drink but were ignored by staff. We saw that one person was not offered suitable meals in line with their weight management care plan. A visiting dietician confirmed that the information on the individual's care plan was current and should have been followed .The person did not receive effective support to manage their weight which could have a negative impact on their health and wellbeing.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw that people were supported to have access to other healthcare services such as GPs, dieticians and speech and language therapists. A visitor told us that their relative had been supported to see a GP and a dietician when they needed to, and we saw several health care professionals visit the home during our inspection. Records showed that people had regular access to community mental health teams. This was confirmed by professionals we spoke with following our inspection. One healthcare professional confirmed that staff had referred a person appropriately to support their physical needs to be met.

Inadequate

Is the service caring?

Our findings

One person we spoke with said, “Some of the staff are ok … but it feels a bit like a prison here.” A relative told us, “I don’t see staff much but when I have seen them, at Christmas time for example, I felt they genuinely cared about people.” Another visitor said, “I try to chat to everyone when I’m here because staff don’t talk to people.”

We saw that very little effort was made to make lunchtime a pleasurable, social experience. The home did not have sufficient space to enable people to eat communally, and where there was a dining area, people were not always offered the choice to use it. We noted that some people were not assisted to eat in an appropriate manner. We saw that staff rushed one person rather than allowing them to set the pace. Another person, who was attempting to reach for their fork, was told by staff, “I am doing it. You’re not doing it.” We observed the delivery of care in each area of the home, and noted that many staff did not engage with people in a meaningful way or support them in a dignified manner. We witnessed a period of 26 minutes, where three staff sat in the lounge with people but completed paperwork and did not communicate with them at all. In another area of the home, staff sat in the same room as people for an hour watching television and again, did not speak to them. A member of staff told us that they understood the importance of talking with people as they cared for them. However, we observed this member of staff ignore people as they provided care to them. We observed that most staff did not treat people with respect or demonstrate that they were valued. The impact of this was that some people were withdrawn and isolated.

Staff discussed people in front of others and pointed at people or used terms such as “him” and “that one” to describe people rather than referring to them by name. Staff were also seen to be talking about people as if they were not present. We also saw staff lead people by the hand in a childlike manner. When they did this, they did not show any consideration for the individuals and they out-paced the person making it difficult for them to keep up and walk alongside the staff member. On our arrival we saw a person was walking around the home naked from the waist down. They were taken to their room by a member of staff who said, “We like to wander don’t we?” People were not therefore treated with respect and their dignity and privacy was not supported. Although we saw that people who could make their wishes known made some decisions about their care, there were no effective procedures in place to ensure that people who lacked capacity or had complex needs participated in this process.

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

In contrast we did see some examples of good care from individual staff who were supporting people well. One staff member sat with a person to assist them to drink, maintained good eye contact and encouraged them gently to have their drink. Another staff member supported someone to eat their lunch with patience and sensitivity.

Inadequate

Is the service responsive?

Our findings

People and their relatives told us that they had not been involved in the planning of their care. One relative told us, "They let me know what is going on but, no, I've not been involved in the planning". One visitor said they used to be concerned that staff did not respond to their relative's preferences but this had started to improve recently. For example, staff made arrangements to offer a hot meal in the evening rather than at lunchtime in line with their preference. However, they also said staff had continued to give the person food they did not like on their plate, which sometimes meant the person would not eat anything.

Although we found that some care records were person centred and outlined peoples care needs, preferences and aspirations, other care plans contained very little information about people's preferences. People who were experiencing poor mental health had no recovery plans or therapeutic interventions detailed within their care plans. We noted that the plans contained insufficient guidance for staff on how to care for people in a way that promoted their mental wellbeing. Several care plans described the individual's mental health diagnosis, but did not explain what this meant for the person or how staff should meet their needs and preferences. There was no clear guidance regarding triggers in relation to people's behaviour or signs that they may be at risk of a relapse in their condition. Nursing staff were unable to provide us with evidence that any interventions other than medication reviews or routine appointments were undertaken.

We saw that staff failed to respond when people showed behaviour that could have a negative impact on others and when asked, they were unable to tell us how they worked with people to identify triggers for the behaviour and reduce incidents. We saw that the way in which two people were treated left them isolated. We were told by three members of staff to not go near the two people because their behaviour could have a negative impact on others. These comments were made in loud voices so that everyone in the room could hear. Throughout our inspection, we observed that staff avoided the individuals, and on one occasion were seen to completely ignore a request made by one of them. A member of staff told us they avoided the people because they had been advised to do this by more experienced staff. These people did not receive care that was responsive to their needs. Staff were unable to tell us how they found out about the needs and wishes of people who could not communicate with them verbally. One member of staff told us that, if people were unable to speak with them, they did not know how they would be able to communicate their needs.

Staff kept individual daily records which detailed important information about people's health and welfare. However, we saw that, although information was recorded, it had little impact on people's experience of care. Records detailed one person's acute distress for prolonged periods over several days. However, this information had not been used effectively to drive improvements or secure the care this person required in a timely way.

We found there was little on offer to stimulate people or create opportunities for them to pursue their interests and hobbies. One person said, "We don't do a lot here. Sometimes I go to the day centre but they play games, not the sort of thing I like". When asked, the person said they would like to do sewing as they used to enjoy it. Another person also told us that they chose not to go to the day service because the activities on offer were not to their liking. They used to like knitting and crafts but these were not available at the day centre. A relative said that there was little for their family member to do and they thought this might lead them to be isolated. Although a range of activities were provided in the day centre from Monday to Friday, we observed that only four out of the 13 people present at a morning session were engaged in the activity provided. Many people remained in the residential part of the home, either in their room or in the lounge, where there was no attempt made to stimulate them other than television. Activities in the community were organised, however not all the people were able to participate in these. For example a holiday was planned, but only seven people out of the 62 people living at the home had been able to go on it.

This was a breach of regulation 9 of the Health and Social care Act 2008 (Regulated activities) Regulations 2010.

People were not treated as individuals or offered opportunities to be involved in or contribute to planning their care. For example, we observed that staff assisted people with personal care at a set time rather than when a person required this care. Staff referred to this as "doing the

Inadequate

Is the service responsive?

pad change". This approach to care showed that staff prioritised the task rather than the individual person and did not promote people's dignity or enable people to have control of how their care was provided.

This was a further breach of Regulation 17 of the Health and Social Care Act 2010 (Regulated Activities) Regulations.

One person told us that they were not happy at the home but they had not made a complaint because they believed it would not make a difference. We saw the home had a complaints policy presented in an easy read accessible format that was held in two of the care records we looked at. We looked at how the service responded to complaints and found that some complaints were not investigated appropriately. One complaint made in December 2013 had not been responded to until June 2014, after prompting on two occasions by the complainant. The response was brief and did not refer in depth to the specific complaints made. There was no evidence to show how the information from complaints had been used to improve the quality of the service provided. However, other complaints we looked at had been investigated and responded to in line with the provider's policy.

Inadequate

Is the service well-led?

Our findings

The registered manager did not have a clear and visible presence in the home nor did they demonstrate strong leadership. People and visitors we spoke with did not feel the service was well led and when asked, were uncertain who the manager of the home was. One visitor said, "The manager? Is that [Name]? Oh, they are friendly enough but I rarely see them." Another visitor said there was, "a lack of staff direction" and that staff "do not get enough information to do a good job." The culture of the service was task led rather than person centred and did not encourage people to share their views or be involved in the way in which the service was run. We found the manager did not have a strong vision of how they intended to run the home and was unable to answer basic questions about the systems and values that underpinned the service.

Systems to monitor the quality of the service were ineffective and had failed to identify issues highlighted during the inspection, such as medicine administration errors and the unsafe use of equipment such as pressure relieving mattresses. We also found that care plans were not monitored to ensure they reflected people's needs or gave staff direction on how to care for people appropriately.

The management team had failed to identify poor practice in the home or the impact it had on the people who lived there. As a result, poor engagement, an environment that was not stimulating and a lack of opportunities for people to be involved in making decisions about their care had not been addressed.

Systems to assess the need for staff training, to keep training up to date, and to monitor the impact it had on practice, were not effective. Most staff had received training in how to provide dignified care, however, we had found that many failed to do this. The manager was unable to show how they monitored the effectiveness of training or how they identified where further training was needed.

The manager failed to ensure that people's records were stored securely. We saw that the records relating to some of the people who lived in the home were kept on shelves in the corridor. The manner in which they were stored meant they could not be locked away and were available to be viewed at any time by anyone on that floor.

People could not be confident they were protected from the risk of unsafe or inappropriate care because the manager had not assessed or monitored the quality of the service effectively.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The manager had notified the Care Quality Commission (CQC) of some significant events in the service such as when a person died. However, there was a lack of understanding about all the events that should be reported such as incidents where the police had been involved and deprivation of liberties authorisations.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **People who use services were not protected against the risks of unsafe or inappropriate care because the planning and delivery of care did not meet individual needs, ensure the welfare of service users. Regulation 9 (1)(b)(i)and(ii)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The registered person did not make suitable arrangements to protect people from abuse because they did not report abuse appropriate and neglect was not identified. Regulation 11 (1)(a)(b) and 3(d)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The registered person did not protect people from the risks associated with unsafe use and management of medicines. Medicines were not administered or recorded safely.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs

This section is primarily information for the provider

Action we have told the provider to take

	The registered person did not ensure people were protected from the risks of inadequate nutrition because a choice of suitable and nutritious food in sufficient quantities was not offered and people were not offered appropriate support. Regulation 14 (1)(a) and (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services People's dignity, privacy and independence were not supported. People were not involved in making decisions about their care. People were not treated with consideration and respect. Regulation 17 (1) (a)(b) and (2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person did not have suitable arrangements in place to obtain and act in accordance with the consent of people who used the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff Staff were not appropriately supported to enable them to deliver care and treatment safely and to an appropriate standard. 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 Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The registered person did not have effective systems in place to regularly assess and monitor the quality of the service or to identify, assess and manage risks relating to the health, welfare and safety of people. Regulation 10 (1) (a) and (b)**

The enforcement action we took:
We have issued a Warning Notice which requires the registered person to become compliant with Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 by 31 December 2014