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Lindenwood Residential Care Home

Inspection report

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Ratings

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

Overall summary

We inspected Lindenwood Residential Care Home on 18 November 2014. The inspection was unannounced, which meant that the service did not know we were coming that day. We carried out the inspection in response to certain information which we had received. At the previous inspection in April 2014 we had found that the service was meeting the regulations in the areas we inspected on that occasion. In our report we commented that we would check on certain areas at out next inspection, in particular on staffing levels.

Lindenwood is a residential care home in the New Moston area of Manchester. The service offers accommodation and personal care for up to 16 people in 13 bedrooms. The home does not provide nursing care. One of the two providers was present during our inspection; we refer to her in this report as the 'proprietor'.

It is a condition of the provider's registration that Lindenwood should have a registered manager. There has not been a registered manager there since December

Summary of findings

2012. 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.

We found that staffing levels between 4pm and 9pm were too low, despite the findings in our previous reports. We found that not all documents relating to safe recruitment were on file. We found these lapses were breaches of Regulations under the Health and Social Care Act 2008.

We found that the food was good. Staff training was not all up to date, and some important areas had not been covered by all staff. Staff supervision seemed to be haphazard, especially since the previous acting manager had left. There was no system of annual appraisals.

The staff were caring and the proprietor was personally involved in caring for people and attended hospital with them. However, the care files did not present person-centred care and were not adequately reviewed.

We were concerned that one person's basic needs were not being met and their health condition was not being properly monitored. This was a breach of a Regulation under the Health and Social Care Act 2008.

There were too few activities available for those people who could enjoy them. There was no systematic way to ask for feedback from family members. A recent serious complaint had not been responded to promptly or in a satisfactory manner. The lack of an effective complaints process was a breach of a Regulation under the Health and Social Care Act 2008.

Many of the above problems were caused by a lack of leadership within the home. There had not been a registered manager for two years, and the previous acting manager had left at the end of September 2014. This had caused a fall in morale among the staff, which inevitably impacted on the quality of care being delivered.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the end 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. There were not enough staff on duty especially in the evenings to ensure people's safety and welfare.

The requirements to ensure safe recruitment were not all met.

The administration of medication had scope for improvement.

Is the service effective?

Inadequate

The service was not effective. Necessary training was not up to date for all staff.

Supervision took place but needed to be more regular. There was no system of annual appraisal.

Food was of a good standard and people's intake was monitored when required.

The service was aware of its responsibilities under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards, but did not always ensure that consent was properly obtained and recorded.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring. The staff were caring but the care files were not well maintained which meant it could not be guaranteed care was delivered in line with people's changing needs.

One person's basic needs were not being attended to on the day of inspection, and their care plan showed that their health condition was not being monitored correctly.

Is the service responsive?

Requires Improvement

The service was not responsive to all of people's needs. There were few activities available or those who would have been able to enjoy them.

The service had been slow to respond to a recent complaint and the complaints policy needed to be improved.

Is the service well-led?

Inadequate

The service did not have good leadership.

The absence of a registered manager for two years was the cause of a poor quality of service.

Staff were not well supported and morale was poor due to a lack of leadership.

Lindenwood Residential 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.

The inspection on 18 November 2014 was unannounced. The inspection team was made up of an adult social care inspector and a bank inspector. A bank inspector is a person who is trained and regularly assists with conducting inspections. In addition an inspection manager attended to observe the inspection.

Before the inspection we considered some information which had been sent to us, and notifications received since the last inspection. We had learnt that a manager (who had not registered with the Commission) had left the service at the end of September.

We talked with three of the 14 people who were living in Lindenwood on the day of our inspection. Not all of the people were able to communicate with us in a meaningful way. We also talked with three family members who were visiting relatives on the day of our visit. We discussed issues with the proprietor, and the deputy manager and we interviewed five members of staff.

We looked at six care records and examined two in detail. We looked to see whether the care plans matched the care people were receiving.

We contacted the contract officer of Manchester City Council and members of the safeguarding team.

We requested some items of information from Lindenwood which were sent to us several weeks later. We also spoke with the operations director, who had previously been an acting manager of Lindenwood and was now acting as an adviser to the proprietor.

Inadequate

Is the service safe?

Our findings

We asked about staffing levels and saw the staffing rota for the week of our visit and the preceding week. We saw that there were three members of staff on duty each day from 8am to 4pm, and two members of staff from 4pm to 9pm. Two staff covered the night shift from 9pm to 8am.

We spoke with staff, who all told us they felt that at times two staff were not enough. They told us that sometimes there were only two staff on duty in the morning, which made it difficult to support people getting out of bed. The proprietor was usually present during the early evening, but sometimes was not available. She also made it her practice to accompany people to hospital, which meant there were times when she was not on site. Three of the people living in Lindenwood required two staff to escort them to the toilet. In this instance other people living in the home were left unsupported if the proprietor was not present.

In addition, staff explained to us the cook's hours had recently been reduced and the cook stopped work at 2pm. This was confirmed by the staff rota (although the cook was off sick at the time of our inspection). As a consequence one of the care staff needed to help with food preparation in the kitchen. The care staff were trained in food hygiene. Although the evening meal was a light meal such as sandwiches, staff needed to bring it out and deal with any special requests. One member of staff described teatime as, "very difficult."

Staff also told us one staff member gave out medication, but would have to pause if someone needed to be escorted to the toilet. In their view this increased the risks of making mistakes with medication. They added that sometimes residents had to wait longer than they should to go to the toilet.

At a previous inspection in October 2013 we found there were only two staff on duty at all times and this was not enough staff to keep people safe. We found the home was in breach of the Regulation relating to staffing levels. We required the service to state how they were going to ensure they met the regulation when we inspected the home again.

At our last inspection in April 2014 we saw there were now three members of staff on the day shift, but only two between 4pm and 9pm. In our report we commented that this would include the time when most people would go to bed. We added: "In particular, we will check at our next inspection that there are three members of staff on duty every day from 8am to 9pm."

At that inspection in April 2014 the proprietor told us the service was about to employ a full time manager and three apprentices, and this would enable the service to have three members of staff on every shift. In November 2014 the manager was no longer employed, but two apprentices were working full time. However, there were still only two members of staff on duty between 4pm and 9pm.

There is no stipulated fixed ratio of staff to residents because the number required depends on the needs of the people living in the home. There were several people at Lindenwood who had complex needs and mobility problems. It was specified in some care plans that people required two members of staff to move them, for instance to take them to the toilet. This was an example of why having only two members of staff on duty was insufficient.

An additional problem for the home was that the staff complement was low. Including the deputy manager there were seven members of staff and two apprentices available. One staff member was on long term sick leave. Soon after the inspection we learnt that two members of staff had left which reduced the numbers of staff even further and put pressure on those remaining to work additional shifts.

We considered the history of previous inspections and the failure to act in relation to staffing levels. We found there were not sufficient numbers of appropriate staff to meet the health and welfare needs of people using the service. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at the paperwork relating to the most recent recruitment of a member of staff. Under the regulations there is a schedule of documents to retain relating to recruitment. Most of the required documents were available: there was a copy of proof of identity, a record of the job applicant's DBS check and names of referees, and a record of their answers to interview questions. However, their job application form was not on the file, which meant there was no evidence of their employment history.

Inadequate

Is the service safe?

Although there was a record of references received the references themselves were not present on the file. This was a breach of Regulation 21(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

In other respects Lindenwood provided a safe environment for the people who lived there. We talked with three people who were able to communicate with us. They each told us they felt safe, one person adding that nobody had ever tried to bully them or harass them. They said if they were worried they would speak to the proprietor and were very confident that they would listen. They said, "I can do what I like, and do what I want. I can get up when I like and go to bed when I like. I can move around the house and garden when I want." This indicated the person felt they were able to move around safely and in a homely environment.

It was stated in all care plans that only staff who had undertaken medication training were allowed to administer medication. We talked with a member of staff who had just finished dispensing medicines. They showed us completed MAR sheets (Medication Administration Record) which recorded each person's medication that had been given to them. There were photographs of each person on their sheet to help ensure medication was given to the right person. As far as we could see these were completed fully and accurately, we could see that the morning's medication which had just been given was recorded. There were some issues. There was a sheet which identified the initials of each member of staff who administered medication. This was to enable the member of staff to be identified in the case of any query. This particular member of staff was not on that list, although they confirmed to us they regularly dispensed medication. Their name and initials were however on a previous list which was still in the file on the medication trolley. We also observed some inconsistency in the symbols used on the MAR sheets. For example "E" was used in the key to mean "refused and destroyed" but some staff wrote "R". It is important to be consistent to avoid any possible uncertainty if an investigation is needed into what medicines people have received. A further concern was that the trolley was not secured to the wall when stored, as it should have been.

We asked five members of staff about their understanding of safeguarding and what training they had received. One permanent member of staff told us, "I honestly can't remember when I last did the safeguarding training." We asked to see the training matrix which was updated before it was sent to us. It showed that seven staff (including night staff) had undertaken safeguarding training, mostly in 2013, but that two had no training recorded. In addition the two apprentices who had started working at Lindenwood in May 2014 had not received any training in safeguarding from the service. They told us they had had an introduction to the subject at their college, which they were now attending one day a month.

All the staff members we spoke with were able to describe types of abuse although some needed prompting to recall all the various types of abuse. They told us they felt confident they would recognise abuse if they saw it, and would know how to report it. They told us they knew there was a policy on safeguarding in the office. We knew from our records that instances of concern or potential abuse had been reported to us by the previous acting manager, up to the end of September 2014.

The lounge and dining room were clean and well maintained. Bedrooms were well furnished and comfortable. One visiting relative commented to us, "They have a very good cleaner."

There were stairgates at the top and bottom of the staircase leading up to the bedrooms on the first floor. They could be locked with a combination lock. In the report of our inspection in April 2014 we observed that the gates were not always closed and locked when staff went up and down the stairs. On this inspection we saw this was still happening. The proprietor told us that people always used the lift to go up and down stairs. However the gates were there as a precaution to prevent accidents if residents did try and use the staircase.

Inadequate

Is the service effective?

Our findings

We looked at the measures taken to ensure that consent to care and treatment was properly obtained. Where people are unable to consent to a particular course of care or treatment there should be a mental capacity assessment in line with the Mental Capacity Act 2005. On one person's file the form headed 'Consent to care and treatment' was signed and dated by a relative. But on another person's file the form was incomplete. It had the person's name on, but was not signed or dated by anyone. It was therefore unclear whether the person themselves had consented or someone on their behalf, or alternatively no-one had consented. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We asked the proprietor whether any people living in Lindenwood had received mental capacity assessments. She told us that two people had, although when we looked at the care file for one of these people we could not find any evidence of this.

When people are considered not to have capacity to consent to a restriction on their liberty, legislation requires that the care home applies for an authorisation under the Deprivation of Liberty Safeguards (DoLS). There were no such authorisations in place at the time of our inspection. However, we were aware from previous inspections that Lindenwood had applied for an authorisation on a recent occasion. This showed that they had been mindful on that occasion of the requirements of the legislation.

We looked to see whether people had their needs met by staff who were suitably trained. Staff told us that they had received training in key areas such as infection control, food hygiene, moving and handling and first aid. We verified this from the staff training matrix which was sent to us after the inspection. We saw that some training topics, namely fire safety and basic life support, had not been undertaken since early 2013 and were overdue since they were listed as being required every 12 months. However, staff were due to attend first aid training a few days after out visit.

The two apprentices had undertaken some training since being at Lindenwood although not in safeguarding as was mentioned under "Is the service safe?". The most recently recruited member of staff had an induction checklist in their file but it was blank.

Since our last inspection a computer had been placed in the dining room which enabled staff to complete e-learning if they did not have the facilities at home. One member of staff told us they did not get on very well with e-learning and preferred face to face tuition.

We asked about supervision and appraisals. Staff told us they had had supervision with the former acting manager, and in some cases with the deputy manager. We were given different answers as to the nature of the supervision. One person described it as a "ten minute chat in the dining room" with the deputy manager, with no notes kept. Another person told us that a record was kept. We found notes of a supervision session on one person's file. It was less clear whether staff had been given an annual appraisal. (This is an opportunity to discuss achievements and issues in the past year, and to set goals for the year to come.) The staff told us they could not recall being given such an appraisal. This meant there was scope for greater management input into monitoring and improving staff performance.

There were occasional staff meetings and several staff told us they could raise matters with the proprietor or deputy manager at any time.

We looked at whether people were supported to eat well and maintain a balanced diet. The permanent cook was on sick leave but another person was standing in. People living in Lindenwood told us they liked the food. One person said: "I have no complaint with the food whatsoever. If there's anything you don't like you can have something else. I've never been hungry and I am a fussy eater." Another person said: "The food is very nice." We observed the hot meal at lunchtime which looked nutritious. One person needed support to eat, and we saw a member of staff sat with them patiently, talked politely with them, supported them with eating their food in an unhurried way and then offered a choice of dessert. All staff wore aprons during lunch time in order to improve hygiene. We observed that one person was asleep throughout lunchtime. A meal was saved for them but there did not appear to be any system to ensure that it was given to them.

Inadequate

Is the service effective?

We saw that records of nutritional intake and fluid intake were kept on some people's care files, but these were usually kept for a short time and then finished without any explanation. One person's record recorded that they had had a cup of tea on two evenings a month apart; without a complete record of their fluid intake this information was meaningless.

Requires Improvement

Is the service caring?

Our findings

We observed the care given to people living in Lindenwood during the course of the day. We saw that staff were attentive to people's needs, often pausing to chat to people or offer them a drink. This caring approach was encouraged by the proprietor. Both residents and visitors told us that she spent a lot of time with people and was genuinely concerned for their wellbeing. It was her policy always to accompany someone to hospital if they needed to go, at any time of day or night.

Two people who were visiting someone on the day of our inspection said they were very happy with the care their relative received. They mentioned that the staff had cut their relative's fingernails and toenails, and they had no concerns about their personal care needs being looked after. Another visitor described the proprietor as: "wonderful, I cannot fault her...how she does it I don't know." The visitor added that the proprietor had recently become concerned about their relative, and had arranged to go with them to hospital, where a health condition was diagnosed. The proprietor had stayed at the hospital with the relative, and reported the diagnosis to the visitor, which had reassured them. This showed that the proprietor was prepared to show special consideration for the needs of people and also their relatives.

We spoke with three people who lived in the home and asked them about the care they received. One person told us: "Yes I'm comfortable. Anything I want I can have within reason...I've got a lovely room." They added: "If you need any help there's always someone to help you." A second person told us the staff were kind and listened to them, and respected their privacy. We observed that staff knocked before entering a bedroom. Another person said: "They look after me very well. Someone is coming to sort out my teeth." They added that very good care was taken of their particular health problem (which required monitoring by external health professionals). While we were there an optician came with new glasses for this person, which they were pleased with. This was evidence that Lindenwood was engaging with outside agencies to maintain people's health.

We were, however, concerned about one person who stayed in the same armchair throughout the day, and was not taken to the toilet. Nor were they given anything to drink. They were asleep, and slept through lunch. It was not clear to us that that this person's basic needs were being met. We also noticed that there was a sore on their right ankle which had not been treated. We asked the proprietor and the deputy manager about this person. They told us that the person had "good days and bad days" - and this was a bad day. They were not aware of the sore on the ankle, and said they would ask a nurse to look at it. They said the lunch had been saved and would be offered later. Following this conversation the proprietor offered the person a drink, which they refused.

We looked at this person's care file. Under the heading 'aim of care' the wrong gender was used when referring to the person. The description of the care to be given did not indicate that the person had some good days and some bad days, and would sometimes refuse food and drink. There was no record of a pressure sore in the file. A risk assessment regarding moving and handling was dated 11 November 2013 and there was no evidence that it had been reviewed in the year since then.

There was a record that the person had recently been in hospital (although the date was incorrect as it referred to the future). The record did not state the reason for their admission or the treatment given. We knew from elsewhere that the reason was a urinary tract infection and that a course of antibiotics had been prescribed upon discharge from the hospital. The proprietor told us that the staff at the home had not tested the person's condition after completion of the course, which meant they did not know whether the antibiotics had worked. This information was necessary in assessing the person's health. Without the health condition being recorded, staff would not monitor the person's fluid consumption and increase it if necessary.

Moreover the care file did not include information about the person's likes and dislikes, or things they enjoyed doing. The care plan lacked detail, was not adequately reviewed and did not reflect the person's current health status.

This was a breach of Regulation 9(1)(b)(i) and (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Requires Improvement

Is the service responsive?

Our findings

We read six care records to check whether the care plans matched the care that was being delivered and provided a good basis for staff to deliver care. We saw on one file that the wrong name was used several times to refer to the person concerned. In one place a woman's name was used but it was a man's care file. We looked at another file and it was clear that the description of personal hygiene needs had been copied from there into the first file, including the wrong name. This showed the absence of person centred care, because the staff member who wrote the file had not been thinking about the person's specific needs.

We looked at what activities and recreation took place to meet people's needs. There was music playing in the lounge and dining area which was on a continuous loop; the same songs came round at least three times during the day. The majority of the people were sitting in armchairs around the lounge for most of the day, except at mealtimes. There was a large television on the wall.

We asked one person who lived in the home whether they took part in any activities. They replied: "There is absolutely nothing." They did then state that they were able to read magazines, and they had a friend (another resident) they could talk to. Another person complained that they never went out. They said they used to enjoy going to the pub for a pint with their friends, but they never did that any more. Another person told us there were parties arranged for events like Christmas. Recently there had been celebrations for two people who had reached their 100th birthday.

One visitor said that the staff sometimes painted their relative's nails, but they were unsure about what other activities there were.

We asked staff about activities. The apprentices told us that when they arrived at the home about six months earlier they had been put in charge of arranging activities. They said they had come up with some ideas but these had not been put into practice, partly because of the numbers of staff available. A longer serving member of staff acknowledged that there was a lack of activities. They said there used to be bingo twice a week and a sing-along but these activities had stopped. There had been a trip in August 2014 to Clayton Vale with five residents, but this had been a one-off event.

While the ability of some people who lived in the home to take part in any kind of activity was limited by their health, this was not the case for all people. If staff numbers increased especially between 4 and 9pm there would be better scope for activities to take place.

Staff told us that informal meetings of residents were held occasionally. This was confirmed by one of the residents who said there had been "one or two" meetings and they could decide for themselves whether to go or not. The main topic of these meetings was food and people's preferences. We knew from a conversation with the cook at our last inspection that these comments were taken on board when planning the menus.

A questionnaire was sent out to family members in February 2014 but no responses were received in the first two months. The questionnaire consisted of 38 questions over 10 pages. The home had not assessed if this was the reason for a poor response. In our last report we suggested that the questionnaire should be redesigned. We saw no evidence that this had been done by November 2014.

Part of the rationale for this inspection was the receipt of a copy of a complaint about the care provided within the home. We requested a copy of the complaint policy which we received after the inspection. The policy stated that, "All complaints were dealt with quickly and effectively." However, it did not lay down any timeframe within which complaints would receive a response. It did however give a deadline for complaints to be made (within 12 months of the issue leading to the complaint). It stated that, "All complaints would be investigated by the manager." This would not be appropriate if the complaint was about the manager. No alternative process was provided in the policy.

The management of the complaint forwarded to CQC had not followed the home's procedure. The policy stated that all complaints would be acknowledged within three working days. In this case the letter of acknowledgment was dated 12 days after the date of the letter of complaint. When we asked to see the home's copy of the complaint we were told the letter had been lost. This did not facilitate a proper response to the complaint, and was indicative of a poor complaints handling procedure. We subsequently supplied a copy of the letter, to enable a response to be made.

Requires Improvement

Is the service responsive?

The complainant had asked for copies of care records, to which they were entitled, but this request was refused in the letter acknowledging the complaint. The operations director told us that the reason was to avoid putting such documents in the post, but it would have been possible to send them by registered post. The refusal appeared to delay the complainant obtaining the full facts.

The above failings demonstrated an inadequate policy and process for dealing with complaints. This was a breach of Regulation 19(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service well-led?

Our findings

At the date of this inspection Lindenwood Residential Care Home did not have either a registered manager or anyone in post who was filling the role of manager. There had not been a registered manager since December 2012. For part of the intervening two years without a registered manager, there had been a person holding the post of 'operations director'. This person had at one stage applied to become registered manager but did not pursue their application. This person had reduced their day to day involvement with the home in May 2014. An acting manager was appointed then, who applied to register with the Commission but left the home on 29 September 2014, before the application was completed.

Having a registered manager is a condition of registration of the service. A registered manager has a legal responsibility to ensure that the regulations made under the Health and Social Care Act 2008 are met. The lack of a manager therefore can have an impact on the safety and welfare of people using the service. While the Commission understands that there may sometimes be a gap between registered managers, it is the responsibility of the provider to appoint a new registered manager within a reasonable period. Because the home did not have a registered manager for two years they were in breach of a condition of their registration. There was evidence that the lack of a registered manager also adversely affected the service and the welfare of people using the service.

We talked with staff about their experience of working at the home. One person said to us: "This is what's wrong, we need a strong manager, and all the staff working the same way." Another member of staff said: "Leadership could be better. It could be more organised. We need more staff and reliable bank staff." Another person said: "We need to focus more on what is right for the residents. We have raised this but it slips back. Perhaps because there is no manager."

The proprietor told us that the operations director had been visiting the home regularly since the previous acting manager had left at the end of September. But three staff told us they rarely saw the operations director. We spoke with the operations director after the inspection who told us they did visit the home but their visits tended to be short because they had their own service to run elsewhere.

The operations director had previously developed a system of audits but had not been present in Lindenwood often enough to implement them effectively.

The absence of a manager and the lack of a registered manager for two years had contributed to the poor quality of service that we observed on this inspection. In particular the inadequate care plans, the lack of activities, the failure to improve staffing numbers even despite the findings of previous inspections, and the inadequate response to a serious complaint, were all attributable to the absence of a day to day manager who would take responsibility for the quality of the service.

The morale of the staff had been affected by the departure of the previous acting manager in September 2014. One staff member said: "The atmosphere has been terrible since [the acting manager] left and since the complaint came in."

Staff were not being well supported to deliver effective and compassionate care. The last staff meeting that people could recall was in May 2014. Although many of them were experienced care workers who were doing their best to deliver good care, there were younger and less experienced staff who were not receiving the leadership, encouragement and support they needed. One of the more experienced staff told us that the younger staff had sometimes been treated in a bullying manner. We obtained confirmation that this was a widely shared view among staff.

All the evidence showed that the proprietor had at heart the best interests of the people living in Lindenwood, but we considered she did not have the skills or qualities to manage the home single handed. The deputy manager was similar. The proprietor had previously relied heavily on the operations director who still provided advice, but this person had not been a significant presence in the home for the six months prior to our inspection.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **The provider was not ensuring that there were sufficient numbers of suitably qualified, skilled and experienced staff at all times.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The provider had not ensured that all of the information required in respect of a person employed by the service was available.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The provider was not taking proper steps to ensure that each service user was protected against the risks of receiving inappropriate or unsafe care, by planning care which met each person's needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints **The provider did not have an effective system for dealing with complaints.**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The provider did not have suitable arrangements in place to obtain and act in accordance with the consent of service users.