Orders of St John Care Trust

OSJCT Townsend House

Inspection report

Bayswater Road
Headington
Oxford
Oxfordshire
OX3 9NX
Tel: 01865 762232
Website: www.osjct.co.uk

Date of inspection visit: 26 January 2015
Date of publication: 27/03/2015

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?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

We carried out this unannounced inspection on 26 January 2015. The service is registered to provide accommodation for up to 44 older people who require personal care.

We previously inspected the service in November 2013. The service was meeting the requirements of the regulations at that time.

People were not always supported in a respectful way. Staff did not always know people well or respect their preferences in how they wanted to be supported. When people were listening to music in the lounge the television was switched on. The music was not switched off and this created a noisy environment. However, people told us they liked living at the home and were treated in a caring and friendly way. People and their relatives were complimentary about staff. People were supported with their personal care discretely and in ways which upheld and promoted their privacy and dignity.

People told us they felt safe and staff were knowledgeable about the procedures in place to

Summary of findings

recognise and respond to abuse. However, when people presented with behaviour that could be described as challenging, staff did not always respond in an appropriate way. Some people were not protected against the risk of developing a pressure ulcer because staff did not support them to use their pressure relieving equipment.

People were not always protected from risks associated with the environment because the carpet was in a poor state of repair in some places presenting a trip hazard. Doors to electric or storage areas were unlocked. These should have been locked to keep people safe. Some areas of the home were not clean.

Some people did not receive their medicines in line with their prescription. There were gaps and omissions in the recording of medicine administration and replacement stocks had not always been ordered before they had run out.

People liked the food. Mealtimes were relaxed and unhurried. However, people were not always supported to eat and drink enough and some records relating to nutrition and weight were not accurate, completed or reviewed.

Some people told us there were not enough staff to meet their needs and the rotas showed that target levels of staff had not always been achieved. People were not always cared for by suitably skilled staff who had kept up to date with current best practice because not all staff had attended training or received adequate supervision and appraisal.

People were involved in their care reviews and were supported to make decisions about their care. However, some care plans did not provide sufficient instruction to staff on how they should be supported. Where required, staff involved a range of other professionals in people's care to ensure their needs were met.

The home had a manager in place who was in the process of registering with the Care Quality Commission to manage the service. Although the manager had some understanding of the changes and improvements that were required they did not always demonstrate good leadership skills. Quality monitoring systems to review the care and treatment offered at the home were not always effective. People, their relatives, visiting health professionals and staff recognised that improvements in the service were taking place.

Staff understood their responsibilities under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may be unable to make their own decisions. Where restrictions were in place for people we found these had been legally authorised.

We found 9 breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see the action we took and 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 because people were not protected against risks associated with the environment.

Some people did not receive their medicines in line with their prescription.

There were not always enough staff to meet the needs of people.

People told us they felt safe. Staff were knowledgeable about the procedures in place to recognise and respond to abuse.

Is the service effective?

Inadequate

The service was not effective. There were gaps in training and staff were not supported to improve the quality of care they delivered through the supervision and appraisal process.

People were not protected against the risk of developing a pressure ulcer because pressure relieving equipment was not always used.

People liked the food but were not always given support to eat and drink adequate amounts.

People were supported by staff who acted within the requirements of the law. This included the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

Is the service caring?

Requires Improvement

The service was not always caring because people were not always supported in a respectful way.

People were complimentary about the care they received. People told us staff were thoughtful and they were treated in a friendly way.

People were assisted with personal care discretely and in ways which upheld and promoted their privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not consistently responsive to people's needs. Care plans and assessments did not always provide instructions on how to support people. Other records relating to people's care were not recorded consistently or accurately.

People were involved in the planning and assessment of their care. People benefited from regular activities.

People knew how to make a complaint and felt confident any concerns would be dealt with.

Summary of findings

Is the service well-led?

The service was not well led. Quality assurance systems had not identified all of the concerns we found. Where concerns had been identified some actions to improve the service had not been completed.

Although the manager had some understanding of the changes and improvements that were required they did not always demonstrate good leadership skills.

Feedback was sought from people and acted upon. Visiting health professionals told us they had recently seen positive changes in the service.

Requires Improvement

OSJCT Townsend 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 was 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 the 26 January 2015. It was unannounced. The inspection team consisted of two inspectors and an expert by experience. 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 our inspection the provider sent us a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the service. This included notifications, which is information about important events the service is required to send us by law. We also received feedback from two health or social care professionals who regularly visit people living in the home. This was to obtain their views on the quality of the service provided to people and how the home was being managed.

During the inspection we spent time with people. We looked around the home and observed the way staff interacted with people. We spoke with nine people and one of their relatives. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with the manager, the head of care, five care staff, three ancillary staff, and the chef.

We looked at records, which included four people's care records, the medicine administration records (MAR) for all people living at the home and five staff files. We also looked at records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

People did not always have their prescribed medicines available. For example, one person had missed at least four doses of a pain relieving medicine because the stock had run out and new supplies of this medicine had not yet been delivered. Two people who were prescribed topical creams did not have these available. Staff had identified one person had run out, however replacement stock had not been ordered. Another person had cream prescribed on their medicine administration record (MAR). Staff responsible for medicine administration told us they did not apply the creams as this task was delegated to other care staff. When we spoke to the member of staff looking after this person they told us they thought this person did not have any creams applied because they did not have a cream application chart in place.

Balances of people's medicines were not always kept and there were a number of gaps on MAR charts where staff had not signed to say they had administered the medicine. This meant staff could not demonstrate that medicine had been given to people as required in line with their prescription.

These issues were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Some people told us there were not always enough staff to meet their needs. Comments included, "Sometimes they are bit short staffed" and "I think they are short staffed. Sometimes I have to wait for a commode." A relative said, "I think there is a shortage of staff. There is a long wait for support especially at weekends." At the start of the inspection there were five care staff and one care leader on duty. One staff member was allocated to each of the four units with one staff member floating to assist with people who required two people to support them with personal care. We were told that one staff member had called in sick that morning. A second care leader was called in and arrived at the service at 9am to replace that staff member. However, the second care leader spent most of their shift completing office tasks. We observed them assist during the activity and at the lunchtime meal but did not observe them assisting with personal care. The first care leader carried out the medication round and liaised with visiting health professionals so was not available to assist with personal care during the morning. Staff told us working with one staff member short impacted on the support they were able to give people. Staffing levels for the home had been worked out using the provider's dependency tool. Where possible shortfalls in the rota were covered with the provider's existing staff working extra shifts or agency staff. However, staff rotas for the four weeks prior to the inspection showed that on 10 occasions target staffing levels had not been achieved.

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

Effective measures were not always in place to ensure the environment was free from risk. For example, there were two areas where the carpet was torn as well as a slightly raised metal joining strip on the carpet between two corridors. This was a trip hazard to people walking freely around the home. Two doors that were clearly marked as needing to be locked at all times because they were a safety hazard were left unlocked.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Some people had risks assessments and care plans that described how they should be supported in relation to behaviour that could be described as challenging. However, this guidance was not always followed. For example, staff had identified the triggers for one person where they may have behaviours which challenged. We observed this person in a trigger situation. Although they were becoming increasingly anxious and began shouting, nearby staff did not intervene until the person became physically aggressive to the person sitting next to them. Staff then moved the person to another part of the room. The strategies identified in their support plan such as, "peace and quiet will calm them down" and "care staff to reassure when things are not going the way they would like" were not used. The person continued to be agitated.

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

Some improvements were required to the cleanliness of the home. For example, the floor of the dining room and carpet in the lift felt "sticky" to walk on. In one of the bathrooms a build-up of dirt was visible around the rim of the bath. There were soiled paper towels, a discarded plastic cup and dirt and dust underneath the bath.

Inadequate

Is the service safe?

Staff followed Department of Health guidance for storage and use of cleaning materials. The service had adequate stocks of personal protective equipment for staff to use to prevent the spread of infection and these were used in line with the services policy on infection control.

People told us they felt safe. Comments included, "Yes I'm quite safe" and "I'm comfortable and safe." People were supported by care and ancillary staff who had good knowledge of the provider's whistleblowing and safeguarding procedures. Staff knew how to report any safeguarding concerns and felt confident in raising any issues relating to peoples safety. People had call bells within reach and on the day of the inspection these were answered promptly.

Equipment used to support people's care, for example, hoists, stand aids and specialised baths were stored appropriately and had been serviced and maintained in line with nationally recommended schedules.

The service had plans in place to keep people safe during an emergency. A 'grab folder' was kept that contained important information about people and their mobility needs as well as an emergency evacuation plan for use in the event of a fire.

Safe recruitment procedures were followed before new staff were appointed to work with people. Appropriate checks were undertaken to ensure that staff were of good character and were suitable for their role.

Inadequate

Is the service effective?

Our findings

People were not always cared for by suitably skilled staff who had kept up to date with current best practice. We identified a number of areas where improvements were required during this inspection and found gaps in staff training in these areas for both new and existing staff. For example, eight staff had not attended initial or update training in infection control, 10 care staff had not undertaken nutrition training, 13 care staff had not attended initial or update pressure area care training and 24 staff had not attended training in dementia.

Staff were not supported to improve the quality of care they delivered through a supervision and appraisal process. For example, 16 staff who had been employed at the service for longer than 12 months had not received their annual appraisal and 9 staff had not received formal one to one supervision. This meant staff were not given the opportunity to discuss areas of practice or identify and discuss their development and training needs. Where care staff had received supervision some viewed this as a disciplinary process rather than a supportive process. For example, one staff member said, "If a bell is not answered within time you get called in for a supervision." Another said, "We have group supervisions but that is telling us what to do."

These issues were a breach of Regulation 23 Health and Social Care 2008 (Regulated Activities) Regulations 2010.

People were not always supported by staff that were knowledgeable about the care they required in relation to preventing a pressure ulcer. Three people had care plans which stated they should sit on specialist pressure relieving cushions because they were at risk of developing pressure ulcers. Although these people had specialist cushions, staff did not always support people to sit on them. For example, one person was sitting for three hours without a cushion. Another person had been sitting on a pressure relieving cushion on a lounge chair. Staff supported them to move to another chair to take part in an activity. Their pressure relieving cushion was placed on the floor. The manager entered the lounge and picked up the cushion from the floor. She asked where the person had been sitting then placed the cushion on that chair. They did not take the cushion to the person for them to sit on. When we asked staff why these people were not sat on cushions we were told one of these people was not at risk and the cushions were not safe to be used on dining room chairs. The dining room chairs were static chairs with armrests. According to the manufacturers instructions the cushions were suitable for use on this type of chair. These people were therefore not protected against the risks of developing a pressure ulcer.

People who had lost weight were not always supported in line with instructions in their care plan. For example, when one person had lost weight they were commenced on a food and fluid chart. An entry was made in their nutrition care plan which stated "at high risk. On food chart for 3 days. To review, re-weigh and inform GP." It had been six weeks since this entry. They had remained on a food and fluid chart but there was no evidence that these had been reviewed. They had not been referred to a GP, there had been no further weights recorded and staff were not able to tell us if any further action had been taken.

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

People told us they enjoyed the food at the home, meals served were of a high quality and there was choice and variety. Mealtimes were a relaxed and sociable event. However, people were not always supported to eat and drink sufficient amounts. For example, one person had a care plan that stated staff should assist them with eating at mealtimes because they had a poor appetite and needed encouragement to eat and drink. A further action was for staff to prompt them throughout mealtimes otherwise they would forget the food was there. This person was served a cooked breakfast and a cup of tea but it was 30 minutes before a staff member assisted them. They left the person after five minutes. The person had only eaten a few forkfuls of food. Although the interaction during the five minutes was very positive the staff member left the person without asking them if they had eaten enough. The person sat in front of their meal for a further 25 minutes before they were assisted to another part of the room to take part in an activity. 20 minutes later they were given a cup of tea and two biscuits. They were not assisted or encouraged by staff and did not eat the biscuits or drink the tea. This person did however eat their lunch because they were supported by staff.

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

Inadequate

Is the service effective?

The interior walls of the building were in the process of being painted and pictures and other items had been purchased to add more interest to the walls. People living on the first floor of the home told us they would like a communal area on that floor. There was a room on the first floor that was called the cinema room. Although it had comfortable chairs for people to use it was not inviting or accessible because it was mostly used for storage purposes. Other communal areas were also used for storage. For example, one person said, “There is a nice summer house but it always seems to be full of storage so it’s not used very much.”

People told us they had regular visits from other healthcare professionals such as, chiropodists, opticians and dentists. People were referred for specialist advice for example, from the district nurse. Professionals told us they were notified promptly of people’s changing needs. Details of any professional visits were documented and included information on outcomes and changes to care if needed.

Staff understood their responsibilities under the Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may be deprived of their liberty for their own safety. Where restrictions were in place for people these had been legally authorised and people were supported in the least restrictive way.

Staff understood their responsibilities under the Mental Capacity Act 2005. Where people had been assessed as lacking capacity we saw that best interest meetings had been held which involved a range of professionals and representatives who knew the person well.

Requires Improvement

Is the service caring?

Our findings

People did not always experience care in a respectful way. For example, some people were sitting in the lounge where music was playing. A staff member entered the lounge with a person and asked them if they wanted the television on. When the person said they did the staff member switched it on. They did not ask the other people if they wanted it on, nor were they given a choice of what to watch. The music was not switched off. This meant that the television was on and the music was playing at the same time. This made it difficult for a person to either listen to the music or to watch the television. At one point the music on the CD player became stuck and repeated the same line of the song for 15 minutes before a member of staff noticed and changed it. There was a care leader in the lounge during this time giving out medicines and three other staff and the manager also walked through the lounge without changing the CD. Later in the morning the adjoining dining area was being used for a game of bingo, the television and music were not switched off. Some people told us they stayed in their rooms because the lounge was "too noisy."

People were not always spoken to in a friendly and respectful way. For example, when one person displayed behaviour that could be described as challenging they were chastised in a way that was not age appropriate.

People's preferences were not always respected. One person did not like to go to bed early. A review of this person's care had identified that this sometimes caused conflict with care staff. Since the care review there had been several entries in the persons care record that showed staff were still trying to encourage the person to go to bed early. For example, one entry stated at 8.45pm "refused to go to bed." Another entry timed at 9.00pm stated "doesn't want to leave the lounge and get ready for bed and got agitated".

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

People told us they liked living at the service and were complimentary about the staff. Comments included, "I'm quite happy here", "I am comfortable and content here and I like my room", "I get on very well with the staff", and staff were "all very kind" and "friendly". One person described staff as thoughtful because they had put festive decorations in their room and remembered their birthday.

People's rooms were arranged how they wanted and staff ensured televisions and other personal items were displayed so they could be seen when people were in bed.

People who had recently arrived at the service, told us staff were caring in their approach to help them settle in. Comments included, "They couldn't have been kinder and there were flowers in our rooms when we arrived." and "so far we love it here and they couldn't have been kinder."

People were assisted with personal care discretely and in ways which upheld and promoted their privacy and dignity. Staff were knowledgeable about how people preferred to be supported in relation to their personal care. For example, if people preferred a bath or a shower or if they preferred a female or male member of staff to support them. People appeared clean, well kempt and were dressed appropriately for the weather. People were asked if they were too warm or cold. One person said they felt chilly and the staff member promptly fetched them a wrap and assisted them to put it on. People were supported at their own pace and staff were gentle and reassuring when supporting people.

People had been involved in decisions about their care and what information could be shared with relatives to ensure they were kept informed of any changes to people's health. People told us their relatives and friends were able to visit whenever they wanted.

People were supported to be independent and were encouraged to do as much for themselves as possible. Some people used equipment to maintain their independence. Staff ensured people had the equipment when they needed it and encouraged people to use it.

Requires Improvement

Is the service responsive?

Our findings

Some people were at risk of receiving inappropriate care because records relating to their care were not accurate. For example, a person who was having a topical cream applied had two application charts in place. One instructed staff to apply the cream from knee to foot, and the other from ankle to waist. Another person had lost some weight but in one part of their care record this amount was recorded as a weight gain. This incorrect weight had then been transcribed onto the monthly weight review that was used by the manager to identify people at risk of becoming malnourished. This put the person at risk as staff had not identified the weight loss nor taken appropriate action.

Some people required their food and fluid intake to be monitored however records were not always completed and did not include enough detail to inform staff if adequate nutrition and hydration had been taken. This meant that records could not be used to determine if people were eating and drinking enough and this information would not be available to inform the care provided by visiting health professionals.

These issues were a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's care plans did not always provide sufficient instruction to staff on how to support people. For example, One person's care record showed they frequently refused daily personal care for periods of up to eight consecutive days. When we discussed this with staff they told us this person was already dressed when they offered assistance but were not sure if they had washed themselves. They did not have an assessment of what they were able to do for themselves or have a plan in place to promote their personal hygiene.

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

People were offered a range of activities. For example, a book club visited the service and games such as bingo were offered. People were also supported to maintain their religious and spiritual needs through a weekly service. Arrangements had also been made for people to attend and take part in activities at a nearby church. People were encouraged and supported to take part in tasks relating to the day to day running of the home. For example, one person told us they enjoyed helping with odd jobs around the home and folded some of the linen. People and staff told us there was no individual activity support offered for those who could not leave their rooms. However, one person told us they had a weekly hand massage and that housekeeping and other staff stopped for a chat when they were passing their room. The manager told us they were recruiting a full time activity coordinator and there were plans in place to improve activity provision. There was also a hairdresser who attended the service every two weeks. One person told us, "The hairdresser is very good and it is a treat to have my hair done."

Before people came to live at the home their needs had been assessed. People and their families confirmed they were involved in the planning and review of their care.

People knew how to make a complaint and the provider had a complaints policy in place. People and their relatives told us when they had raised issues with the manager, these had been resolved. Feedback from people and their relatives about the quality of the service was sought. For example, resident satisfaction surveys had identified the quality of food needed to improve. Meetings were held with the chef to discuss the required actions and weekly sampling and monitoring of the food was carried out by the head of care and manager. People were now happy with the quality of the food

Requires Improvement

Is the service well-led?

Our findings

The provider, manager and other staff carried out a range of quality monitoring to review the care and treatment offered at the home. Where management had identified concerns around some of the issues we found during the inspection for example, people's care plans, issues with topical medicines application and people refusing personal care, actions had been put into place to address them. However, these actions were not always followed and therefore improvements had not been made, sustained or embedded.

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

Care staff were not supported to improve the quality of care they delivered through effective leadership. Care staff were directly supervised by care leaders. However, apart from when they were giving out medicines or assisting at the lunch meal care leaders spent their time in their office engaged in paperwork and liaising with other healthcare professionals. During the afternoon handover care staff were stood outside of the care leader's office for 20 minutes waiting for their handover because care leaders had their own handover first. We asked care leaders why the handover was conducted in this way and they told us there was some information which care staff did not need to know. Carrying out handover in this way meant there was a risk important information about how people should be cared for would be missed. We discussed this with the manager, who was not aware that handover was conducted in this way.

Staff did not see themselves as part of a team. The manager recognised that the culture of the service needed changing however they told us they were finding it difficult to achieve this. The manager did not always demonstrate good leadership skills. For example, they did not identify the issues with the music or pressure relieving cushions during the inspection despite being in the lounge whilst this was happening.

The manager had been in post for eight months and was in the processes of applying for registration with the Care Quality Commission. The manager had recognised that improvements to the service were required and had taken account of people's views through satisfaction surveys and residents and relatives meetings to make some positive changes to the service.

Visiting health professionals told us they had recently seen positive changes in the service that had directly improved the experience for people. For example, in the way staff communicated with them and accompanied them during their visit. They felt staff worked well with them and the management team were open to suggestions of how further improvements could be made.

Any accidents or incidents relating to people who used the service were documented on a standardised form and actions were recorded. These were stored electronically and trends were monitored to identify areas where action was required to keep people safe. For example, an analysis of falls had taken place and it was established there was an increased number of falls whilst staff were taking their breaks. The timings of breaks were changed and reductions of falls at that time were noted.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered person did not take proper steps to ensure people always received care that had been planned or delivered in a way that met their individual needs or which ensured their safety and welfare. Regulation 9 (1) (b) (i) (ii) (iii).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **Effective systems were not in place to monitor the quality of the service delivery. Regulation 10 (1) (a) (b).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **People were not always supported to eat and drink sufficient amounts. Regulation 14 (1) (c).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **Appropriate arrangements were not in place for obtaining and recording of medicines. Regulation 13.**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises People who use 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	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services The registered person did not make suitable arrangements to people were always treated with consideration and respect. Regulation 17 (1) (a), (2) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The registered person had not ensured that service users were protected from the risks of inappropriate care and treatment because an accurate record in respect of services users including appropriate information had not always been kept. Regulation 20(1) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The provider did not take appropriate steps to ensure that, at all times there were sufficient numbers of suitably qualified, skilled and experienced persons employed for the purpose of carrying on the regulated activity In order to safeguard the health, safety and welfare of service users. Regulation 22.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person did not have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard by receiving appropriate training, professional development, supervision and appraisal. Regulation 23 (1) (a).