Care Quality Commission

Subhir Sen Lochun

High Dene

Inspection report

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Suffolk
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Ratings

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

Overall summary

We inspected on 26 January 2015. High Dene provides accommodation and personal care for up to 15 older people who require 24 hour support and care. Most people using the service were living with dementia. There were 14 people using the service when we visited. At our last inspection on 12 June 2014, we asked the provider to take action to make improvements in protecting the care and welfare of people, respecting and involving people, records and assessing and monitoring the quality of the service. The provider wrote to us to tell us how they had implemented these improvements. During this inspection we found that there was need for further improvement and we had identified further issues which needed action.

The service is not required to have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for

Summary of findings

meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Overall responsibility and accountability for the service lies with the provider, who owns the service.

The provider did not have in place a robust system to ensure that the staffing level was appropriate to the needs of people using the service. People, their relatives and health professionals raised concerns about low staffing levels and how this impacted on people's needs being met.

The provider did not have in place a robust system to ensure that new care staff were of suitable background and character for the role. Appropriate checks had not been made before staff started work to ensure that they were safe to work with vulnerable people, and this put people at risk of harm.

People were put at risk because staff had not received sufficient training to carry out their caring duties safely. Staff were unable to explain how they would safely reposition someone, and were unaware of their responsibilities with regard to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLs). This put peope at risk of physical harm and at risk of having their liberties unlawfully restricted.

People's welfare was compromised because staff did not demonstrate a good knowledge of the people they were caring for and interactions observed between staff and people using the service were not always caring and caused distress to people. Staff did not know enough about people to engage them in appropriate meaningful activity, and this led to some people to become bored and distressed.

People were put at the potential risk of receiving unsafe or inappropriate care because their care plans did not contain specific and individualised information about how their needs should be met.

People's health, welfare and safety were compromised because the provider did not have in place a robust quality assurance process that independently identified issues in service provision and potential risks to people. People did not feel listened to because views they expressed did not lead to the provider implementing changes.

People and their relatives told us they felt safe living at the service and staff were aware of their responsibilities with regard to protecting people from abuse. The provider carried out appropriate investigations when concerns were raised.

People received their medications when they needed them and medications were stored and administered safely.

People and their relatives were involved in the planning of their care, and signed their care documents to indicate their involvement.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

This service was not safe.

There were not enough staff to meet people's needs.

The service did not carry out adequate background checks to ensure the suitability of new care staff.

People received their medications when they needed them, and medicines were stored and administered safely.

Is the service effective?

Inadequate

The service was not effective.

Care records relating to nutrition and contact with other professionals were poor and did not reflect people's current needs.

Despite receiving training, staff did not demonstrate an understanding of the needs of the people they provided care for. This included dementia care.

Staff did not have sufficient knowledge of people's nutritional support needs.

Is the service caring?

Inadequate

The service was not caring.

Staff interactions with people were not always caring, and staff did not always respond to people's needs for emotional and social support.

People's privacy and dignity was not promoted and respected.

Is the service responsive?

Inadequate

The service was not responsive.

People were not engaged in meaningful activity or supported to enjoy hobbies and interests.

Care was task focused and not personalised to the individual.

Complaints and concerns which were raised with the service were not used as a way to improve upon the service provided to people.

Is the service well-led?

Inadequate

The service was not well led.

Quality assurance process in place was not extensive or robust enough to identify issues in the service and risks to people.

People did not feel listened to, as their views and feedback were not acted on by the provider.

The provider did not encourage a positive, open, transparent and proactive culture focussed on continual improvement the service provided to people.

High Dene

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 26 January 2015 and was unannounced. The inspection team consisted of one inspector and one 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 the inspection, the provider completed 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 spoke with four people who were able to express their views verbally and four 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 spoke with three health and social care professionals about their views of the care provided.

We looked at the care records for seven people. We spoke with three members of care staff, the cook, and the manager. We looked at records relating to the management of the service, staff personnel and training records, and the systems in place for monitoring the quality of the service.

Inadequate

Is the service safe?

Our findings

There were not enough staff available to keep people safe. One person said “There’s never enough staff. They are hardly ever around.” Another commented “Staff? What staff? You barely see any there’s so little of them.” This meant that some risks to individual's were not appropriately managed so that people were protected and received safe care. We observed two people using the service between 9.00am and 4.30pm. They had no way to call for staff assistance despite being identified as needing a high level of emotional and physical support from staff. One person continually called out, "I can’t be here. I’ve got no money, I’ve got no friends. I can’t be here."

We had to intervene and provide emotional support to ease their distress because there were no staff available. On another occasion, we had to intervene to protect someone from the risk of falling because staff were not close by. This person was highlighted as being at risk of falling. However, we observed that staff were not following this risk assessment, which stated the staff should monitor the person to ensure they did not mobilise unaided. Relatives also felt there were not enough staff. One told us, “The thing I could fault is the number of staff, sometimes there just aren’t enough.” Another relative commented “The staff really try but you can see they’re rushed. They don’t have the time to spend with people.”

The manager of the service told us that they could not raise the staffing level due to budgetary restrictions which were out of their control. This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were placed at risk of potential harm because sufficient checks were not conducted on care staff who had recently come to the UK from outside of the European Union. The provider had not checked that the applicant did not have criminal convictions obtained in their country of origin. Professional references had not been obtained for care staff before they began work to ensure they had the appropriate background for the role. For example, one staff member had been employed on the basis of one reference from a friend who stated they had known the person for six months. Applicants were not asked to provide a full employment or education history, and were not asked to explain gaps in employment or education. The manager did not acknowledge that these recruitment practices could put people at risk of potential harm as the backgrounds and skills of staff had not been fully explored. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were unable to tell us about the care they provided for a person who had a catheter, such as how often they needed to change the catheter bag or what the signs of urinary tract infections were. This information was also not included in the persons care plan. An assessment identified another person as at risk of pressure ulcers because they remained in their chair at all times. Their care plan did not document what pressure relieving equipment they required or how staff should support them to maintain their skin integrity when seated in their chair for long periods of time. Staff could not tell us this information.

There were no formal contingency plans in place to inform staff of what they should do in the event of an emergency, such as a power cut or what steps would be taken by the manager if all the staff were unable to get to work. Staff could not tell us what they would do in the event of an emergency, such as a fire, and this put people at risk.

There was no system in place to monitor and analyse accidents, incidents, pressure ulcers, falls, safeguarding's and whistleblowing concerns. This meant that the manager could not identify any themes and take action to address these and protect people from harm. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

One person told us "I feel very safe here.” Another said "It is a safe place to be, I don’t feel threatened.” One relative told us “They’re safe for sure. I wouldn’t have them here if they weren’t.” Another said “I know there’s nothing to worry about. They’ll always be safe here.”

Staff demonstrated knowledge of their responsibilities to keep people safe and protect them from harm. We saw that investigations were carried out when concerns were raised, and that action plans were completed and signed off as appropriate.

We found that medications were administered and stored safely, and people received their medication when they needed it. People told us that they felt supported by staff to take their medications, one commented “I do get my medications when I need them, they always make sure of it.” Another said “They’re very helpful in reminding me to take them.”

Inadequate

Is the service effective?

Our findings

People were not supported by care staff who always have the skills, competence and support to ensure their needs were met consistently. Care staff did receive training in key competencies relating to their role, but received no extra training to further develop their skills and experience to help them in their job. Staff were unable to demonstrate a working knowledge of subjects they had received training in, such as dementia, the Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLs) and moving and handling. The provider did not have links to organisations which could provide up to date and sector specific training which reflected best practice. Kitchen staff had undertaken duties prior to having the appropriate training in food hygiene and food preparation, and this had led to mistakes in paperwork which were identified by the Food Standards Agency (FSA). Staff we spoke with told us they thought the training they received was sufficient. However, when we asked staff to tell us how they would safely reposition someone in bed, the method they described did not include the use of appropriate equipment and could put the person at the risk of potential harm. In addition we saw that staff did not understand how dementia effected those they cared for, including how to reduce their anxiety. Health professionals felt that staff were poorly trained and said that they had observed staff carrying out unsafe moving and handling techniques on a number of occasions, which put people at risk of harm.

Staff were not assessed for their competency at work and there were no observations of their performance carried out to ensure the quality and safety of the care they delivered to people. This meant that the provider had not independently identified shortfalls in staff practice. There was no structured supervision or appraisal of staff to help identify their training needs. We saw that some training completed in MCA and DoLS was ineffective because it was not being used to inform practice. For example, staff couldn't tell us what their responsibilities were in protecting people from the risk of having their freedom restricted and upholding their rights. This was a breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were able to choose what they wanted to eat at meal times from a menu, but did not have the opportunity to request meals not offered on the menu. One person told us, "I've been asking for bacon and eggs for weeks, but I still haven't got it." People's nutritional needs were assessed by the manager and their weight monitored for changes, but this information did not feed into a plan of care to inform staff on how to meet their needs. For example, we observed that one person required a plate guard and spoon to eat independently, but this was not documented in their care plan. We were told another person required a food supplement, but their care plan did not document the need for a food supplement. Care staff who supported these people to eat their meals were unable to tell us this information, and this put people at risk of receiving inappropriate or unsafe care and support.

Where care planning stated people needed to be offered regular snacks and drinks, we observed that this did not always happen. One person had the same drink for five hours, despite telling staff on a number of occasions they didn't like the drink. A member of staff got them a hot drink, but did not support them to drink it and it was still in front of the person three hours later. Another person did not have a drink offered to them all day except during the lunch time meal, even when a staff member got a drink for the person seated opposite them. The care plans for both these people stated they needed support to maintain good hydration, and should be offered drinks hourly throughout the day. A care plan and nutritional assessment also stated that they needed to be offered snacks regularly between meals to boost their nutritional intake, because they were unable to verbally request these. We observed that they were not offered anything else to eat in between meals for seven hours. Weight records showed that these people had not recently lost weight, but there was a potential risk that their nutritional needs may not be met by staff. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Three health professionals told us that the service did obtain advice from them but that the management did not communicate well with other agencies, and often disagreed with their professional opinion. It was not clear from care records when or how people were referred to other health professionals. Care staff we spoke with were not clear on when it was appropriate to make referrals to other health professionals, and said that they would usually wait for the manager to do this. They said that if the manager was not working, they would wait until they were back at work to raise concerns about a persons welfare.

Inadequate

Is the service effective?

This left people at risk of harm as a result of not having timely access to support from other health professionals. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's capacity to make decisions had not been assessed and guidance was not available to staff on supporting people who may lack capacity. Staff were not clear on how they would obtain consent from people who lacked capacity, and we observed incidences where staff made decisions on the behalf of people without acting in accordance with the MCA. For example, we were told by staff that one person did not have capacity to choose their meals, so staff chose these for them. Staff could not tell us what the person liked and disliked, and told us they had not asked the relatives what the person liked to eat. There was no care plan or MCA assessment in place for this person, so it was unclear how staff knew that the person could not make this decision for themselves. Staff could not tell us about these safeguards in place to protect people's freedoms or how they affected the people they cared for. They did not understand what would constitute a restriction of someone's liberty. This put people at risk of having their liberty and rights restricted.

Inadequate

Is the service caring?

Our findings

We observed that the interactions between staff and people were not always caring, and did not always meet their social and emotional needs. For example, we observed two people seated in the dining area of the service and observed incidences where they were ignored by staff, and did not have their emotional needs fulfilled. Care plans for both these people stated that staff should interact with them as they were at risk of social isolation. On three occasions, we observed staff members ignoring people when they were trying to attract their attention or interact with them, and we saw that this led to both people becoming upset and distressed. On another occasion one person threw a book on the floor, and a staff member picked it up and gave it back to them. The person commented "I don't like this one" and the staff member told them to "Look at it anyway" and then left the room. We observed a staff member look through the crack in the open door rather than come into the room and interact with the people. One person was crying and whilst staff acknowledged this they did not attempt to give them emotional support.

Care staff could not tell us information about the people they cared for, such as their interests, hobbies and their life history, and this was not documented in people's care records. A relative of one person commented "They know absolutely nothing about my [relative]." As staff did not know about the people they cared for, they had failed to develop any meaningful relationships with them. The care they provided was task based and did not consider how people felt about how they spent their time or how their care was provided.

We observed that people living with dementia were not supported by staff to make decisions such as where they wanted to spend their time, what they wanted to do during the day or where they wanted to eat their meals. This meant that people's sense of independence was compromised.

People did not feel listened to or valued because changes were not implemented as a result of their feedback. For example, trends in feedback in a survey of people's views in 2012 and 2014 had not been identified and acted on by the management of the service. A person said "we've been waiting for a shower to be fitted for over a year. When, or if, it'll come I don't know." One relative told us "I'm not confident that changes will be made, it always seems as if it comes down to money, and someone doesn't want to spend any money on this place."

People's dignity was not consistently promoted or respected by staff. For example, we observed that two people sitting in their chairs for seven consecutive hours without being supported to use the toilet. Their care plans stated that they wore incontinence pads, but still required staff to take them to the toilet regularly, as they were unable to verbally request this support from staff.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they and their family were involved in the planning of their care. One person told us "They ask you if you want to be involved in your care plan or not. I don't really mind." A relative told us "They involve me as much as possible." Relatives also told us they could visit whenever they liked, commenting "We are always welcome, whatever time."

Inadequate

Is the service responsive?

Our findings

People were at risk because changes to their current needs did not consistently feed into their plan of care. Staff did not have access to sufficient information about how to meet their needs and how they wanted their care to be delivered. Care records did not always reflect the needs of people that staff told us about or that we observed. For example, the kitchen staff told us that one person required a pureed diet as they were at risk of choking. The care records did not reflect this and staff who were responsible for supporting them to eat and also responsible for preparing meals after the kitchen staff went home, were unaware the person required pureed food. This put the person at risk of receiving inappropriately prepared food. One person required a food supplement, but this was not documented in their records. The care staff we spoke with couldn't tell us whether the dietician had given any advice, and were unsure of why the person now required a supplement. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's dignity and respect were not upheld because staff did not have access to sufficient information about people. This meant they could not support people in a way which reflected their lives prior to coming to live at the service. There were no life histories for six of the seven people whose records we reviewed, and staff could not tell us about these people's personal history or past life. These people were unable to recall this information for themselves. The management of the service said that relatives were not asked directly for information about people's preferences with regard to their care, their likes and dislikes before moving into the service.

People told us they were bored. One person commented "I don't have a choice of activities because there simply isn't any to choose from." Another person said "Normally I watch something I don't really like on television because that's what's on and the television stays on the same channel all day. Sometimes it's just on the news and we watch that depressing rubbish all day." Staff were unable to tell us who chose what to watch on television or what people liked to do with their time. They did not know about people's hobbies or interests and therefore they did not offer opportunities to continue these or suggest alternatives.

Staff did not provide people living with dementia with adequate activity or stimulation. One person said "I don't like this music", but staff did not respond either by turning it off or exploring what they did like. One person showed signs of being bored and distressed throughout our inspection. We observed that when staff did interact with them, they became happier, however a book the person had been given was aimed at children, which was not appropriate for their knowledge and interests. The person was not always able to communicate clearly, and could not seek entertainment for themselves so relied on staff to help them do this.

Another person had a doll given to them and they were engaged in an activity with the doll for a short time, before being given a book, which they threw across the room. Staff made no attempts to engage the person in any other activity. Throughout our observation the persons behaviour changed and they banged on their table, threw items on the floor and shouted, but staff did not respond. The persons care records indicated they were at risk of social isolation and that they needed regular interaction from staff to remain happy. Staff were not responding to this persons needs, and this caused them distress and anxiety.

One person told us "If I could change anything, I'd like for them to make the days a little bit more interesting." Another person commented "We sometimes play bingo, sometimes every day, but nothing else." Another person said "I really used to enjoy knitting, sewing, making things. I don't do it anymore though. I haven't got anyone to get me the wool." The television was on in the lounge area, and one person told us "I don't like this programme, but there's nothing else to do. A relative said "There could definitely be more activity for people, it is a worry that people always seem to be sitting doing nothing." Health professionals told us that people didn't have much to do, and staff didn't always have time to entertain people. Staff could not tell us what people's individual interests were and how they supported them to continue these, and this meant that people felt bored and as if they did not have control over the way they spent their time.

People told us that there had not been a meeting for people or their representatives for some time and that they hadn't had the opportunity to feedback their views via any other means. One relative told us "We haven't been invited to a meeting for ages. We sometimes get the opportunity to

Inadequate

Is the service responsive?

fill in a survey once every couple of years, but they are tick box jobs, there's nowhere to write anything else you want to say. Not much seems to happen after the questionnaire anyway." This led to people feeling that their views were not valued, listened to and acted on. We saw that complaints people made were not thoroughly investigated and responded to appropriately. The provider had no system in place to analyse trends in complaints to identify where changes could be implemented. People and their relatives told us they didn't feel supported to make complaints and felt that if they did complain, these would not be acted on by the provider.

One person said "There's no point in complaining. Nothing will ever change." Another person told us "I don't even know how to complain. Even so, I doubt they'd do much about it. A relative commented "We've complained time and time again, we never receive a response and nothing changes." Another relative said "They really do not care what you think here. Nothings changed in years and nothing will change because they don't care enough about what we think". There was no system in place for seeking people's views on the service through meetings, surveys or complaints, and acting on these. As a result, people felt that their views were not valued and that they did not matter to the provider. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Is the service well-led?

Our findings

There was a lack of managerial oversight leading to a failure to recognise and identify issues we found that impacted on the quality of the service, and that posed risks to people. There was no quality assurance process in place to identify shortfalls and then take appropriate action to improve. The management had been asked to make improvements to the service following an inspection in July 2014, and provided us with an action plan stating they would have complied with the Regulations by 28 August 2014. At this inspection, we found that the service had not made the improvements they told us they would make, and there were still serious shortfalls in the quality and safety of the service provided.

The provider did not ensure that the manager of the service had access to sufficient funds to implement changes and improvements to the environment, activities and facilities on offer to people. For example, during our inspection in 2014, we identified that people wanted to have a shower, but the service only had a bath. During this inspection, a shower had not been fitted and the manager acknowledged that people requested a shower, but said one had not been fitted because they didn't have the budget and this was out of their control. In addition, the management of the service had been unable to sustain improvements made during an inspection by the Food Standards Agency (FSA) in 2013, and in December 2014 they were told that standards had fallen and they needed to make improvements in several areas. The manager told us that improvements required, such as purchasing separate utensils for cooked and raw foods and carrying out essential maintenance to the kitchen could not be completed because of budgetary restrictions which were out of their control. There was a risk of cross contamination between raw and cooked foods within the kitchen which could impact on the health of people using the service, but action had still not been taken to mitigate this risk.

The manager had been unable to replace ripped carpets which we highlighted as a risk in July 2014, because they did not have access to the funds to do so. This meant that people continued to be at risk of harm, because their mobility was poor and many people used frames which could catch on the ripped carpet and result in falls. In addition, the manager had not taken timely action to address an unpleasant odour in the service, which they said resulted from the carpet in one persons bedroom that needed replacing. They told us that they had not yet addressed this as they did not have access to the funds to replace the carpet.

The manager and provider were not visible within the service. The location of their office meant it was difficult for staff to direct queries to the manager without taking themselves away from their caring duties. Staff told us that the manager did not work full time at the service because they had another job. The manager was not present when we arrived for our inspection, and staff had to request them to come to the service to support the inspection.

Relatives told us they were not sure who the manager was. One said "There's a man and a woman, but I'm not sure who is in charge." Another commented "I never see them much, I come in every week but I've never spoken to the manager. I'm not entirely sure who actually is the manager." Health professionals told us they often communicated with the senior carer on duty when they visited rather than the manager, who they told us was very often not present at the home or were in their office on the third floor. They told us that they rarely saw the manager in communal areas speaking to staff, observing what was going on or speaking to the people living there, and raised concerns about the management of the staff. The care staff told us the manager was available if they needed them, but that they had lots of paperwork to do in the office.

The manager and provider were unable to demonstrate that they had an awareness of the challenges and risks faced by the service, and that they had plans in place to address these. There were no plans in place to develop the skills and knowledge of the staff team, and there was not an emphasis on driving improvement within the service. This meant that poor staff practice which may impact on the health, safety and welfare of people was not identified and action taken to mitigate the risks and protect people from harm.

The manager and provider did not cultivate a transparent, open and honest culture among the staff team. Staff were not aware of what the future aspirations of the service were, and were not willing to talk with us or express their views about what they thought could be improved. They told us that they didn't feel it was appropriate for them to suggest changes or improvements to us or the manager.

Is the service well-led?

Staff meetings that took place infrequently were not used as an opportunity for staff to feedback their views or concerns, and this meant that staff did not feel supported to question practice.

The manager and provider of the service did not have systems in place to keep up to date with best practice and told us they did not have any links with the community at present. For example, they did not take part in any initiatives to keep up to date with developments in the care of people living with dementia or have links with other organisations or care services to share best practice. The provider was reliant on others to identify areas to improve, which led to them being consistently behind in their practice and the quality of care people received.

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

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed We found that the registered person did not operate effective recruitment procedures in order to ensure that no person is employed for the purposes of carrying on a regulated activity unless that person is of good character and has the qualifications, skills and experience which are necessary for the work to be performed. This was in breach of Regulation 21 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2010, which corresponds to Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing We found that the registered provider did not have sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in order to meet all the needs of all the people using the service at all times. This was in breach of Regulation 22 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2010, which corresponds to Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff

This section is primarily information for the provider

Action we have told the provider to take

We found that the registered person did not ensure care staff received appropriate support, training, professional development, supervision and appraisal as is necessary for them to carry out the duties they are employed to perform.

This was in breach of Regulation 23 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2010, which corresponds to Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect We found the registered person had not protected people against the risk of receiving of care and support that was undignified and disrespectful, and did not support their independence. This was in breach of Regulation 17 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2010, which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered provider had not protected people from the risks of receiving care that is unsafe or inappropriate. People's care and support was not planned and delivered in a way that met their personal care and support needs and reflected best practice.**

The enforcement action we took:
We served a Warning Notice which gave the registered provider a timescale by when compliance must be achieved.

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 provision **The registered provider did not have an effective operation of systems to monitor the safety of the service and the quality of the service provided that enabled them to identify where improvement was needed and take prompt and appropriate action.**

The enforcement action we took:
We served a Warning Notice which gave the registered provider a timescale by when compliance must be achieved.