Care Quality Commission

Elmcroft Care Home Limited

Elmcroft Care Home

Inspection report

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Ratings

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

Overall summary

Elmcroft Care Home provides accommodation, personal care and nursing care for up to 54 people. Some people have dementia, dementia related needs and require nursing care. The service consists of two units: The General Nursing Unit and Blythe Unit.

The unannounced inspection was completed on 28 October 2014 and 29 October 2014 and there were 31 people living in the service when we inspected.

A registered manager was 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 last inspection on 24 June 2014 and 2 July 2014 found that the provider was not meeting the requirements of the law in relation to the care and welfare of people who used the service and records management. They had also failed to ensure there were

Summary of findings

sufficient numbers of staff to meet people's needs and to implement a system to effecitively monitor the quality of the service. An action plan was provided to us by the registered manager on 11 September 2014. This told us of the steps taken and the dates the provider said they would meet the relevant legal requirements. During this inspection we looked to see if improvements had been made and progress sustained.

People did not always feel safe or feel that the care and support provided to them was appropriate to meet their needs. People's needs were not met by sufficient numbers of staff. The latter remained outstanding from our previous inspection to the service in July 2014.

Suitable arrangements to safeguard people against the risk of abuse were not in place. Safeguarding concerns and complaints had not been managed effectively. This remained outstanding from our previous inspection to the service in July 2014.

Staff had not received a comprehensive induction and suitable arrangements were not in place to ensure that staff were appropriately supported in relation to their roles and responsibilities.

Suitable arrangements were in place for supporting people to take their medicines safely.

People were positive about the quality of the meals provided. The dining experience for people within the service was variable and not always positive.

People did not consistently receive a service that was caring or that treated them with respect.

People's care plans did not always reflect current information to guide staff on the most appropriate care people required to meet their individual and assessed needs.

Not all people were supported to participate in meaningful activities to meet their needs.

People and those acting on their behalf did not have confidence that the service was well-led or managed in the best interests of the people living there. An effective and proactive quality monitoring and assurance system was not in place to ensure that the service functioned safely and to an appropriate standard so as to drive improvement. We found that the majority of improvements required from our last inspection in July 2014 remained outstanding and had not been addressed.

The registered manager was up-to-date with recent changes to the law regarding the Deprivation of Liberty Safeguards (DoLS) and at the time of the inspection they were working with the local authority to make sure people's legal rights were being protected.

You can see what actions 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. We found that appropriate steps had not been taken by the provider and registered manager to ensure that there were sufficient numbers of staff available to support people living at the service.

Not all people who used the service and those acting on their behalf told us that the service was a safe place to live.

Safeguarding concerns had not been used as an opportunity for learning and improvement. This meant that people could not be assured that robust procedures for responding to abuse would be followed up promptly, and action taken recorded.

The provider had arrangements in place to manage people's medicines safely.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective. People were not looked after by staff who were trained and supported to carry out their roles and responsibilities.

We found that the dining experience for people across the service was not always positive.

Appropriate assessments had been carried out to assess people's capacity and any deprivations of their liberty.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring. People's comments relating to the quality of care received at the service was variable and several people living at the service and those acting on their behalf told us that the care and support provided was not caring and they were not always treated with kindness.

People and those acting on their behalf told us that they were not involved in making decisions about their care.

People were supported to maintain important relationships. Relatives told us they could visit at any time.

Is the service responsive?

Inadequate

The service was not responsive. We found that people's care plans did not reflect current information to guide staff on the most appropriate care people required to meet their individual and assessed needs.

People told us that staff were not always responsive to their care and support needs.

Summary of findings

Not all people were supported to participate in meaningful activities to meet their needs.

Appropriate steps had not been taken by the provider or registered manager to ensure that people who used the service and those acting on their behalf could be confident that their complaints would be listened to, taken seriously and acted upon.

Is the service well-led?

Inadequate

The service was not well-led. We found that the provider and registered manager had failed to implement a robust quality monitoring system that managed risks and assured the health, welfare and safety of people who received care.

People who used the service and those acting on their behalf told us that they did not have confidence in the management of the service.

Elmcroft 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 inspection took place on 28 October 2014 and 29 October 2014 and was unannounced.

The inspection team consisted of two inspectors, a pharmacist inspector 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 service.

We reviewed the information we held about the service including notifications received from the provider and from contacting the Local Authority. This refers specifically to incidents, events and changes the provider and manager are required to notify us about by law.

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 spoke with 10 people who used the service, three relatives, two qualified nurses, 10 members of care staff, the registered manager and the regional manager.

We reviewed 12 people's care plans and care records. We looked at the service's staff training plan, staff recruitment records, staff induction, staff supervision and appraisal records. We also looked at the service's arrangements for the management of medicines, complaints and compliments information, safeguarding alerts and quality monitoring and audit information.

Inadequate

Is the service safe?

Our findings

At our last inspection of the service in June 2014 and July 2014, we were concerned about staffing provision and the impact this had on staff's ability to meet people's needs on the General Nursing Unit (GNU) and Blythe Unit. We asked the provider to send us an action plan outlining the actions taken to make improvements. The action plan provided no date as to when the provider would achieve compliance.

At this inspection we found that there were areas of improvement needed regarding staffing provision on the GNU and the Blythe unit to meet people's needs safely.

At our previous inspection we raised concerns about the use of the dependency tool the provider had in place. The same dependency tool remained in place and was still being used to assess the service's staffing levels. It provided broad guidance to assess people's level of dependence but did not provide an accurate assessment of people's individual needs. For example, the dependency tool did not take into account the fact that one member of staff spent a considerable amount of time in the kitchen on each shift. In addition it did not consider that some people required assistance with eating and drinking, had difficulty in communicating their needs and required additional support due to high levels of anxiety related to their dementia.

The Local Authority had raised concerns about inadequate provision of nursing cover to meet people's needs. The provider's action plan described the arrangements in place to ensure that nurses were on duty at all times. However, on one occasions the service had not provided adequate nurse cover. This meant that people in need of nursing care were at risk of not having their needs met in a timely manner.

On the day of our inspection we found that the staffing levels on the Blythe Unit were as per their dependency tool. The majority of people on Blythe Unit required two care staff to assist them with their moving and handling needs and to meet their personal care needs.

We found on Blythe Unit that one qualified nurse and three members of staff were allocated to the early shift and in the afternoon this was reduced to one qualified nurse and two members of staff to provide care for nine people. One member of staff was assigned to work in the kitchen to serve people's breakfast and the teatime meals although they were rostered to provide care.

People told us that there were insufficient staff available to meet their needs. One person told us, "Sometimes, they (staff) are rushed. I think they could do with more staff." Another person told us, "They (staff) come eventually; they (staff) are busy with breakfasts."

We spent time in the communal lounge. During our observations there were no staff to support people because all staff were supporting people with personal care in their bedrooms. Two people were very unsteady on their feet. One person got up from their chair and walked about the lounge using their walking frame and calling out for staff to attend to them. We had to intervene and ask the nurse who was undertaking the lunchtime medication round to assist. The care plan for this person recorded that they were at high risk of falls and that they required close monitoring which had not been provided during our observations.

One person told us that on occasions they had had to wait a long time to be helped with personal care and had been left in the bathroom for 30 minutes which had distressed them. Staff told us that care provided to people was rushed particularly if they requested care and support to be provided at the same time. Staff said they supported people in very short timeframes of 10 to 15 minutes with all their personal care needs. Staff told us that if they did not work within these timeframes people would not receive support to get up until lunch time because of the staffing levels.

The provider continued to place people at risk of unsafe care because they were not using effective tools to assess people's needs against staffing levels and there were not enough skilled staff to support people safely. Staff did not have the time to support people safely.

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

People's comments throughout the service were variable. Some people told us they felt safe. One person who used the service told us, "I feel safe and they (staff) are very careful with you." Other people told us they did not feel safe.

Inadequate

Is the service safe?

The staff training plan showed that all staff employed at the service had received safeguarding training. We spoke with 10 members of staff and they were able to demonstrate a good understanding and awareness of the different types of abuse and how to respond appropriately where abuse was suspected.

Since June 2014 there had been 17 safeguarding alerts raised about issues that had caused harm to people, 10 of which were fully or partially substantiated by the Local Authority Safeguarding Team. Five safeguarding investigations remained on-going. The registered manager and provider had failed to ensure that actions highlighted by the Local Authority had been completed or were robust. For example, the actions from one safeguarding investigation stated that the registered manager was required to ensure that a member of staff was to receive appropriate re-training and supervision prior to them commencing care duties unsupervised. This had not taken place and the member of staff was working unsupervised. Through not following the safeguarding team's recommendations the manager had not taken appropriate steps to reduce the risks to people's safety.

Following our observations of poor care practice on the day of our inspection we raised a safeguarding alert with the Local Authority due to our concerns about a person's welfare.

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

We found that the arrangements for the management of medicines were safe. Medicines were stored safely for the protection of people who used the service. Arrangements were in place to record when medicines were received into the service, given to people and disposed of. We looked at the Medication Administration Records (MAR) for 12 of the 31 people who used the service. These were in good order, provided an account of medicines used and demonstrated that people were given their medicines as prescribed. We observed medicines being given to people during lunch time and saw that this was done in line with people's wishes.

However, improvements were required in some areas of medication record keeping. We found that where medicines were given at different times to those on the printed medication record form, the actual time it was given was not recorded. This could result in people being given their medication too close together. Where people were prescribed their medicines on a 'when required' basis, for example, for pain relief, we found, in some cases, there was insufficient guidance for staff on the circumstances these medicines were to be used which meant that people might not receive their prescribed medicines for pain when they needed it. The recording errors were discussed with the registered manager and an assurance was provided by them that the accurate recording required on the MAR forms would be addressed.

Requires Improvement

Is the service effective?

Our findings

Staff told us that they had completed training in a range of topics. They told us that this provided them with the skills and knowledge to undertake their role and responsibilities to meet people's needs. However, we found examples of poor staff practice which indicated a lack of learning from training provided to staff.

For example, one person told us, "They (staff) use the belt (manual handling 'holding belt') on me and some do not know how to use it. A couple of times I have felt unsafe." We observed two members of staff assisting a person to move in a way that was unsafe and put them at risk of harm. The person was observed to look uncomfortable and grimaced when being moved. We spoke with the staff concerned. One staff had not received practical manual handling training and although the other member of staff had received training, they clearly had not put their learning and knowledge into practice.

Although staff told us that they had completed dementia training, when we looked at the training plan provided this showed that only four members of staff on Blythe Unit had completed this. Due to a lack of training and understanding, staff were not sufficiently skilled or confident in engaging with people who had dementia associated needs. For example, staff did not have any understanding of how to engage people living with dementia in a way that would reduce their anxiety.

The provider did not have an effective induction programme in place. Two recently appointed staff members told us that they had only received a couple of days of orientation to the premises and no support or guidance on the needs of people. The newly appointed nurse requested additional training for specific clinical tasks but two months later this had still not been provided. They told us that the induction had not been suitable. Agency staff had not received any induction in regards to how they needed to support people.

Staff told us that they had not received regular supervision or an annual appraisal. Staff told us that supervision was not used to support them to improve their practice and no senior staff had assessed their competency in the role they were employed. The manager confirmed that there were no effective systems in place to assess the effectiveness of training staff received to enable them to deliver care to people safely.

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

Comments about the quality of the meals provided were positive. One person when asked about the quality of the meals provided, told us, "The food, I cannot complain." Another person told us, "The food is not too bad." A third person told us, "The food is pretty good."

Our observations of the breakfast and lunchtime meals showed that the dining experience for people on the General Nursing Unit was positive and flexible to meet people's individual nutritional needs. Where people required support and assistance to eat their meal or to have a drink, staff were observed to provide this with sensitivity and respect. For example, people were not rushed to eat their meal and staff were noted to provide positive comments to encourage individuals to eat and drink well.

On Blythe Unit the mealtime experience was not so positive as staff regularly stopped supporting people with their meals to carry out other tasks. We saw that people were not able to make choices about when they had something to eat and drink. For example, on two occasions during our inspection we saw that where people requested a drink, this was denied, and they were told by staff that they would have to wait until the scheduled drinks round.

The nutritional needs of people were identified and where people who used the service were considered to be at nutritional risk, we found that an appropriate referral to a healthcare professional such as GP, Speech and Language Therapist and/or dietician had been made.

The registered manager and senior staff had a good understanding of Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) legislation. Appropriate assessments had been carried out to assess people's capacity and any deprivations of their liberty. A few staff did not have a full understanding of MCA and DoLS but confirmed that they would refer to senior staff if they had any queries or concerns.

Requires Improvement

Is the service effective?

People told us that their healthcare needs were well managed. People's care records showed that their healthcare needs were clearly recorded and this included evidence of staff interventions and the outcomes of healthcare appointments. Each person was noted to have access to local healthcare services and healthcare professionals so as to maintain their health and wellbeing. For example, to attend hospital appointments and to see their GP.

Requires Improvement

Is the service caring?

Our findings

People did not consistently receive a service that was caring or compassionate. People's comments relating to the quality of care received at the service was variable. One person told us, "Staff are very good. They fix my whiskey four times a day, doctors orders." However, another person told us, "It is a care home but they [staff] are not that caring." They also told us that not all of the staff were kind.

People were not always treated in a respectful way by staff. For example, one person told us that when they wished to use the toilet some staff could get cross with them. Another person told us that there had been an occasion whereby when they had experienced a bout of illness they had used their call alarm to summon staff assistance and had been told by staff that they were not important. Staff did not always interact with people in a dignified way. We observed one member of staff assisting one person with their breakfast between 8.50am and 9.15am. On six occasions they were seen to leave the person and to complete other tasks. One person told us that although staff had responded to their manual handling needs, they advised that they could be left swinging in the air especially when being turned round. They told us, "It is not a nice experience."

One relative told us that staff were slow to attend to their relative's personal care needs and their call alarm was frequently not placed near them so that they could summon assistance. They told us that they had discussed this with the management team and was told that action would be taken but nothing had changed.

We observed some positive interactions. Some staff were observed to demonstrate affection, warmth and compassion for the people they supported. For example, one member of staff was observed to support a person to have a drink. They assisted them to drink at a correct pace without rushing them and talked to them in a calm manner. It was evident from our discussions with staff that they knew the care needs of the people they supported.

We found that there was little evidence to show that people were involved in the planning of their own care and support. Relatives told us that they had never been asked to be involved in the planning of their relative's care and their views were not sought about their relative's care. We asked one person who used the service if they had seen their care plan. They told us, "No, not got one." Following the inspection the provider told us that in June 2014 a written invitation was sent to people's relative to participate in care planning and care file reviews.

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

Inadequate

Is the service responsive?

Our findings

At our last inspection of the service in June 2014 and July 2014, we were concerned that people's individual needs were not being met. We asked the provider to send us an action plan outlining the actions taken to make improvements and they told us that they would do this by 30 September 2014.

At this inspection we found that improvements had not been made and people's needs were not being met. We observed care was task led and did not allow time for staff to deliver care that was personalised.

We looked at the care plans of 12 people and we found that these were not fully reflective of people's care needs. In addition, where a person's needs had changed, the care plan had not always been updated to reflect the new information. For example, for one person their care plan relating to the use of oxygen was inadequate. Information did not include what the oxygen was prescribed for and when it should be used. In addition, the care plan did not include how the oxygen needed to be monitored to ensure that the person it was prescribed for received it as they should. Because of this staff we spoke with did not have a clear understanding of how to ensure that this person received their oxygen as prescribed.

We asked staff how they were made aware of changes in people's needs. They told us that information was shared through handover meetings and from discussions with senior members of staff. Staff told us that they did not always have the time to read people's care records or familiarise themselves with the most up-to-date information. We observed two members of staff assisting a person to move with a handling belt. The care plan for this person stated that they required a hoist for all transfers. The nurse confirmed that this person had not been assessed for the use of a handling belt and that staff should have used a hoist for all manual handling procedures. This demonstrated the risks to people of staff not adhering to the care plan.

Staff told us that six people on the Blythe Unit could become anxious and distressed. The care plans for these people did not consider individual people's reasons for becoming anxious nor steps staff should take to reassure them. We discussed this issue with staff and it was clear that they had very little understanding of how to support people during these times. The care plans did not provide staff with clear guidance about how to support people at these times which meant there was a risk that the person would not receive the care and support they needed.

People on the General Nursing Unit told us that they were able to participate in meaningful activities to meet their needs. One person told us, "I make cards, we had a book and you answer the questions, bingo, nails done yesterday and they trimmed my hair." Another person told us, "My sister and a friend come and I get communion every Friday and anyone else is able to join us." There was evidence of some group activities facilitated by the activities co-ordinator.

We found little evidence that the majority of people on Blythe Unit were supported to enjoy and participate in activities. Staff told us that they found it difficult to engage with some people as a result of their limited communication skills and dementia related needs. The care plans relating to people's hobbies or interests were generic and did not consider people's individual's needs. The majority of these had not been reviewed since January 2014.

On Blythe Unit there was an over reliance by staff on routine and tasks, rather than focussing on people's individual needs. We observed long periods of inactivity where people were either sleeping or disengaged. Other than the two members of staff who provided one-to-one support for two people, staff were observed to be focused solely on tasks, for example, people were only offered drinks at set times and personal care was provided at set times of day, rather than staff concentrating on people's individual needs. People's requests for additional support was declined by staff. For example, requests for drinks outside the arranged times when drinks were provided. People's welfare was not taken into consideration when tasks were undertaken and care was being delivered. Our observations during the two days showed that staff gave more time and attention to those people who were able to verbally communicate with them. People who were more withdrawn and not able to engage easily without a lot of staff input received little verbal interaction and support outside of set tasks.

Inadequate

Is the service responsive?

One person told us that they feared to go to bed at night because not all of the night staff were aware of how to meet their specific care needs. Another person told us of their distress at being assisted with their personal care in an inappropriate way.

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

At our last inspection to the service in June 2014 and July 2014, we were concerned that the complaints process had not always been followed according to the provider's policy and in a timely manner. We asked the provider to send us an action plan outlining the actions taken to make improvements and they told us that they would do this by 30 September 2014.

At this inspection people told us they knew how to complain and staff told us that they knew how to deal with concerns. However, we found that the provider was still failing to fully investigate complaints made by people who used the service or those acting on their behalf. Appropriate steps had not been taken by the provider to ensure that people who used the service and their relatives could be confident that their complaints would be listened to, taken seriously and acted upon. One complainant told us that they had no confidence that the registered manager or senior management team had acted in their relative's best interests when dealing with their complaint. We found that the person's concerns had not been investigated thoroughly and yet the registered manager had already reached their conclusion. For this person it meant that their care needs, that had been raised as a concern had not been reviewed and therefore their needs were not met.

Following another complaint relating to alleged poor care practices, the registered manager had not carried out an effective investigation. Therefore the complainant could not be fully satisfied that their complaint had been investigated and no action had been taken to ensure that this situation would not reoccur.

This is a breach of Regulation 19 of the Health and Social Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service well-led?

Our findings

At our previous inspection in July 2014, we found that the provider did not have an effective system in place to regularly assess and monitor the quality and safety of the service that people received. As a result of a continual breach of this regulation, a warning notice was issued on 4 August 2014 and the provider was required to achieve compliance by 30 September 2014. The majority of improvements the provider and registered manager had told us they would make had not been made.

The majority of comments about the management and leadership were less than favourable. For example, one relative told us, "This home is for residents but they are not being looked after properly. It is despicable, they are not kind enough and everything is done for expediency." Another relative told us, "The management is inadequate and weak." One person who used the service told us, "It is the worst." Overall, people told us that they did not have confidence in the manager to effectively manage the service in their best interests. However, one person told us that the manager was extremely willing.

The registered manager did not communicate a clear sense of direction and leadership. Staff told us that they did not find the registered manager to be effective and that they rarely came out of their office and when they did they found that their communication with them was often discourteous and belittling. For example, calling staff by the wrong name and talking over staff and not allowing them to have a 'voice.' Staff also told us that where they had raised requests for additional training to be provided or for support, the manager had not actioned this. Staff did not feel supported by the registered manager or the organisation. Staff told us this was partly due to the mixed messages they received from both the provider and the registered manager which often left them not knowing which information was correct. Staff told us that they were not encouraged by the senior management team to stop and spend time talking with people living at the service. Staff told us that they were judged by the senior management team to be lazy if they did this.

At this inspection we found that although there were arrangements in place for assessing and monitoring the quality of service provision, these had not highlighted the areas of concern we had identified. We found that the provider and registered manager had failed to implement a robust quality checking system that managed risks and assured the health, welfare and safety of people who received care. For example, the provider did not have an effective system in place to review staffing levels, to demonstrate how they were calculated and how staffing levels were determined. The impact of this on people was that there were insufficient staff to meet people's needs.

The provider had not taken appropriate action following safeguarding investigations to reduce the risk to people's safety. Complaints had not been fully investigated and the outcome of the complaints had not been used to improve the service for people.

The quality assurance system in place did not identify that people's needs were not being met. The provider told us that people's views and those acting on their behalf were sought in June 2014. However, evidence to support this was not available at the time of the inspection. Concerns raised by staff were not listened to or acted upon in order to ensure that people's needs were met. The provider and registered manager failed to have regard to our previous inspection reports and had not responded to our continued concerns.

Overall the provider and registered manager were unable to demonstrate how they intended to comply with the regulations as set out in the Health and Social Care Act 2008.

This demonstrated a continual breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and non-compliance with the warning notice issued on 4 August 2014.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **People who used the service were not protected against the risks of receiving care that met their individual needs and ensured their welfare and safety.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **People who used the service were not safeguarded against the risk of abuse as suitable arrangements were not in place to identify the possibility of abuse and respond appropriately to any allegation of abuse.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **Suitable arrangements were not in place to ensure that people who used the service were treated with respect and dignity.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints **People who used the service did not benefit from a service provider that had robust systems in place to handle, respond and ensure that any complaint is fully investigated and resolved to the satisfaction of the service user and those acting on their behalf.**

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing People who used the service did not have their health, safety and welfare needs met by sufficient numbers of appropriate staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff Arrangements were not in place to deliver care and support safely and to an appropriate standard to people who used the service as staff had not received suitable training, induction, supervision and appraisal.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers People who used the service did not benefit from a service provider that had robust systems in place to monitor and improve the quality of the service that people received.

The enforcement action we took:
We have served a warning notice to be met by 22 February 2015.