Duncan House

Quality Report

Bridges Healthcare (PDU) Limited
Duncan House
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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location

Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	
Are services responsive?	
Are services well-led?	Inadequate

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

Professor Sir Mike Richards
Chief Inspector of Hospitals

Overall summary

Duncan House was operated by Bridges Healthcare (PDU) Ltd. The service was a short stay, 30 bedded planned discharge unit operated by registered nurses, health care assistants, a therapy team and a visiting GP. The service offered short term stays of about one month for medically fit patients awaiting placement or next move following an admission to an acute hospital.

The service had a registered manager registered with the Care Quality Commission (CQC) in place and the registered manager was also the director of Bridges Healthcare (PDU) Ltd. The service registered as Duncan House on 31 March 2020, after a change of legal entity. Due to a need for hospital beds because of the COVID-19 crisis, local health commissioners had plans to transfer patients from a local acute hospital to Duncan House. At registration with the CQC on 31 March 2020, the registration had a condition placed on it. The condition was that Duncan House should provide the regulated activity treatment of disease, disorder or injury, to people who were referred by NHS Greenwich Clinical Commissioning Group or NHS Bexley Clinical Commissioning Group, for patients from the boroughs of Greenwich and Bexley only. As of 1 April 2020, Greenwich and Bexley CCG's became part of South East London Clinical Commissioning Group (SELCCG).

Also, the local clinical commissioning groups provided additional assurance to ensure quality and safety on this unit was achieved. This included providing a task force to provide clinical oversight and leadership to Duncan House and that the service did not exceed 30 bed capacity. The task force had staff specialising in medicines management, safeguarding, nursing and governance who provided support into the service.

This was the first inspection since registration in March 2020. We inspected the service as we had concerns about the safety and leadership of the service. We inspected aspects of the safe, effective and well-led key questions.

We carried out the focused announced visit to Duncan House and held virtual staff interviews on 17 July 2020. As this was not a comprehensive inspection, we rated the key questions of safe, effective and well-led as breaches of regulations limited the key question ratings, but did not give an overall rating to the location.

The Clinical Commissioning Group made a decision to withdraw commissioning arrangements with the provider as of 31 July 2020. Following this inspection the provider cancelled the registration for the location and the registered manager. The service has now closed an de-registered with the CQC on 7 August 2020.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Our findings from this inspection were:

•The registered manager had a limited understanding and oversight of governance in the service to ensure operation of effective systems and processes to assess and monitor the service effectively.

•The registered manager had worked with commissioners of the service to introduce and review governance processes, when the service was registered in March 2020. However, the registered manager did not take action on the issues raised.

•The registered manager was unable to provide a comprehensive answer of what the expectation was for staff supervision, yet was responsible for providing supervision for registered nurses. This meant that there was a risk of staff missing opportunities to develop skills, identify solutions to problems, learn from incidents and improve standards of patient care.

Summary of findings

•Not all registered nurses employed by the service had received supervision from a suitably qualified professional. This meant that there was a risk that staff were not appropriately skilled and competent to improve standards of care.

•The service had an insufficient governance policy that did not clearly define the service assurance processes. This meant that staff did not have adequate principles to guide their decisions.

•The service risk register did not include the risks posed by COVID-19 during the national pandemic.

•The registered manager had not ensured that staff in the service had a formal risk assessment or formally recognised the disproportionate impact of COVID-19 on Black Asian Minority Ethnic (BAME) staff and staff who were vulnerable and in an at-risk group. As a result, staff may have been subject to risks without adequate mitigation.

•Not all staff knew how to make a safeguarding referral to the local authority. This meant that raising safeguarding concerns could be delayed if the registered manager was not on shift and immediately available.

•Staff did not complete comprehensive incident forms consistently.

•Staff did not record discussions and learning from incidents. Staff were reliant on verbal handovers of information and could not confirm what action had to be taken to support individuals and mitigate risk.

However:

•The service provided mandatory training in key skills to all staff and made sure everyone completed it.

•Staff adhered to infection control principles. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Summary of findings

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Duncan House

Services we looked at
Community health inpatient services.

Summary of this inspection

Our inspection team

The team that inspected the service comprised three CQC inspectors.

How we carried out this inspection

This was an announced focused inspection. During the inspection we asked questions related to aspects of the safety, effectiveness and leadership of the service.

Before the inspection visit, we reviewed information that we held about the location. This included information about safeguarding concerns, whistleblowing reports, and statutory notifications.

We contacted commissioners who provided us with information about the service.

At the time of the inspection the service employed 20 registered nurses, 30 non-registered nurses and there were 15 patients. The inspection consisted of an onsite visit to the location and additional interviews with staff that took place virtually.

During the inspection visit, the inspection team:

- spoke with nine staff including registered nurses, non-registered nurses, physiotherapist, human resource staff, and the registered manager
- reviewed three sets of patient care records
- reviewed four incident records
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We identified the following areas for improvement:

- Not all staff knew how to make a safeguarding referral to the local authority. This meant that raising safeguarding concerns could be delayed if the registered manager was not on shift.
- Staff did not complete comprehensive incident forms consistently.
- Staff did not record discussions and learning from incidents. Staff were reliant on the verbal handover of information at shift changes and could not confirm what action had to be taken to support individuals and mitigate risk following incidents.

However,

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff adhered to infection control principles. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- Staff records of patients' care and treatment were clear, up-to-date, stored securely and easily available to all staff providing care.

Are services effective?

Requires improvement

- Not all registered nurses employed by the service had received supervision from a suitably qualified professional. This meant that there was a risk that staff were not appropriately skilled and competent to improve standards of care.

Are services caring?

We did not inspect this key question.

Are services responsive?

We did not inspect this key question.

Are services well-led?

Inadequate

We identified the following areas for improvement:

•The registered manager had a limited understanding and oversight of governance in the service to ensure operation of effective systems and processes to assess and monitor the service effectively.

Summary of this inspection

•The service lacked effective governance systems to enable it to operate safely and ensure compliance with the regulations. Although the registered manager had introduced systems to assess, monitor and improve the quality and safety of the service, they had not led to improvements in several areas.

•The registered manager had worked with commissioners of the service to introduce and review governance processes, when the service was registered in March 2020. However, the registered manager did not take action on the issues raised.

•The registered manager was unable to provide a comprehensive answer of what the expectation for staff supervision was, yet was responsible for providing supervision for registered nurses. This meant that there was a risk of staff missing opportunities to develop skills, identify solutions to problems, learn from incidents and improve standards of patient care.

•Effective systems were not in place to share, record information and learn from service updates and incidents.

•The service had an insufficient governance policy that did not clearly define the service assurance processes. This meant that staff did not have adequate principles to guide their decisions.

•The service risk register failed to acknowledge the risks posed by COVID-19.

•Staff did not have documented risk assessments in respect of COVID-19. Staff we spoke to did not have an individual formal risk assessment in respect of COVID-19 acknowledging the disproportionate impact on Black Asian Minority Ethnic (BAME) staff and staff who were in a higher risk group. As a result, staff may have been subject to risks without adequate mitigation.

However:

•Staff felt respected, supported and valued.

•Data and notifications were submitted to external bodies as required, without delay.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had access to training on the Mental Capacity Act, which included training on capacity and consent.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health inpatient services	Requires improvement	Requires improvement	N/A	N/A	Inadequate	N/A
Overall	Requires improvement	Requires improvement	N/A	N/A	Inadequate	N/A

Community health inpatient services

Safe	Requires improvement
Effective	Requires improvement
Well-led	Inadequate

Are community health inpatient services safe?

Requires improvement

Mandatory training

Staff had received appropriate training to keep patients safe. The completion rate for mandatory training was 100% overall. The registered manager had access to business information, to monitor training completion rates for each member of the team. Mandatory training included basic life support, emergency first aid, deprivation of liberty safeguards and fire safety.

Safeguarding

Some staff knew systems, processes and standard operating procedures to keep people safe.

Not all staff knew how to make a safeguarding referral to the local authority. Staff had received mandatory training in safeguarding, and staff we spoke to were able to recognise a potential safeguarding concern and were aware of the need to raise concerns with the service management. Whilst two of the five staff we spoke to did not know how to make a safeguarding referral to the local authority. This meant that raising safeguarding concerns could have been delayed if staff were unaware of how to raise it with the local authority and waited for the registered manager to be on shift.

Commissioners of the service had provided staff with additional training for safeguarding,by a designated nurse for adult safeguarding that included, types of abuse, raising safeguarding concerns, whistleblowing, the Human Rights Act, Care Act, delivering the Social Care Act, involving police, mental capacity and Deprivation of Liberty Safeguards. The commissioners had provided oversight to ensure that staff identified safeguarding's were identified by staff and reported to the local authority. The service identified four safeguarding concerns with the local authority between March 2020 and July 2020 in relation to patients who were admitted with pressures sores of grade three and above.

Staff worked with other agencies to promote safety, including systems and practices for information sharing for example, staff liaised with patients' social workers as required. The safeguarding lead for the location was the registered manager. The commissioners had ensured that a designated nurse for adult safeguarding from the commissioning group was working with the registered manager and the team to provide operational expertise and support for staff.

Cleanliness, infection control and hygiene

The service kept equipment and the premises visibly clean and the service controlled infection risk as needed. However, the environmental audits lacked general assessment of infection control and prevention across the service.

The premises were visibly clean at the time of our inspection. An external cleaning company provided services and the service kept up-to-date cleaning schedules.

Staff adhered to infection control principles, including handwashing and wearing personal protective equipment such as masks, aprons, goggles, visors, and disposable arm sleeve covers. Staff gave examples of guidance for the use of personal protective equipment in the context of the current COVID-19 pandemic. Clinical waste was collected by an external company. Staff had arrangements for putting on and removing personal protective equipment. Staff had received additional training on infection control and personal protective equipment in relation to COVID-19.

Staff completed weekly environmental audits. The audits were completed by the registered manager of another community service, belonging to the provider, who acted

as the health and safety lead. The audit covered bathroom and shower rooms, passageway checks, dining areas, communal lounge and external areas. This was a brief assessment but adequate in ensuring that the environment was cared for and issues of concern were raised on a regular basis.

Staff completed weekly infection control audits. The audit asked 11 questions that mainly related to infection control principles around COVID-19. The assessment made about infection control across the service was not comprehensive. For example, the waste management of sharps and whether regular water assessment checks were being completed were not included. This meant there was no evidence that general risks were assessed so as to safeguard people at the service. The audit did not include the name and designation of the member of staff completing the audit.

Between 1 April 2020 and 17 July 2020 the service reported no in-patient cross COVID-19 infections. Patients had been isolated in their rooms and family contact was limited to video calls.

Environment and equipment

Staff had access to equipment and control measures to protect patients, themselves and others.

Staff had easy access to alarms. Staffing levels were adequate to appropriately respond to alarms promptly and manage risks to patients and staff. Patients also has access to alarms in their rooms.

Staff had completed a fire risk assessment. We saw that a fire drill had taken place within the previous 12 months prior to inspection and all staff, patients and visitors had been evacuated safely. Staff also had grab bags that contained personal emergency egress plans for all patients.

Patients were using and had access to the specialised equipment they needed to meet their needs. The provision of standard furniture in the service was the responsibility of the provider while the occupational therapist (OT), from a local NHS trust, was responsible for recommending specialist equipment for patients. This included specialist pressure relieving mattresses and individual slings to be used with hoists.

Assessing and responding to patient risk

Risks to people who use services are assessed and monitored. During the inspection, we reviewed the risk assessments and care plans for three patients and found that staff completed and updated risk assessments on admission for each patient and removed or mitigated risks.

Staff were able to give examples of patient record audits. The nurse who conducted the audits communicated the results with staff through emails, text messaging, handovers and verbal feedback. For example, one patient record did not have a risk assessment completed for mobility and moving and handling by staff. We saw evidence that staff completed a risk assessment as highlighted in the audit and this was shared ths with other staff in handover. We saw evidence that staff acted on patient record audit findings and updated records without delay. Staff we interviewed were able to share learning from patient record audits and audit findings were shared with the team in quality assurance meetings.

Staff maintained regular contact with the GP surgery covering the service, community health teams, social workers and other social care agencies involved in patients' care. This was evident in their written handover notes and patients' records.

Staffing

Safe staffing levels were maintained. Managers reviewed and adjusted staffing levels and skill mix according to patients' needs. Annual leave and sickness absence was covered by existing staff or staff from the domiciliary care service run by the same provider.

Staffing for each day shift included four registered nurses and four non-registered nurses. This also applied to the night-time and weekend shifts. A local GP provided cover through on-line platforms. In case of a medical emergency staff dialled 999.

Staff access to essential information

Patient care records were stored securely. Staff maintained all care records electronically and they could be accessed by all staff. This included risk assessments, care plans and crisis plans. Information for all new clients was recorded on the electronic records.

Medicines

Community health inpatient services

Systems and processes to administer and record medicines were in place. Staff administered medicines in the way the prescriber intended. Staff conducted a medicines audit on a weekly basis and audit records showed that medicines issues were being identified.

We reviewed three medication administration records for completeness, legibility and inclusion of relevant client details, including allergies. The service had introduced a 'peer check' on medicine charts to ensure that charts had been signed by staff administering medicines.

All medicines were stored securely in a clinical treatment room. Controlled drugs (CD) were in a locked CD cabinet in line with legislation. Access to medicines was limited to authorised staff only. Staff monitored the temperature of medicines storage areas to assure that they were suitable for use.

The GP surgery prescribed all medication for clients. Staff could refer patients to a GP who reviewed patients via video link if review was required. We saw that any medicines changes and the rationales were documented to ensure that all staff were aware of them.

Incident reporting, learning and improvement

Information about safety is not always comprehensive or timely. Although staff recognised incidents they did not always complete comprehensive incident records and learning from incidents was not routinely shared. As a result there was a risk that staff would not be able to put appropriate risk mitigation in place and patients would be at risk of avoidable harm.

Between 1 April 2020 and 17 July 2020, the service reported no serious incidents.

Staff had a knowledge of incidents that had occurred. However, learning from incidents was not routinely discussed at team meetings, supervision and in the quality assurances panels. Quality assurance panels were meetings that involved the leadership of the service and used to determine if policies and procedures in the service were consistent and effective.

Staff did not complete comprehensive incident forms consistently. We reviewed four incidents; three incidents of patient falls and one pressure ulcer. Two of the four incident reports we reviewed were not completed in full. For example, the incident reports did not include the member of staff who reported the incident, meaning it would make it difficult to identify the member of staff who reported the incident. There were also no examples of follow up actions or support after a patient fall. The health and safety lead had oversight of incidents, but there was no evidence of audits to review the quality of documentation of incidents to ensure they led to learning or effective strategies to prevent further similar incidents occurring.

Staff did not record discussions and learning from incidents. Staff were reliant on the verbal handover of information and could not confirm what action had been taken to support individuals and mitigate risk following an incident. The registered manager stated that incidents were discussed and recorded on the handover sheet but two of the four incidents we reviewed during inspection were not recorded in handover sheets. This meant that there was an increased risk of staff not being aware of the patients' falls and the action they should take to protect the patient and reduce incidents.

Are community health inpatient services effective?

(for example, treatment is effective)

Requires improvement

Competent staff

There were gaps in management and support arrangements for staff such as supervision and professional development. Not all registered nurses employed by the service had received supervision from a suitably qualified professional.

During the inspection we spoke to four registered nurses; two of the four registered nurses were unable to provide a comprehensive answer of what staff supervision consisted of. Staff responses to supervision included; supervision occurred every six months, supervision was an informal conversation during shifts, supervision was a structured observation of staff competencies carried out by a non-registered member of staff, such as moving and handling. Three of the four registered nurses we spoke to were not aware of the supervision policy that had been introduced by the registered manager. This meant that

there was a risk of staff missing opportunities to develop knowledge and skills, identify solutions to problems, learn from incidents and improve standards of patient care.

The registered manager we spoke with reported that supervision was held every three months, the supervision policy recommended managerial supervision of no more than eight weekly. During the inspection we saw evidence of one staff supervision recorded by the registered manager. The registered manager could not provide evidence that supervision had taken place. We spoke to the registered manager whose rationale for staff not having supervision was that the policy and supervision template suggested by commissioners was not suitable for this service and was subject to review. However, there was no evidence of discussion that the policy was due for review. The next review date for the policy was for May 2022.

Are community health inpatient services well-led?

Inadequate

Leadership of services

The registered manager was visible in the service and approachable for patients and staff. They were based on site.

The registered manager had put in place four senior clinical lead nurses in place of a deputy manager lead nurse role. This was to ensure that there was a senior lead nurse available on each shift. Senior lead nurses roles included completing audits and leading shifts. However, there was no additional training provided to the senior clinical lead nurses in leadership and management, to support them in these roles and no written guidance. During the inspection senior lead nurses we spoke to reported their leadership role was limited to shift leadership as a nurse in charge only. This meant staff may have not been aware of leadership and managerial accountability of the roles.

Governance, risk management and quality measurement

The registered manager had a limited understanding and oversight of governance in the service to ensure the operation of systems and processes to assess and monitor the service effectively.

Although the service had made small improvements in developing a governance system with the help of the commissioning body, these remained insufficient. The registered manager was unable to provide a comprehensive understanding of many aspects of the service and did not have clear oversight across the day to day running of the service. For example, the registered manager could not explain the auditing and operational processes in place in the service and relied on other staff for information. During the inspection the registered manager consistently referred to other staff for information in relation to the governance of the service that we asked for. They were unable to give comprehensive answers to questions about governance processes and how effective oversight of the service was maintained. For example, oversight of incidents and environmental audits.

The service had an inadequate governance policy that did not clearly define the service assurance processes. This meant that staff did not have adequate principles to guide their decisions. The policy highlighted assurances such as the registered manager's dedication to kindness, which was not appropriate or sufficient as assurance. It also included the senior operations team carrying out spot checks on the service during the day or night. During the inspection the registered manager was unclear about who in the senior operations team conducted the spot checks and what the spot checks included. The registered manager could not provide any record of spot checks at the time of the inspection.

The registered manager had worked with commissioners of the service to introduce and review governance processes, when the service was registered in March 2020. However, the registered manager did not take action on the issues raised by the commissioners or use the information given by commissioners to make improvements to the service. This meant that the service was at risk of not fulfilling its regulatory responsibility to deliver safe care. For example, the commissioners' task force informed us that they had devised an action plan for the registered manager to ensure supervision was embedded, policies updated, and incidents shared with

staff documented in team meetings, monthly newsletters and through individual clinical supervision, as appropriate. We found during this inspection that these actions had not been implemented.

The registered manager was unable to provide a comprehensive or consistent answer to what the expectation was for staff supervision in terms of frequency and content, yet was responsible for providing supervision to registered nurses. We spoke to the registered manager whose rationale for staff not having supervision was that the policy and supervision template suggested by service commissioners was not suitable for Duncan House staff and was subject to review. However, there was no evidence of discussion of review of the policy. The next review date for the policy was stated as May 2022. There was no evidence during the inspection that staff had planned supervision dates. A clinical lead who worked for the provider, provided supervision for the registered manager. During the inspection we were unable to get a comprehensive or consistent answer about the supervision received by registered manager.

Effective systems were not in place to share, record information and learn from service updates and incidents. Staff we spoke with said safety information, such as that relating to incidents, accidents, safeguarding data and service updates were discussed in handover meetings. However, these discussions were not recorded. The commissioners' task force had made recommendations to the registered manager to document shared learning during team meetings, monthly newsletters, and supervision, but we found during the inspection that this had not been done.

The registered manager had introduced a quality assurance group and kept a log of meetings. However, outcomes of audits were not consistently and clearly recorded, including follow-up and review of actions from previous meetings. It was difficult to identify the areas for improvement and areas of good practice. The lack of clear documentation from the meeting meant that the log was not a useful guide to refer to. The frequency of quality assurance meetings was not always consistent. For example, the service held a quality assurance meeting on 30 June 2020 and a follow-up meeting on 1 July 2020. Although this gave the appearance of meetings being held on a monthly basis, they were not. The lack of a consistent frequency meant that the service was at risk of having extended periods without discussion of quality matters.

The registered manager introduced a risk register in March 2020. However, this was not robust. For example, the risk register included a mixed sex accommodation breach in April 2020, but there was no further evidence that the mixed sex breach had been reviewed on the risk register. The risk register did not highlight infection control risks related to COVID-19, and staff who were vulnerable to COVID-19, as stated in the services infection prevention and control assurance framework. There was no record that the risk register was reviewed regularly in quality assurance meetings. The service did not consider organisational level risks such as changes in legislation, short-term commissioning resources and the impact it could have on workforce risks around recruitment and retention. This meant that the service did not manage or mitigate these types of risks and adapt the service to deliver care and treatment if risk levels changed.

The service had a business continuity plan that covered disasters such as an office fire, earthquake, robbery, terrorist attack and extreme weather conditions. There was no evidence that the service had considered the impact of disruption in relation to the COVID-19 pandemic and short-term commissioning arrangements.

Staff did not have documented risk assessments in respect of COVID-19. Staff we spoke to did not have an individual formal risk assessment in respect of COVID-19 acknowledging the disproportionate impact on Black Asian Minority Ethnic (BAME) staff and staff who were in a higher risk group. This meant that staff did not have comprehensive assessments to consider workplace hazards and identify appropriate work place adjustments for each member of staff. We spoke to the registered manager who reported having informal daily conversations with staff in handover meetings about the risks of COVID-19 and testing for staff but acknowledged that no formal risk assessment process or documentation had been completed.

We found that the service could not identify and make improvements without the input and reliance of external organisations. The service had not made an improvement in governance despite support from commissioners.

Community health inpatient services

The service had submitted data and notifications to external bodies as required, for example to social services with the oversight of commissioners. Notifications had also been made to the Care Quality Commission in accordance with regulations, without delay.

Innovation, improvement and sustainability

The service did not have quality improvement or research projects at the time of the inspection.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

We understand that provider cannot take action as the location was de-registered on 7 August 2020. If the location had continued to be registered with the CQC, we would have expected the provider to make the following improvements:

- The provider must ensure there are effective systems in place to assess, monitor and improve the quality and safety of the service. This must include effective systems for reviewing and learning from incidents and a clearly understood and comprehensive governance policy. Regulation 17 2 (a)(b)
- The provider must ensure that documentary evidence of effective quality monitoring, assurance, risk management and effective governance systems. This must be completed along with other records required for the management of the regulated activity are kept and are available to evaluate and improve the service. Regulation 17 (1)(2)(a)(b)(d)(f).
- The provider must ensure that nurses employed by the service receive clinical supervision from a registered nurse to support their professional development. Regulation 18 2 (a) (c)
- The provider must ensure all staff know how to raise a safeguarding with the local authority to safeguard service users from abuse and improper treatment. Regulation 13 (2)(3).
- The provider must ensure the registered manager is able to properly perform tasks that are intrinsic to their role and have the competence to manage the regulated activity. Regulation 7 (2)(b).
- The provider must ensure that the service risk register reflects known serious risks, such as the COVID-19 coronavirus pandemic. Regulation 17(2)(b)
- The provider must ensure that staff complete comprehensive incident forms consistently and the learning from incidents is recorded and shared with all clinical staff. 17(2)(f)

Action the provider SHOULD take to improve

We understand that provider cannot take action as the location was de-registered on 7 August 2020. If the location had continued to be registered with the CQC, we would have expected the provider to make the following improvements:

Action the provider SHOULD take to improve

- The provider should consider formally risk assessing vulnerable staff in relation to COVID-19 and document these.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014: Good governance.**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 7 HSCA (RA) Regulations 2014 Requirements relating to registered managers **Regulation 7 HSCA 2008 (Regulated Activities) Regulations 2014: Requirements relating to registered managers.**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014: Staffing.**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2014: Safeguarding service users from abuse and improper treatment.**