Fountain Lodge Care Home Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

At our previous two inspections the service was rated as 'requires improvement'. This included our last inspection undertaken on 20 September 2016.

This inspection took place on Wednesday 6 September and was unannounced. At this inspection the service continued to be rated as requiring improvement. However, the provider had recently made changes in their senior management structure and this had started to improve the quality of the service provided.

Fountain Lodge is a nursing home which provides care and support to people who require nursing care in their old age, and who require support to live with dementia. The home can support a maximum of 30 people. On the day of our visit 26 people lived at the home and one was in hospital.

The home had a registered manager until recently. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'.

Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager left the service in May 2017 and submitted an application to cancel their registration. The current acting manager will be applying to register with the CQC.

The acting manager and new regional manager were open and transparent about the service and the improvements required.

Medicines were mostly managed safely, but we were concerned that one person's pain was not managed well. This was responded to on the day of our inspection visit.

Risks to people's health and well-being had been identified, but the actions taken by staff to reduce the risks related to one person were not in the person's best interest as intended. Staff monitored those who were at risk of malnutrition or dehydration, but monitoring systems were not effective.

There were enough staff to meet people's needs, but the use of agency staff meant people did not always get support from staff who knew them or their needs well. The provider was recruiting new staff and their own 'bank' staff, to make sure people were familiar with the staff who cared for them.

We received mixed opinions about the quality and choices of food available.

Not all staff had received the training the provider considered essential to meet people's health and safety needs. The home provides specialist dementia care and staff had not received specialist dementia training. The acting manager was putting training in place to ensure staff had the skills and knowledge to support people effectively.

People told us most staff were kind and caring, and treated them with respect and dignity. Staff interaction with people was mostly when undertaking tasks as they did not have time to engage with people at other times. Sometimes some staff did not fully understand written or spoken English.

The provider understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty safeguards. People told us they were asked if they consented to care tasks being undertaken most of the time.

The provider had systems in place to ensure the premises were safe for people to live in, and the equipment was safe to use. The gardens were not safe or accessible for people to use.

The provider employed an activity worker who supported activities in the home on Mondays to Fridays. There were limited activities from external organisations.

The provider's recruitment practice mostly reduced the risks of employing people unsuitable to provide care. Staff received training to safeguard people however this was not always put into practice.

Relatives and friends were welcomed at the home at any time during the day or evening.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report. We have also asked the provider to send us an action plan informing us of how they will continue to improve the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were mostly given as prescribed. Risks associated with people's care continued to not always effectively be managed to ensure people's on going health and wellbeing. Staff understood the importance of protecting people from harm and recruitment procedures reduced the risks of recruiting unsuitable staff.

Is the service effective?

Requires Improvement

The service was not always effective.

Most staff had not undertaken specialised training to work with people who lived with dementia, and some had not received 'refresher' health and safety training. Where restrictions on people's liberty had been identified, appropriate applications had been made to the supervisory body. Some people felt they were not always asked their consent before tasks were undertaken to support them. People were supported to attend appointments with external healthcare professionals to maintain their health and wellbeing. There were mixed opinions about the quality of, and choice of meals provided.

Is the service caring?

Requires Improvement

The service was not always caring.

People thought most staff were kind and caring, but felt staff had limited time available to them to engage with them. Staff mostly respected people's privacy and dignity. Visitors were welcomed at the home.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People and their relatives were not fully involved in care planning or reviews of their care. Social activities had improved since our last visit and the activity worker was getting to know people's individual interests. The internal and external environment was not always responsive to people's needs. People felt able to

complain about the service and felt their concerns were responded to.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was no registered manager in place and the service had not had consistent management for a few months. The acting manager and regional manager had in a short period of time started to make improvements to the service. They were open and transparent about the areas of improvements required. Staff felt supported by management.

Fountain Lodge Care Home Limited

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 visit took place on Wednesday 6 September 2017. It was a comprehensive, unannounced visit. The inspection team consisted of two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information we held about the service including the statutory notifications the manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We also contacted the local authority and clinical commissioning staff to find out their views of the service. They had no major concerns about the service.

During our visit we spoke with six people who lived at the home, three relatives, two care staff, a nurse, the acting manager and the regional manager. We spent time with people and staff looking at the care provided to people, and reviewed the care plans of four people in detail.

We also reviewed other records to demonstrate the provider monitored the quality of service such as staff meeting minutes, staff training plans, quality monitoring questionnaires, audit checks, accident and incident records, health and safety and medicine records.

After our visit we requested further information from the regional manager and the acting manager about staff training, complaints and management oversight. This information was provided to us when requested.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we rated 'safe' as requires improvement. At this inspection visit we found improvements had been made with regard to most of the concerns identified at the last inspection. However, we found different areas of concern which meant further improvements were still required.

Whilst we found improvements were required, people and their relatives told us they felt people were safe at the home.

We looked at the administration of medicines. People told us they received their medicines as prescribed, for example one person said, "They are good with the medication, it's always on time." Although another person told us they sometimes had to wait longer than they wanted for tablets prescribed 'as required' for pain relief.

Prior to our visit we had received concerns that a person was being restricted in their access to stronger medicines to control pain. We looked at the records of two people who received stronger medicines to help them with their pain. One of the people told us they were always asked if they were in pain and given their medicines if they needed them.

However, records showed the other person had very rarely received the pain relief they were prescribed on an 'as required' basis. The person had wounds to their skin, the type of which would usually cause pain, particularly when dressings were changed. The person was not able to say whether they were in pain, so the acting manager and nurses assessed whether the person needed pain relief by looking at their facial expressions and by listening for any other vocalisation of pain.

The acting manager told us they had previously assessed the person as not showing any pain, but a nurse told us there had been a couple of occasions when they had assessed the person was in pain. Pain relief had been given to the person with positive effects and the nurse had fed-back that this needed to be given in the future. The nurse's advice had not been recorded in the person's notes, and the medicine had not been administered since. A care worker also told us the person "winced with pain" when they were re-positioned in bed.

The acting manager and regional manager acknowledged that because the wound was healing, there was more likelihood the person would now experience pain. They said they would ensure medicines were given to reduce the risk of the person experiencing any pain. After our visit they confirmed they had introduced a recognised 'pain assessment' tool to help them identify when people were in pain.

We looked at how other medicines were administered. One person had their pain medicine administered directly into their skin by a patch placed on their chest. The manufacturer's guidance says the patch should be placed on a different part of the upper body each time it is replaced. Staff were expected to record where each patch had been placed, but the last record had not been completed. The person told us the last patch had been placed on their chest, but had fallen off. This meant they were not receiving their medicines as

they should, and staff on the next shift might not know where the last patch had been placed. We informed the nurse on duty to make sure the person received the medication they needed.

Prescribed topical creams were not dated on opening. This is important because topical creams can become ineffective after a certain period of time once opened. Without knowing how long the cream had been opened, staff would not be able to tell whether it was still effective. The provider expected staff to record the administration of creams on charts to demonstrate they had been administered. These were not always completed to confirm creams had been applied as directed.

Risks related to people's health and welfare were documented in people's care records. For example, where people were at risk of skin damage, or not drinking or eating sufficient quantities to remain healthy, these risks had been identified.

However, whilst the risks had been identified, the reasons for the identified actions to reduce the risks related to one person's skin were unclear and potentially damaging to their health and well-being. When people are unable to move themselves, they are at risk of damaging their skin because of pressure on vulnerable areas of their body. Staff usually supported people who were at risk of pressure damage to move position every two to four hours depending on the risk assessment. We found this person was being re-positioned hourly in bed.

The person had skin damage, but this was unusual practice and exhausting for the person who was woken every hour during the night to be repositioned. The care plan contained no information to explain why this frequency of re-positioning was in place. The acting manager agreed that re-positioning a person so often was highly unusual and said they would re-assess the risks to this person. They could not give us any reason why the person was being repositioned so frequently.

People identified as being at risk of not eating or drinking enough were on food and fluid charts to monitor their intake. At our last inspection we found the charts were not accurate because they only recorded the amount given to the person and not the amount consumed. We found the same at this inspection visit. Staff recorded the amount of food and fluid provided, but did not monitor how much had actually been eaten or drank. For example, one person's record showed they had drank two glasses of squash, but we found the glasses in the person's bedroom and very little had been drank from them. Another chart showed that a person had eaten all their pudding, but the pudding was still in front of them and most had not been eaten. Inaccurate records meant staff might not recognise when people needed to be encouraged to eat and drink more which could put their health at risk.

The regional manager acknowledged this continued to be an issue and showed us a new form they were going to introduce to the home which they felt would make people's nutritional intake clearer.

This was a breach of Regulation 12, of the Health and Social Care Act 2008 (Regulated Activities) 2014 Safe Care and Treatment.

The number of staff on the rota reflected people's assessed needs and dependencies. However people and their relative told us at times the home appeared to be short staffed, particularly at weekends. One relative told us their relation had to wait longer to go to the toilet at the weekend because there seemed to be less staff. The acting manager informed us when staff were absent at the week-end it was sometimes difficult to cover their shift with agency staff at short notice.

The acting manager acknowledged that due to recent changes in staff, people had not always received

continuity of care because the provider had been relying on agency staff. They were actively recruiting new staff, and hoped to have their own pool of 'bank staff' to use when the need arose instead of agency staff. The acting manager was confident this would provide people with more consistency of care.

The provider's recruitment procedures contributed to people's safety. Staff were not recruited to work at Fountain Lodge until their DBS (Disclosure and Barring Service) checks or references had been received. These were then checked to ensure the person had no prior history which would mean they were unsuitable to work with people who lived at the home. However, we were concerned that the provider had not checked nursing and care staff's verbal and written understanding of English prior to commencing employment. This impacted on the care given to people. For example, during our visit, we saw that a staff member experienced difficulty in reading the menu and therefore was not able to accurately relay to a person what the menu options were.

We were concerned some staff's command of English made it difficult to understand some of the questions asked of them. This might put people at risk if staff did not comprehend what they were being told by people or their relatives. We discussed our concerns with the provider's regional manager. They told us the provider was bringing in systems to check staff competency in relation to verbal and written English language and where necessary, staff would be offered extra support to help them with their language skills.

Staff had received training to safeguard people from abuse. However, we could not be confident that all staff put their learning into practice. This was because during our visit we saw a person with bruising on their lower arms who told us this was from staff trying to pull them up from a sitting position. We informed management of the person who told us of their bruising. Management were not aware of this and informed us they would alert the safeguarding authorities to the safeguarding concerns raised. After our visit they confirmed this had been done. Two other people told us staff were sometimes rough when moving them.

One member of staff when asked about what they would do if they saw unexplained bruising said, "I would report it to the nurse and record on a body map chart. Even shouting is abuse and I would report it." They went on to say that understanding body language and facial expressions would give an indication those people who could not communicate were unhappy or in pain. "I look at people to make sure they are comfortable, I look at their body and face." The previous management of the home had alerted us through notifications to the CQC when they had concerns over a person's safety. The acting manager and regional manager had a good understanding of safeguarding practice and procedures and gave us confidence these would be followed.

The home was maintained to a satisfactory level and records demonstrated that there were regular checks for fire safety, gas and electric safety, water safety and to make sure the equipment used was safe. People had individual evacuation plans to help fire and rescue services evacuate the premises if the need ever arose.

Requires Improvement

Is the service effective?

Our findings

At our last inspection visit we rated 'Effective' as requires improvement. During this inspection visit we found the home continued to require improvements in this area.

The majority of people we spoke with felt staff had the knowledge and skills to support them. However, when we looked at training records we found that whilst some of the health and safety training considered mandatory by the provider had been undertaken, there were a number of 'refresher' training sessions which had not taken place within the expected time frame of a year.

The acting manager was aware of this and showed us a training schedule which meant all essential training would be covered by November 2017. We were concerned staff may not have understood their training to safeguard people, or move people safely as we received comments from people that sometimes staff were 'rough' when they were being re-positioned or moved. The regional manager told us they were introducing a test after each training session to check staff understood the information given.

The home specialised in supporting people who lived with dementia and this could mean supporting people who had behaviours which could challenge others. At the time of our visit, none of the staff had received specialised dementia training and only the acting manager had undertaken training to help manage people's behaviours more effectively.

The acting manager had booked dementia training for staff, but acknowledged it was an over sight not to support staff with training about behaviours which challenge. None of the nursing staff and only half of the care staff had been trained to understand person-centred care. Person centred care is where the individual's personal needs, wants, desires and goals are central to the care and nursing process. The acting manager told us this was also on their list of training to arrange.

The acting manager and nursing staff felt they had received sufficient training to deliver safe nursing care. This included training to use a syringe driver safely (to give stronger medicines in a syringe to people who are at the end of their lives).

The clinical support nurse from the clinical commissioning group told us the home had recently received the 'React to Red Skin' accreditation. This meant all staff had been trained to a competent level to be able to identify and react to early signs of skin damage such as pressure sores.

At the time of our inspection, the home was not supporting staff with the Care Certificate. The Care Certificate is expected to help new members of staff develop and demonstrate key skills, knowledge, values and behaviours, enabling them to provide people with safe, effective, compassionate, high-quality care. The regional manager told us the provider's policy was to recruit experienced staff who had already undertaken a level two, national vocational qualification in health and social care. They confirmed to us that all staff who worked at the home were qualified to this level. This meant staff had already received training on essential standards of care.

Staff told us they were supported to further their qualifications. One member of staff told us they were in the process of obtaining a level three qualification in health and social care.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA , and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found where people were assessed as not having capacity to consent to their care and treatment, DoLS applications had been submitted to the local authority who were the supervisory body responsible for authorising applications.

At our last inspection visit, we found staff had undertaken DoLS and MCA training but we were not sure that staff fully understood what it was and how it impacted on the care given at Fountain Lodge. The acting manager told us they were still not sure that all staff were fully understanding of this, but they were working with the staff group to support them in their knowledge.

We received mixed responses from people about whether their consent was always sought before staff undertook a task to support them. One person said, "They are very good, they usually ask me when they want to do something." However, another person said, "No they don't, they just do it – like when they put my ointment on." And, a third said, "Sometimes they ask us when we want to go to bed, other times they just do it."

We asked people what they thought of the meals provided. Again we received mixed responses. One person thought the food was "Beautiful" and told us they received two choices. Whereas another person thought the food was "fair enough" but said they did not get a choice; and a third said if they didn't like the food provided they were offered a choice of something different. A relative told us their relation was unable to choose their meals and the home's staff had consulted with them about the person's likes and dislikes. They told us, "He seems to like the food, he eats it all." Another relative told us their relation did not like fish, and the person was always given an alternative when people had fish on a Friday.

The regional manager had undertaken a mealtime experience audit in August 2017. They had identified from speaking with relatives and people who lived at the home that the choices of meals were limited. They were intending to act on this, but were waiting for a new cook's recruitment checks to be returned before the person could start working at the home. During our visit we saw people were not rushed with their meals and their specific needs were catered for. For example, one person was vegetarian and they received a vegetarian option.

People told us their health care needs were being met, although two relatives told us they previously had to inform staff of their concerns about a person' health changes as staff had not identified this themselves. They told us on being informed, staff acted swiftly to get the relevant healthcare professional to attend. A relative told us their relation had undergone an eye test earlier in the year, and had seen a dentist for new

dentures. Care records demonstrated healthcare professionals were contacted when required.

Requires Improvement

Is the service caring?

Our findings

At our last inspection visit we rated 'caring' as good. At this inspection visit, whilst the majority of staff were seen to be kind and caring, we found improvements were required.

People and their relatives told us staff were mostly caring. One person told us, "Staff are very nice", and another said, "They treat me well." However others said, "It's not too bad here, it could be better, the attitude of the staff could be better. They say 'I'm too busy' or 'you will have to wait'. That applies to some staff, but not all of them." One person remarked, "They are a little rough when I'm in bed. They turn me over roughly and I tell them not to be so rough."

Relatives told us, "They treat her [relation] as their mum." And, "They are very good to him." A relative said they would like staff to interact with their relation on more than just a 'need' basis.

During our visit we saw staff mainly interacted with people when they were undertaking care tasks with them. We saw staff being kind and caring, but they did not have time to do anything other than the personal care tasks required for each person. A member of staff said to us, "We do our best, we try to look after them like our own family." Another said, "People here are like my own family."

People with differing ethnicities were supported by staff who could speak their language. A person whose hearing was impaired, communicated with staff via a communication book. However, a person who spoke English told us they found it hard to understand what some of the staff were saying to them as English was not always the member of staff's first language.

Staff understood the importance of showing respect for people's privacy and maintaining their dignity. They told us when they provided personal care they would shut the bedroom door and curtains so nobody could see what they were doing. They also explained they knocked on doors before they entered a person's room. However, on a few occasions during our visit, we saw staff walking into bedrooms without knocking or waiting to be invited in.

Staff told us they understood the needs of each person who lived in the home. A member of staff said, "The managers tell us to read the care plans." "The nurses tell us about any changes in people and there is great communication with the staff." However, people told us they could not remember being included in any care planning.

During our visit people were involved in daily decision making such as what they wanted to eat, choices in clothing, and whether they wanted to sit in their bedrooms or in the communal lounge or dining areas. Although some people told us they were not always offered choices.

Friends and relatives were able to visit the home at any time during the day and evening. One relative told us, "The atmosphere is welcoming, the staff always say hello." Another said, "It's a friendly atmosphere."

Requires Improvement

Is the service responsive?

Our findings

At our last inspection 'responsive' was rated as requires improvement. At this inspection visit we found some areas previously identified as requiring improvement had been improved, but further improvements were still necessary.

Previously we found people had little social and emotional stimulation. Staff supported people with social activities when they had time between providing care. This had meant there was not much time available for social activities. During this visit we found an activity worker had been employed by the provider. The activity worker worked between 9.30 and 3.30pm each week-day. This meant an organised activity took place each morning, and individual activities took place in the afternoon.

The activity worker had started to get to know each person and was working to provide individualised activities for them. However, one person told us they had never been asked about the activities they liked. They told us they liked to do jigsaws, but there was no space available to do them. Another told us they would like to go out of the home, but because they needed staff to go with them, this did not happen. There were few external organisations which visited the home to provide a different range of activities to people.

People's needs had been assessed before they came to Fountain Lodge to ensure the home could meet their needs. Care plans had been put in place for each person. Prior to our visit the acting manager and regional manager had identified care plans required improvement because they did not always have appropriate action planning for identified needs, assessments were missing, and the care plans did not focus on the person as an individual and explain how they preferred their care to be provided.

At the time of our visit, this was a work in progress. We looked at care plans which had recently been updated by the acting manager and saw these were reflective of the individual and their wants and needs. The acting manager told us it would take time to go through all the care plans until they were satisfied care planning was of an acceptable standard. They told us they were introducing the concept of 'resident of the day.' This is where each day, the home focuses on one or two people to make sure they are getting the support they need in the way they prefer. It includes talking to the chef, care and domestic staff; talking with the person and their relative; and reviewing the written information to make sure it is accurate and up to date.

The home supported people who lived with dementia as well as older people with general nursing needs. The environment was not supportive of this. There was no secure garden area people could use. The garden was in a poor state and the only place people could sit in the fresh air was in a small patio area just outside the front of the home. This was not safe for people to use without assistance.

The communal lounge had a mixture of striped wallpaper, and armchairs with different patterns. The ranges in colours and patterns were not conducive to good dementia care. Whilst there had been some improvement and redecoration of individual bedrooms and some communal areas, some of the bedrooms and corridors, as well as the external building looked 'tired' and uninviting. The regional manager told us

they had identified that redecoration was required within the home, and said they would look at how they could make best use of the external space to give people a safe garden space for outdoor activities.

People and relatives told us they felt able to raise concerns or complaints but did not know about the provider's formal complaints procedure. One relative said, "I don't know the correct complaints procedure, I just grab someone. I haven't needed to make a complaint." Another said they had raised a complaint which the provider took seriously. It resulted in disciplinary action for a member of staff, and they had received a written apology. The acting manager confirmed there had been five complaints about the service since our last inspection visit.

Requires Improvement

Is the service well-led?

Our findings

Our last two inspections of Fountain Lodge resulted in an overall rating of requires improvement. This inspection also resulted in a rating of requires improvement for the service. As a result of this we asked the provider to send us an action plan informing us how they will improve their service.

We looked at why the home had not improved since our last visit. Since our last visit the service had undergone management changes. The previous deputy manager left the service in February 2017 and the registered manager left the service in May 2017. A new manager was recruited and started working for the organisation. The provider found this person was unsuitable for the role of manager. They left their employment at the end of July 2017.

At the time of our visit, the clinical lead nurse who started work at Fountain Lodge in November 2016 was acting up as the manager. After our inspection visit we were informed the acting manager would be permanently employed as the manager of the home, and was starting the process of applying for their CQC manager registration.

The acting manager was a registered general nurse, but also had a lot of experience in working with people who lived with dementia, and people who experienced mental health challenges. Through discussion with them, we saw they had a good understanding of people's physical, emotional and psychological needs.

The regional manager was new in post and told us they had been a registered manager of another home within the provider's group of homes. They told us the provider had created the regional manager position in August 2017 as they wanted a clearer understanding of what was happening in each home, to provide more effective support to each registered manager, and to improve the standards of care delivery.

The regional manager explained they would provide weekly support to the new manager until they were confident in their role and would thereafter visit the home at least once a month to check on service delivery. They also informed us they were holding monthly managers meetings to provide support to managers and to improve practice within the provider group of homes.

The acting manager and regional manager were both aware of the areas of improvement identified at the CQC's last visit. In the short period of time they had taken on their additional responsibilities, they had started to work towards improving the service.

We saw records of quality assurance visits undertaken by the regional manager. The records showed the regional manager had identified similar themes to us, and were in the process of working on the areas they had identified as being of concern. For example, they had identified and acted on safety concerns, and work by staff which had fallen short of expected standards. They and the acting manager, both felt improvements had already taken place, but acknowledged they had not had time to work on other areas which they felt required improvement. During our visit we saw some improvements had been already been implemented

Staff felt supported by the acting manager. One member of staff said, "[Acting manager] is good, he solves any problems, he understands us and what we do." They went on to say, "We have staff meetings and supervision. It helps us improve if there have been any mistakes."

The acting manager and regional manager were open and transparent with us about what was working well and what the service needed to do to improve. They told us they were confident they could improve the service. They also felt they had the backing of the provider to provide them with the resources to do so.

The provider understood their legal responsibilities to notify us of incidents which affected the health and well-being of people who lived at the home. The provider also had a legal duty to publicise their inspection rating both in a visible area within the home, and on the provider's website. We found the previous report was in a visible area to people who lived in, and visited the home. The provider does not have their own website.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not always do all that was reasonable to mitigate the risks in relation to people's health and welfare.