Keychange Charity

Keychange Charity Sceats Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Keychange Charity Sceats Care Home provides accommodation and personal care for up to 30 older people. At the time of our inspection 18 people were using the service.

This inspection was unannounced and took place on 8, 12 and 13 April 2016.

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager registered with the Commission left the provider's employment some time ago. A manager has been employed since October 2015 but has not yet registered with CQC.

Our inspection highlighted shortfalls where some regulations were not met. We also identified areas where improvement was required and made recommendations that the service should adopt.

People did not receive a service that was safe. Risk assessments were not always in place and those that were lacked sufficient detail to safely provide care. Staff did not receive regular training on keeping people safe and were not familiar with safeguarding procedures. Pre-employment checks to ensure people were safe to work with vulnerable people were not always carried out before staff started work.

The service did not provide effective care and support. Staff had not received training on caring for people living with dementia or receiving end of life care. Newly appointed staff had not received basic training required to provide effective care to people. Staff were not receiving regular supervision. The service was not adhering to the principles or requirements of the Mental Capacity Act 2005 (MCA) or Deprivation of Liberty Safeguards (DoLS).

People did not always receive a caring service. Staff did not always give people the care and attention they wanted or needed. People generally spoke positively about the staff caring for them. Care staff did not know the people they were caring for well.

The service was not responsive to people's needs. Care plans were not person centred and lacked the detail required to provide consistent, high quality care and support. Daily records were not completed thoroughly. There were not enough activities for people. People's views regarding their care were not actively sought.

The service was not well-led. The manager had been in post since October 2015 but had not submitted an application to register with CQC. The ratings from our inspection on 15 and 16 June 2015 were not on display at the service. The operations manager and manager said they would ensure ratings were displayed with immediate effect. Quality checks were not in place to assess the quality and safety of the service and plan for improvements. The provider had written an action plan for improvements they planned to make.

However, this plan showed no prioritisation and timescales for completion did not appear realistic.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

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.

Risk assessments were not always in place and those that were lacked sufficient detail to safely provide care.

Staff were not familiar with safeguarding procedures and had not received training on keeping people safe.

Pre-employment checks to ensure people were safe to work with vulnerable people were not always carried out before staff started work.

Is the service effective?

Inadequate

The service was not effective.

Newly appointed staff had not received the basic training required to provide effective care to people.

Staff had not received training on caring for people living with dementia or receiving end of life care.

The service did not comply with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). This meant people's rights were not protected.

Is the service caring?

Requires Improvement

People did not always receive a service that was caring.

Staff did not always give people the care and attention they wanted or needed.

Care staff did not know people they were caring for well.

People generally spoke positively about the staff caring for them.

Is the service responsive?

Inadequate

The service was not responsive to people's needs

Care plans were not person centred and lacked the detail required to provide consistent, high quality care and support.

Daily records were not completed thoroughly.

There were not enough activities for people.

People's views regarding their care were not actively sought.

Is the service well-led?

Inadequate

The service was not well-led.

The manager had been in post since October 2015 but had not submitted an application to register with CQC.

Accurate records on the care and treatment people received were not maintained.

Quality checks were not in place to assess the quality and safety of the service and plan for improvements.

Keychange Charity Sceats Care 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 comprehensive inspection took place on 8, 12 and 13 April 2016 and was unannounced. The inspection team consisted of two adult social care inspectors.

The last full inspection of the service was on 15 and 16 June 2015. At that time we found the service was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014;Safe care and treatment. This was because people were not protected from unsafe medicine management and, people were not protected from the spread of infection. Following that inspection the provider sent us an action plan detailing the action they would take to improve these areas in order to comply with this regulation. In June 2015 as a result of that inspection, we rated the service as 'requires improvement'.

Prior to this inspection we looked at the information we had about the service. This included information of concern shared with us by relatives and health and social care professionals and information from 'whistle-blowers'. We also reviewed the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law.

We contacted four health and social care professionals, social workers and commissioners. We asked them for some feedback about the service. We were provided with a range of feedback to assist with our inspection. We spoke with a health care professional visiting the service during our inspection.

Most people were able to talk with us about the service they received. We spoke with nine people using the service. We also spoke with relatives of two people using the service.

We spoke with eight staff, including the manager, the provider's operations manager, three care workers, an agency care worker, kitchen and maintenance staff.

We looked at the care records of seven people living at the service, four staff personnel files, training records for all staff, staff duty rotas and other records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

People said they felt safe living at Keychange Sceats Care Home. Comments included, "Yes, I feel I'm safe here" and, "The staff are good and I'm all right here". One relative said, "We've never had any concerns". However, prior to the inspection relatives had expressed concerns regarding the service provided. During the course of our inspection we identified concerns which meant that the service was not safe.

Risks to the health and safety of service users had not been assessed and the provider was not doing all that was reasonably practicable to mitigate any such risks. Care records contained a sheet which acted as an overall checklist of risks to service users. This checklist was arranged under various headings and allowed space for a brief statement and a tick to indicate if an individual risk assessment and plan was required to mitigate the risk. The overall quality of these statements did not give sufficient detail on the risks to people. The statements were basic and, with all except one of the records we looked at, the box identifying if a detailed individual assessment and plan was required had been left blank.

For example, one person at risk of falling and injuring themselves did not have a risk assessment in place to keep them safe. Another person identified as not being at risk from malnutrition had been found to have lost a significant amount of weight, they were also found to have significant bruising. These concerns were identified when they moved to another home and neither had been recorded in the person's care records. A third person had lost a significant amount of weight. There was no assessment in place identifying a risk of malnutrition or weight loss for this person. This person was very unwell when we visited. We were also concerned that they were not able to communicate if they were in pain. This risk had not been assessed and there was no guidance for staff to identify if they were in pain. On 8 April 2016 we became concerned as they were in pain and had to request that the person's GP was contacted by staff.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Checks were not always carried out on staff to ensure they were safe to work with vulnerable people. One care worker who had commenced employment six weeks before our inspection did not have a Disclosure and Barring Service (DBS) check in place. A DBS check allows employers to check an applicant's police record for any convictions that may prevent them from working with vulnerable people. A check had been applied for but not received. The manager and provider's operations manager confirmed this staff member was providing care to service users. They said this was not consistent with the policy of the home and they would ensure the staff member was supervised and did not provide care on their own until a DBS checks had been received and assessed as satisfactory by the manager. This meant people had been put at risk of receiving care from a person who had not undergone satisfactory checks to ensure they were safe to work with vulnerable people.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

People living on the first floor and using one of the two staircases at the home were being placed at risk. Four people's bedrooms opened onto a landing at the top of this staircase. A stair lift had been installed on this staircase which was used by one person. The three other people used the stairs. The stairway was narrow and the design of the stair lift was a clear trip hazard. This was discussed at the inspection and recognised by the manager and operations manager as a risk. We were told this would be immediately rectified.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

We noted that on the 8 and 13 April the home smelt strongly of stale urine, although this was not so apparent on the 12 April. Staff we spoke with were aware of the offensive smell but were unable to identify why it was so apparent. Staff said there was a lack of personal protective equipment, such as gloves and aprons.

At our last inspection on 15 and 16 June 2015 we identified a breach of regulation regarding the prevention and control of infection. The provider sent us an action plan which stated; a senior member of staff would be identified and trained as an infection control lead and, weekly checks would be carried out on infection control measures. These actions had not been completed. We were told an infection lead had been in post but had left two weeks before our visit. This meant people remained at risk of infection not being prevented, detected and controlled.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

There were safe medication administration systems in place and people received their medicines when required. Medicines were administered by staff trained to so. Some people were prescribed 'as required' medicines. Guidance on how and when these should be offered to people was in place. People were able to self-administer their medicines with the support from staff. One person told us how they self-administered their insulin. They said they preferred to do this themselves but were happy the staff were present when they did.

People were not kept safe by staff who knew about the different types of abuse to look for and what action to take when abuse was suspected. Newly appointed staff had not received training on safeguarding. Staff we spoke with did not have a good understanding of how to report any concerns they had about a person's safety or welfare. The manager had reported safeguarding concerns to the local authority and CQC and had responded when asked for further information regarding this. However, health and social care professionals did not express confidence in the ability of the service to keep people safe from harm.

We received mixed feedback from people using the service regarding whether there were enough staff to meet their needs. Relatives we spoke with felt there were enough staff. One said, "I think you could always have more but there seems enough". Staffing levels at the service had recently reduced. The manager said this was because there were less people living at the service and the previous staffing levels had been too high. Prior to the inspection we had received information telling us there was not enough staff. During our inspection we saw there were enough staff to care for people. The manager had not used a recognised dependency tool to assess the staffing levels. We discussed this during our inspection as we felt using a recognised dependency tool would help ensure safe staffing levels. The manager said they would introduce a dependency tool to ensure people were provided with sufficient staff to keep them safe.

Inadequate

Is the service effective?

Our findings

People and relatives were positive about the care provided. People told us they had confidence in the staff that cared for them, they felt staff understood their needs and knew how to meet them. Comments included, "They look after me well" and, "All of the staff are very nice". People and their relatives said that staff communicated with them well. Although people commented positively, we found areas of concern that meant the service was not effective.

One staff member who had commenced employment six weeks before our inspection had not received basic training to ensure they were able to provide care and support to people. They said they had not received any training other than 'on the job' shadowing of more experienced staff. Training records confirmed this. This meant they had not had any training on, safeguarding vulnerable people, moving and handling, infection control, first aid or fire safety.

Two more care workers said they had not received training on working with people living with dementia or receiving end of life care. They felt training in these areas would help them to provide more effective care and support to people. Training records for all staff showed no recent training had been provided in these areas. A number of people using the service at the time of our inspection were living with dementia and one person was receiving end of life care. The lack of staff knowledge and skills in these areas had a negative impact on how effective the service provided to them was.

The manager and operations manager said they were in the process of introducing an 'on line' training system, which would allow them to provide and monitor the training required by staff. However, no action had been taken to ensure staff received the training needed to safely provide care to people whilst this system was being introduced.

Staff were not receiving regular one to one supervision with a line manager. . Individual supervision is an opportunity for the staff member and line manager to evaluate performance and plan to improve their effectiveness in providing care and support to service users. Staff supervision files did not contain records of any supervision meetings held in 2016.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests

and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

The provider had policies and procedures on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). However, people's capacity to make choices and decisions had not always been assessed. Where assessments had been completed they were not well developed or decision specific. Staff did not have an understanding of the principles of the MCA and did not demonstrate an understanding of their responsibilities to promote people's choice and decision making.

The provider had identified where some people's freedom and liberty was being restricted. We saw applications had been made to the appropriate authorities for four people. The outcome of some of the applications was still awaited. The manager was not aware of the need to inform CQC of the outcome of these. We discussed this with the manager who said they would inform us when the outcome of applications was known.

One person shared concerns with us regarding lack of access to their money and limits on how many cigarettes they were given. The manager and staff were not able to explain to us how the person's capacity to make these decisions had been assessed, whether the restrictions imposed amounted to a restriction on their liberty or how their best interests had been considered. They said they would meet with other professionals to investigate this example fully.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.

During our lunchtime observations we saw the food was well presented and that people seemed to enjoy their meals. People had chosen their main course the day before from a choice of dishes. Some people had changed their mind and their revised choice was accommodated. Menus were available on each table. Most people had their meal in the dining room with some choosing to eat in their rooms. These choices were respected and staff took food to people's rooms when required. Drinks were available to people throughout the day in the dining area. We saw people taking advantage of this and getting themselves hot and cold drinks.

Following our last inspection in June 2015 we stated in our report, 'We recommend the service seeks advice and guidance from a reputable source, about the management of fluid intake for people at risk of malnutrition'. During this inspection we saw people's food and fluid intake was not clearly recorded in care records. One visiting healthcare professional told us they felt the service, "Generally meets people's needs but they could be better at recording people's weight and food and fluid intake". Where the service had identified people's food and fluid intake required monitoring, intake charts were put in place. However, we found that these charts were incomplete, not up to date and had not been monitored or reviewed. This meant that staff would not be able to identify where people had not received enough to eat and drink.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

Requires Improvement

Is the service caring?

Our findings

People told us staff were caring. One person said, "I like the staff they're nice". A relative told us how staff always greeted their family member warmly and affectionately when they returned to the service. However, during the course of our inspection we identified concerns which meant that the service was not always caring.

Staff said they felt the service provided was caring. However, when asked, they said they would not be happy for a relative of theirs to use the service. A number of care staff were new to the service. They did not know people well. We had a number of conversations with staff where they were unsure of how care was provided to people. On several occasions staff confused people and it was clear they were talking about a different person entirely. For example on day one of our inspection when we became concerned about one person, we asked staff to check if they had recently seen their GP. The staff member checked another person's care records as they thought the person was someone else. This requires improvement. The manager must ensure staff have enough time to get to know people before providing care.

Care plans were not always dated and were not regularly reviewed. A number of the care plans we looked at did not show any attempt to involve people and their families in the care planning process.

At mealtimes we saw that people who required assistance to eat their lunch were helped. Some staff were caring and attentive and helped people at their own pace, ensuring they were not rushed. However, some staff did not communicate or engage positively with people whilst doing this. They seemed to view this as a task to be completed rather than an opportunity to spend time with the person.

We did see some positive interactions with people from the some staff who were clearly trying very hard to provide the care people required. However, we saw that people were not always treated in a caring way. For example, one care worker walking through the dining area asked a person if they were OK. The person said, "No". However, the staff member carried on as though they either had not heard their answer or were ignoring them.

People were able to move around the home freely. Staff told us that people were encouraged to be as independent as possible. We saw people were supported to help themselves wherever possible.

People's bedrooms were personalised and decorated to their taste. Some people showed us their rooms and were pleased to talk to us about their families and their hobbies and interests. We asked if they had the opportunity to talk with staff. Comments included, "Well they're very busy you know" and, "Not really, they're usually in a hurry".

Staff had not received training on equality and diversity. People's care records did not include an assessment of their needs in relation to equality and diversity. Staff we spoke with did not understand their role in ensuring people's equality and diversity needs were met. This requires improvement to ensure people's needs are identified and met.

The service was providing end of life care. Staff said they had not received training in this. Care records did not give consideration to proving person centred care for people at the end of their life. We saw that relevant health care professionals visited people and documented their advice and guidance for staff.

We recommend the provider seeks advice from a reputable source on providing end of life care.

Inadequate

Is the service responsive?

Our findings

The service was not responsive to people's individual needs.

Care plans were not sufficiently detailed or written in a person centred manner. Some people did not have any guidance in their care plans for areas important for them. For example, people assessed as being at risk of falling or of developing pressure sores did not always have a plan in place to reduce this risk. People's care plans did not detail their life histories interests and preferences. There was little information for staff to 'get to know' the person and talk with them about things that were important to them.

We found daily recordings lacked detail on what care was actually delivered. Recordings were brief and did not always record the care people had received. For example, it was not always possible to determine when people had last bathed or showered, how much they had eaten or drank, when their weight had last been recorded and how any bruising or wounds were healing.

One person's care records contained a specific instruction dated 29 February 2016 that stated, 'weight to be continually monitored'. There was no further record of their weight being recorded. The lack of information in daily records meant that care could not be evaluated and amended as service user's needs changed. Care records were not always dated and dates they were to be reviewed by not always identified.

Another person's relative told us how their family member's low mood was improved by having their hair done. Staff we spoke with were not aware of this and the person's care records did not detail the importance of this to the person.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

People said there were not enough activities at the service. One person said, "There's not a lot to do really". Relatives also said there were not enough activities. An activities programme was on display, detailing activities due to take place that week. However, on the days of our inspection the scheduled activities did not happen. There was no activities coordinator at the service. Staff told us they wanted to see more activities for people. A newly appointed spoke passionately about wanting to fundraise for a minibus so trips out could be provided. They said, "People have said they'd like to go out, particularly in the summer to the seaside".

One person told us they would like to be able to go out to the local pub for a drink. Staff told us person's current wheelchair was too wide to allow them access to the pub. They said they thought an assessment for a new wheelchair had been carried out. We spoke with the manager about this. They did not know if an assessment had been completed or if a new wheelchair was being sought. The person's care plan did not contain any information regarding this.

People's bedroom doors were marked with the name of the occupant but had no other distinguishing

features. There were few photographs or other items to help the person recognise the room as theirs. Some people using the service were living with the early to mid-stages of dementia. Items linking them with their past would give them a sense of security and help staff communicate meaningfully with them.

People we spoke with were unsure of how to complain but did say they could talk with the manager. The provider had a policy on complaints and comments. A record of complaints was kept at the service. We looked at the record of complaints and saw they had been investigated and feedback provided to the complainant. However, there was no record of people's views being sought other than through formal complaints.

We recommend the provider seeks advice from a reputable source on providing a service for people living with dementia.

Inadequate

Is the service well-led?

Our findings

The service was not well-led.

The manager had been in post since October 2015 but had not submitted an application to register with CQC as manager. The ratings from our inspection in June 2015 were not on display at the service. Displaying these ratings has been a requirement since 1 April 2015. The manager and operations manager said they would ensure the ratings were displayed with immediate effect.

Personal information for some people had been incorrectly placed in other people's care files. One person's file contained information relating to the capacity to make decisions and, deprivation of liberty applications for another person. This meant people's personal information was not maintained appropriately and would be difficult to find when needed.

Care files contained on the front page a photograph. We were told photographs were placed on the front sheet of care files so they could be quickly and easily identified by staff. One person's care file had a photograph of another person on the front sheet. We spoke to staff about this, as we were trying to confirm the person's identity, they were not able to immediately confirm if the photograph was of the correct or a different person.

One person's surname had been spelt incorrectly on a number of documents; their room number had also been incorrectly recorded on a number of occasions. Their room number was 14 and this had been recorded as 4 on some documentation.

These examples raised the possibility of people being incorrectly identified, particularly as many staff were new to the service and did not know people well. During our visit an agency staff member was working as the senior carer on duty. They said it was their first time at the home and care records had not helped them easily identify people and the care they required.

Feedback from people using the service was not regularly sought. Comments and views were not recorded in care records, minutes of meetings held with people, comments or complaints received or as a result of satisfaction surveys. The failure to assess the quality and safety of the service provided meant regular monitoring and plans to improve the service provided were not in place.

This showed a failure to ensure, that people were protected from the risks of unsafe or inappropriate care and treatment. This is because there was a lack of effective systems designed to enable the manager to regularly assess and monitor the quality of the service, incorporating feedback from people and reviews of any events to look for any themes.

Internal auditing and quality assurance systems were not planned or carried out on a regular basis. As a result the provider had not identified errors and omissions in people's care records, meaning people were at risk from inadequate or inaccurate information in their care records.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

People knew who the manager was and seemed to have a good relationship with them and be comfortable in their presence. Relatives spoke positively about the manager. One said, "She's good and seems to care". Staff gave mixed feedback regarding the manager. Some, particularly more recently appointed staff, said the manager had made improvements over the last six months. Other staff said the manager was not a good listener.

The manager knew, with the exception of DoLS authorisations that we clarified during our inspection, when notification forms had to be submitted to CQC. These notifications inform CQC of events happening in the service. CQC had received notifications from the provider in the 12 months prior to this inspection.

On day three of our inspection we gave feedback to the manager, the provider's operations manager and the newly appointed deputy manager. We spoke about the concerns we had identified. Our feedback was listened to and we were told there was nothing of surprise in what we had found. We also spoke of the potential for the manager to become isolated and, the need for them to develop positive supportive relationships with other health and social care professionals, in order to improve the service. The manager confirmed they had imposed a voluntary embargo on new admissions. They said, "We want to make sure the service is safe before anyone else is admitted".

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured care and treatment of service users was only provided with the consent of the relevant person. Regulation 11 (1).

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks to the health and safety of service users receiving care or treatment had not been assessed. Regulation 12(2)(a). The provider had not done all that was reasonably practicable to mitigate risks. Regulation 12(2)(b). Satisfactory pre-employment checks had not been carried out before staff commenced. Regulation 12(2)(c). The provider had not ensured the premises were safe for their intended purpose. Regulation 12(2)(d). Infection control measures were not in place. Regulation 12(2)(h)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured there was an effective system in place to assess, monitor and improve the quality of service provided. Regulation 17 (2) (a). The provider had not assessed, monitored and mitigated the risks relating the health, safety and welfare of people who used the service. Regulation 17 (2) (b). Accurate, complete and contemporaneous

	records of care and treatment provided were not kept. Regulation 17 (2) (c).

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure service users were cared for by staff who receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2) (a).

The enforcement action we took:

Warning notice