Sharda Care Limited

Victoria Care Centre

Inspection Report

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Summary of findings

Overall summary

Victoria Care Centre registered as a new provider with the CQC in January 2014. At the time of our inspection, there were 42 people living at Victoria Care Centre. There were twenty people on the first floor which was an elderly/frail unit and there were twenty two people on the second floor which was a dementia unit but also had some people that were staying there short term on a re-ablement programme before going home. The environment was new and all bedrooms were ensuite. There was a cinema and a coffee shop available for people to use and spend time with their families.

People that we spoke with found staff to be caring and were happy with the care they received. Staff treated people with respect and listened to them.

There was a dedicated activities co-ordinator at the home who was enthusiastic about the services on offer to people living at the home. There were many resources available for activities to take place within the home.

We identified five breaches of regulation during our inspection.

We found that the provider did not have procedures in place for reporting safeguarding concerns.

There was a lack of appropriate training for staff.

People were not always referred to healthcare professionals when their health deteriorated.

There was a lack of staff understanding around restrictive practices.

We found that the provider had failed to notify CQC of certain incidents that had occurred.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that there were two breaches of the relevant legal requirements (Regulation 11 and Regulation 18). The action we have told the provider to take can be found at the back of this report.

Although people that we spoke with told us that they felt safe living at the home, some staff were not clear on safeguarding procedures. There was no safeguarding policy at the home and no flowchart for reporting concerns. No safeguarding training had been provided for staff.

Some of the people living at the home were diagnosed with dementia and lacked the capacity to make decisions related to their care and safety. Staff did not fully understand the requirements of the Mental Capacity Act and what may constitute restrictive practices. There was a lack of clarity amongst staff as to whether people were allowed to leave units that that were secured with a keypad system.

Appropriate staff recruitment checks had been made before staff started employment.

Are services effective?

We found that there was a breach of the relevant legal requirement (Regulation 23 (1) (a). The action we have told the provider to take can be found at the back of this report.

We found that there was a lack of staff training to enable staff to care effectively for people. Staff had not completed training in some specialist areas of care such as end of life care, pressure ulcer care, MCA 2005 and DoLS.

People were assessed prior to their stay at the home and were allocated a named nurse and a keyworker once they began to use the service.

Are services caring?

We observed staff while they cared for people. We saw staff explaining to people what they were doing before moving them. Staff treated people with respect, listened to them and answered their questions calmly. People that we spoke with felt staff listened to them and took their views into consideration.

We found that although the premises were brand new, some aspects of it were not effective for caring for people with dementia.

Summary of findings

All the doors and corridors were uniform and there was nothing to identify individual bedrooms such as photographs or memory prompts. Although corridors were clear of obstacles, there was no personalisation in the units.

Are services responsive to people's needs?

We found that there was a breach of the relevant legal requirement (Regulation9 ((1) (b) (ii). The action we have told the provider to take can be found at the back of this report.

We found that some people did not have their individual needs regularly assessed and met. People's whose health had deteriorated were not cared for appropriately by staff and had not been referred to other healthcare professionals.

The activities co-ordinator was experienced in providing activities for people living with dementia and was enthusiastic in their aims for the service. There was a mixture of individual and group activities and activities that were sensitive to people's cultural needs.

People using the service told us they knew how to complain if they had concerns and that they felt listened to.

Are services well-led?

We found that there was a breach of the relevant legal requirement (Regulation 18 (2) (a) (ii). The action we have told the provider to take can be found at the back of this report.

There was a registered manager in post at the time of our inspection, however we found that the commission had not received statutory notifications at the time of our inspection.

Since the service had opened, there been a number of changes in senior staff which had an impact on the running of the service.

The provider monitored the quality of service through staff meetings and a number audits.

We found that there were enough staff to meet people's needs.

Summary of findings

What people who use the service and those that matter to them say

People that we spoke with told us that they felt safe living at the home. One person said "I like it here I can't ask for much else, it is very safe in my room and in the lounge." Other comments included "I like the carers, they come and chat to me and I always feel safe" and "I feel ever so safe here because they are people to look after me, all the time."

People told us that they were treated with kindness and compassion and that their dignity was respected. Some of the comments from people included "the staff are very caring, and they are polite", '"they are very caring and treat everybody as an individual", "the carers ask for permission all the time, they really care for me here" and "the carers are good, they treat me with respect and dignity that I deserve and when I call for help, they always are there even in the night."

Relatives also echoed the fact that staff spoke with people as individuals and cared for their wellbeing and were happy with the care provided at the home. "Fantastic", "exceptional", "staff are great", "consistent" and "cannot fault them" were some of the comments that we heard from people regarding their care. One relative told us they visited at different times of the day and the care they saw was "consistent". Staff told us "we help to rehabilitate people that are here for a short while", "we try and make their stay comfortable."

One person told us "the carers are always making light banter with me and treating me nicely". Another said "the carers always listen to me, I tell them stories about my past" and "the manager comes to me twice in a day, he is a great guy." Relatives also told us that when they came to visit staff always took time to speak with them. One relative told us "we visit regularly and the nurse or manager always keeps us updated."

Everyone that we spoke with told us staff always involved in their day to day care. They told us that care workers always asked what and how they wanted things done and always used phrases like "would you like". One relative said, "carers always ask mum politely before any procedure." During our observations at lunch, people told us the care workers always asked them what they liked and whether they were happy before they proceeded with providing support. Comments from staff that we overheard included " what drink would you like", "do want me to give you a hand" and "would you like help with that."

Victoria Care Centre

Detailed findings

Background to this inspection

We visited the home on 12 and 13 May 2014. The inspection team consisted of an inspector and an Expert by Experience (Ex by Ex) who had experience of using adult social care services. 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 regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1.

Victoria Care Centre registered as a new provider with the CQC in January 2014. This was its first inspection since it registered. Before our inspection we reviewed the information we held about the home. At the time of our inspection, there were 42 people living at the service.

We spent time observing people in various areas of the home including the dining room and lounge areas. We were shown around the building and saw people's bedrooms, bathrooms as well as the living, dining and communal areas. We also spent time looking at records, which included people's care records, and records relating to the management of the home. On the day we visited we spoke with twenty people who were using the service. We also spoke with five relatives and ten staff.

During the inspection visit we looked at five care plans, four staff files, training records, audits and some of the home's policies and procedures. Following our visit, we reviewed information given to us by the provider on the day of the inspection.

Are services safe?

Our findings

We found that there were two breaches of the relevant legal requirement (Regulation 11 and Regulation 18). The action we have told the provider to take can be found at the back of this report.

People that we spoke with told us that they felt safe living at the home. One person said "I like it here I can't ask for much else, it is very safe in my room and in the lounge." Other comments included "I like the carers, they come and chat to me and I always feel safe" and "I feel ever so safe here because there are people to look after me, all the time."

We asked staff about safeguarding training and procedures for reporting safeguarding concerns. One staff told us "I had training in safeguarding adults in my previous job but not here". They told us that "safeguarding is keeping people safe", "making sure people have the equipment they need." Some staff that we spoke with were not clear on safeguarding procedures and who to contact if they had concerns apart from the manager. There was no safeguarding policy at the home and no flowchart for reporting concerns. We noted that safeguarding procedures were not covered in either of the induction packs that we saw. Although, the manager told us "the previous manager did cover Safeguarding of Vulnerable Adults (SOVA) and Mental Capacity Act (MCA)", the training matrix for the home showed that there was no safeguarding training provided for staff. They told us they were planning on booking safeguarding training with Brent Social Services in the future but did not have any confirmed dates for this. We found that incidents that had occurred at the home that should have been reported to the local authority as a safeguarding alert had not been raised.

Staff that we spoke with told us they did not receive training in the Mental Capacity Act 2005 (MCA 2005) or Deprivation of Liberty Safeguards (DoLS). Staff did not fully understand the requirements of the MCA 2005, its main Codes of Practice and DoLS and what may have constituted a restriction of people's liberty. We saw that there was a keypad entry to both units and also the lift. One staff told us "this unit has a mixture of people, some respite, some long term and some with a diagnosis of vascular dementia." Other staff told us "some people are OK to leave, others are not." There was a lack of clarity amongst staff as to which people were allowed to leave the unit independently. The manager told us that people needed to speak with staff if they wanted to leave, and told us this was "purely for their safety and fire safety." There was no formal recording in place to tell staff which people were safe to leave the units by themselves or with staff support.

All care plans and risk assessment at the home were computerised. The registered manager carried out a pre-admission assessment in which eleven different aspects of support were considered, including communication, skin integrity, personal safety and mobility, breathing and medication. Once people had been admitted, individual risk assessments in night care, moving and handling, continence, FRASE (a risk assessment tool for falls), waterlow (risk assessment for pressure ulcers), nutrition and bed rails were carried out by a nurse. The services manager told us that people were risk assessed and appropriate fire evacuation procedures were carried out for each person. We saw records corresponding to this. We also saw that appropriate checks on the hoists were carried out to ensure they were safe for people to use.

On the second floor, there were six staff on duty at the time of our inspection, one nurse and five care workers. We observed staff on the day of the inspection, they attended to people using the service in small groups or individually. Staff that we spoke with felt that staff levels were adequate and they told us that if they were short, management always arranged for cover. The manager said "there is always on nurse on each floor at each shift." People who used the service told us "I think we have enough staff, they always come to help me with my personal care; no, they do not rush me." One visitor said they had noticed some people sat alone in the lounge a number of times, however, our observation was that there were always one or 2 staff available.

We spoke with the registered manager and staff about their recruitment and induction procedures. One staff told us they completed an application form, a Disclosure Barring service (DBS), check and was interviewed by the registered manager before starting. They told us they had to provide original copies of their passport and proof of address. Staff told us their induction "was good, no problem" and "I had a rigorous interview."

We looked at four staff files. The provider had carried out appropriate checks on staff before they started employment. These included applicants submitting an application form and attending an interview. Applicants

Are services safe?

were required to provide proof of eligibility to work, appropriate identity and written references. The provider kept an accurate personnel audit file which confirmed that all pre-employment identification and eligibility checks were complete.

Are services effective?

(for example, treatment is effective)

Our findings

We found that there was a breach of the relevant legal requirement (Regulation 23 (1) (a). The action we have told the provider to take can be found at the back of this report.

Staff completed mandatory training when they first started employment with the service. This consisted of basic fire training, manual handling, health and safety awareness, food hygiene, first aid and infection control. The training matrix that we saw showed that the majority of mandatory training had been completed by staff. We saw that there were gaps in infection control training; however the provider had taken steps to resolve this and we saw that infection control training had been booked for the 27 May 2014.

We asked staff about the ongoing training they had received; they all said that they had completed mandatory training but not in some specialist areas of care such as End Of Life (EOL) care, skin integrity and pressure ulcer care. Comments from staff included, "I have not had training in dealing with challenging behaviour, but I have done mandatory training" and "I did mandatory training first, infection control and fire safety but I did not do dementia training." Other staff told us they had "no training in MCA or DoLS" whilst they were in employment of the service. The lack of training was an area of concern that had been noted from people that had contacted CQC prior to the inspection. Recent investigations following serious incidents at the home highlighted a lack of staff knowledge and training on pressure ulcer care as one of the contributing factors to the cause of the incidents.

Staff told us there was one person on palliative (end of life) care. We saw evidence that referrals had been made to specialist palliative nurses and they had come to the home to support this person. We also saw evidence that a referral to Health Authority had been made because their funding had changed. This person's care plan had no care plans based on their palliative needs, although their daily records and risk assessments were complete. Some staff told us that they were not aware that this person was on palliative care, one staff said "no one told me she is on end of life care but she has had Macmillan nurses come in." Staff had not received training in end of life care during their time at the home. We found that there was a lack of staff understanding around supporting people on EOL care.

Some people were staying at Victoria Care Centre as 're-ablement', for a short while before going home. Staff told us about how they supported these people in their recovery. They told us they worked together with Occupational Therapists (OT) in supporting people. Staff told us "our job is to make people more independent, so they are ready to go home", "we have OT's coming in do assessments such as kitchen and personal care and we feed into that", "we speak with families during assessments" and "OT's come in and give us exercise sheets so we can do exercises with them."

Everyone that we spoke with told us staff always involved in their day to day care. They told us that care workers always asked what and how they wanted things done and always used phrases like "would you like". One relative said, "carers always ask mum politely before any procedure." During our observations at lunch, people told us the care workers always asked them what they liked and whether they were happy before they proceeded with providing support. Comments from staff that we overheard included " what drink would you like", "do want me to give you a hand" and "would you like help with that." Staff told us "families are involved in their care, they can tell you preferences which helps when reviewing care plans."

People were allocated a named nurse and a keyworker when they came to live at the home. They were registered with a GP, and a nurse would complete a risk assessment and generate a care plan, usually within 72 hours of admission. A care worker carried out a body check, weight and vital signs. Care plans were computerised and reviewed monthly. Other care records were kept in individual folders in the nurse's office on each floor. These included a daily care record, in which staff recorded fluid intake, food continuation and bowel movement. There was also a two hour comfort round check and a falls avoidance tool. These had been completed by staff. A care worker told us "the nurses update the care plans, we complete the daily checks and look after the residents." The manager showed us the care records system and we saw that when a care plan was due for review an alert would be generated.

Are services caring?

Our findings

People told us that they were treated with kindness and compassion and that their dignity was respected. Some of the comments from people included "staff are very caring, and they are polite", '"they are very caring and treat everybody as an individual", "the carers ask for permission all the time, they really care for me here" and "the carers are good, they treat me with respect and dignity that I deserve and when I call for help, they always are there even in the night."

Relatives also said staff spoke with people as individuals and cared for their wellbeing. They were happy with the care provided at the home. "Fantastic", "exceptional", "staff are great", "consistent" and "cannot fault them" were some of the comments that we heard from people regarding their care. One relative told us they visited at different times of the day and the care they saw was "consistent". Staff told us "we help to rehabilitate people that are here for a short while", "we try and make their stay comfortable."

We observed staff whilst they cared for people. We saw staff explaining to people what they were doing before moving them. Staff treated people with respect. In one example, we saw staff attending to one person who was calling for them, they listened to them and answered their questions calmly. Another care worker supported a person when they tried to get up from their chair. We observed a care worker supporting a person during lunch who was very restless in his room, the care worker was very patient and kept talking to the person. When the person requested another blanket, they arranged it with the laundry staff. One staff told us "it's their home." Other staff told us "we give people choice on everyday matters like what they would like to wear" and "you have to give people options, close the door, ask them what they would like to wear, give them a chance to decide."

The manager told us they had recently introduced some new ideas for staff to promote respectful behaviour and positive attitudes. Examples included a designated 'butterfly time' at a set time each day. The manager explained that this was a protected time in which "the whole building stops, including domestic, kitchen and laundry staff and all the staff have to go and visit one resident and speak to them for 15 minutes." They had also started a 'resident of the day' scheme, where every day one person who was the resident of the day would have all their care plans and risk assessments reviewed, they would be visited by staff, whether carers, activities staff, kitchen staff so that their care could be personalised their care and provide an environment for them to enjoy as much stimulation as possible. Staff would also contact their family at the end of the day and invite them to any upcoming reviews.

The ground floor of the home was a lobby area which contained a cinema, a hair dressing salon which was open four days a week, a bar/bistro and an empty unit which the manager planned to open as a convenience store. The manager told us that the amenities available on the ground floor were commissioned to be used by people who used the service and their families as they wanted to encourage people and their relatives to use it as much as possible. To aid this, the prices were kept at a minimum and "not for profit." All bedrooms were en-suite and were furnished and decorated to a good standard. People were able to personalise their rooms and we were told that internet connectivity was available throughout the building. There were two dining rooms and two lounges on each floor. One lounge had a TV and there was a second, 'quiet lounge'. There was a dedicated library on the first floor and an enclosed outside space.

We found that although the premises were brand new, the environment was not an effective environment for caring for people with dementia. All the doors and corridors were uniform and there was nothing to identify individual bedrooms such as photographs or memory prompts. Although corridors were clear of obstacles, there was no personalisation in the units. For people on the second floor, including people with a diagnosis of dementia there was no free access to an outdoor space without compromising their safety or having to wait for staff to take them outside. We also noted that all the staff wore the same uniform which made it difficult to identify who staff were; some people told us they did not know the difference between nursing staff and care workers. There was no staff identification board for people to familiarise themselves with staff. The manager told us they planned to introduce specific uniform for staff to identify them.

People that we spoke with felt staff listened to them and took their views into consideration. One person told us "the carers are always making light banter with me and treating me nicely". Another said "the carers always listen to me, I tell them stories about my past" and "the manager comes

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to me twice in a day, he is a great guy." Relatives also told us that when they came to visit staff always took time to speak with them. One relative told us "we visit regularly and the nurse or manager always keeps us updated."

We saw minutes of residents meetings that had been held on the 06 April 2014 and 30 April 2014. Although attendance was relatively low, with only five people in attendance, we saw from the minutes that the meeting was an open forum and residents were encouraged to raise any concerns and provide feedback, whether good or bad.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We found that there was a breach of the relevant legal requirement (Regulation9 ((1) (b) (ii). The action we have told the provider to take can be found at the back of this report.

We found that some people did not have their individual needs regularly assessed and met. A GP visited the service twice a week. People were given the choice to remain with their own GP or transfer to the visiting GP. The manager told us they had access to other healthcare professionals such as the speech and language therapist, physiotherapists and the dietician if required. At the time of our inspection, there were eight people with pressure ulcers; three had developed them during their stay at the home and five people were admitted with pressure ulcers. We looked at two of the investigations that had taken place as a result of some people whose pressure sores had deteriorated during their stay. We noted that there were common themes that arose from these incidents, which included a delay in writing up the care plans, staff not following the care plans with regards to the frequency of changing the wound dressing, wound evaluation charts not being completed properly and turning charts not being used. In safeguarding referrals related to pressure ulcers which had been substantiated, it was noted that people had not been managed appropriately by nursing staff and no referrals had been made to a GP or a tissue viability nurse (TVN).

We spoke with the activities manager at the home. They were experienced in providing activities for people living with dementia. They showed us examples of work they had completed in their previous employment and also their plans for the Victoria Care Centre. They were enthusiastic in their aims for the service and wanting to involve all staff in the service. They told us were responsible for planning the activities for all the people who used the service and they incorporated group activities in additional to allocated one-to-one time with each person. We looked at the activities timetable at the home and saw that between 09:30 and 10:30 every morning, the activities co-ordinator did a morning round "getting to know people." They told us "people that don't get involved in group activities are allocated 1:1 time." Support was available for people with religious or cultural needs, staff told us "there is space for a multi-faith room", and "we have Asian films available in the cinema". Wembley Christian fellowship also visited the home every month.

During the first week of their stay, people had a choices assessment and a social & leisure care plan developed. The activities co-ordinator told us "people are shown flash cards to help them choose the type of activities they would like." The social and leisure care plan considered what type of activities they enjoyed, whether they enjoyed group or one-to-one activities and if they had any religious or cultural activities that they wanted to take part in. Each person had an activities record in which staff recorded what activity, if any, people attended on daily basis. They told us "I make sure I have close links with family" and "if there is anything they are not happy with they can come and see me."

We saw that the provider had made numerous resources available for staff to carry out activities but we did not see care workers taking an active part in delivering the activities to people. The activities co-ordinator told us "I struggle with numbers" and "we don't get much support with 1:1 time with people". One person told us "I prefer being in my room because sometimes I prefer not to chat, I join the activities sometimes though." The activities manager highlighted that although many resources were available to care workers to start activities, they needed a lot of encouragement in this aspect. We noted during the inspection that, apart from the activities co-ordinator not many of the staff took charge of activities.

We looked at the complaints, concerns and compliments folder during the inspection. We saw that there had been one formal complaint that was recorded. The complaint had been acknowledged and a formal response was being prepared. The manager told us that any formal complaints that were not resolved to the satisfaction of the complainant would go to the directors.

People using the service told us they knew how to complain if they had concerns. One person said "no I do not complain, there is nothing to complain about, when I ask for something, I get it", another said "staff are very good, can't complain." Relatives told us "the manager is always around, we know we can speak with him if we are worried."

Are services well-led?

Our findings

We found that there was a breach of the relevant legal requirement (Regulation 18 (2) (a) (ii). The action we have told the provider to take can be found at the back of this report.

There was a registered manager in post at the time of our inspection. The provider had failed to notify the commission of some serious injuries that had occurred at the home. There had been two incidents were people had developed pressure sores of grade 3 or above whilst at the home, the commission had not received a statutory notification of these injuries at the time of our inspection.

The service had been open in January 2014 and there had been a number of changes in senior staff since that time which had an impact on the service. There had been two registered managers and changes to the clinical care manager. At the time of our inspection, there were supposed to be two clinical care managers who worked with the registered manager, however one left and one was on long term sick. This did not allow the registered manager to delegate certain areas of responsibly and relieve some pressure off their workload. Investigations following the development of a pressure sore for two people who used the service highlighted that there was deterioration in people's condition while the manager was away on holiday and the senior staff on duty had not followed correct procedures.

People that we spoke with told us "the manager is a good manager he cares for everyone", "I know that if I need anything I can ask sister or the manager, they are lovely" and "he makes it a point to come and greet everyone." The manager told us that due to a lack of senior staff, including a clinical care manager he felt he had to be visible on the floors and supervising people but acknowledged that he would take a step back once senior positions had been filled. They also acknowledge that because the home had been only been open for a relatively short time, it had been a challenge to bring a stable team together. The registered manager told us "gelling the team has been the biggest challenge; we had a change of manager and change of staff which has impacted on morale somewhat."

Although staff told us they enjoyed working at the home, some expressed reservation as to the management style of the manager. Some of the positive comments from staff were "it's lovely, enjoy it (working here)", "he is approachable, listens to problems" and "we had a few changes in staff but the team is good". Other comments were "he (the manager) shadows a lot, it can be overbearing at times", "he (the manager) is always on the floor" and "sometimes it is difficult with him looking over you, the nurses are there so we can ask them."

We spoke with the manager about the improvements they had implemented since they started and also how they monitored the quality of service. Staff allocation sheets were introduced so that care workers were assigned to certain rooms. The manager told us "their job is to look after people, complete their daily record, and make sure their personal care needs are met." Staff told us "we allocate care workers every morning." Allocation sheets were on display in the clinical rooms on each floor.

One person told us "this place is well run, the manger knows what he is doing and the nurse is great." There were a number of audits completed at the home. The manager had started a home audit and we saw a personnel audit file for pre-employment checks. We saw a medication audit which had been completed by the clinical care manager in March 2014. The services manager had completed a kitchen audit in March and May 2015. A health and safety audit had been completed in March 2014.

Various checks were completed throughout the home, these included monthly checks on each room, water temperature checks on basins, emergency lighting and fire doors. Two weekly checks were carried out on the shower room and vacant rooms were flushed weekly to protect against the risk of legionella. Appropriate fire safety checks were carried out, we saw a report from external contractor in which the fire alarm and emergency lighting had been checked in April 2014.

We saw a care assessor review that had been carried out by a social worker and saw positive comments related to four people that had been reviewed. There had just been some minor issues raised regarding the Wi-Fi connection which had been rectified.

We found that there were enough staff to meet people's needs. Staff told us that staffing levels were adequate. We looked at the staff rota and saw that there were eight care workers on during the day and on other days there were nine. The manager told us "we work on dependency rather than ratio so we allocate more care workers where there is

Are services well-led?

a greater need." There were three RMN's employed by the service and there was always one RMN on duty during the day and at night. Staff told us that support within the team was very good, one staff said "the carer workers are very helpful", another said "if one care worker is on a break, the others will cover" and "sometimes night staff help out with personal care in the morning."

We looked at the complaints and incidents folder. We saw evidence that complaints and concerns that had been raised by people using the service and staff had been responded to. Where a staff member had raised concerns a meeting had been held to discuss the concerns. Although incidents were recorded, issues identified and actions noted we found that some of the actions were general and not assigned for a particular person. This could make it difficult for the provider when following these up.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them.

Regulated activity	Regulation
	Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The registered person did not take proper steps to ensure people were protected against the risks of receiving care and treatment that was inappropriate, by planning and delivery of care and treatment that ensured the welfare and safety people who used the service.

Regulated activity	Regulation
	Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The registered person did not have suitable arrangements to ensure that people using the service are safeguarded against the risk of abuse by means of taking reasonable steps to identify the possibility of abuse and preventing it before it occurs.

Regulated activity	Regulation
	Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

Compliance actions

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 were appropriately supported in relation to their responsibilities by receiving appropriate training and professional development.

Regulated activity	Regulation
	Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. The registered person did not notify the Commission without delay of incidents which occurred whilst services are being provided in the carrying on of a regulated activity, or as a consequence of the carrying on of a regulated activity.