Kendalcourt Limited

Home Park Nursing Home

Inspection report

Home Park, Knowle Lane
Horton Heath
Eastleigh
Hampshire
SO50 7DZ
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Website: www.homeparkcarehome.co.uk

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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?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

The inspection took place on 14, 16 and 21 July 2015.

The home provides accommodation and care for up to 35 people. There were 34 people living at the home when we visited, all of whom were living with dementia.

There was a registered manager in place. 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 and associated Regulations about how the home is run.

At the last inspection on 30 and 31 October 2014, we asked the provider to take action to make improvements in the following areas: respecting and involving people; care and welfare; safeguarding people from abuse; cleanliness and infection control; recruitment procedures; staffing; medicines and assessing and

Summary of findings

monitoring the quality of the service provision. Action had been taken to make improvements in line with the provider's action plan but during this inspection we found two continuing breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found one new breach. You can see what action we told the provider to take at the back of the full version of this report.

The home was clean but there were were areas of the home where risks had not been identified or action taken to minimise them. Care plans were not up to date and one person did not have a care plan in place. Medicines were stored safely but people did not always have effective care plans in place for medicines prescribed as 'when needed'.

Staff were aware of risks to people, such as using the hoist to support people to move. They knew about people's moving and handling care plans which detailed what equipment people needed to ensure they were supported to move safely.

Most people needed staff support to eat and drink and this was done in a patient and caring way. However, we saw two incidents where people were not getting the support they needed and the registered manager dealt with the incidents. Staff formed positive caring relationships with people and spoke about them in a caring and compassionate way. People's dignity was respected when staff supported them with personal care. The provider employed an activities co-ordinator who used a range of techniques to interact with people.

New staff started work after satisfactory pre-employment checks had been completed. Staff completed a thorough programme of induction training as well as further training, relevant to their work. Staffing levels were calculated based on the number of people living in the home rather than on assessed needs and staff said most people needed support with eating and many needed two staff to support them with moving and personal care. However, staff did meet people's needs. The registered manager was well thought of and ensured an open and positive culture within the home.

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?
The service was not always safe.

There were risks in the environment which had not been previously identified.

Medicines were stored safely but there were not care plans in place for medicines prescribed as 'when needed'.

New staff started work only after satisfactory checks had been completed and there were enough staff to meet people's needs.

Requires improvement

Is the service effective?
The service was not always effective.

Most people got the support they needed to eat and drink but we saw two incidents where people did not have the best experience at mealtimes.

Staff did not have access to regular supervision but did complete a thorough induction and further training.

People had access to healthcare professionals when necessary.

Requires improvement

Is the service caring?
The service was caring.

Staff formed positive caring relationships with people and supported them to make decisions.

People's privacy and dignity was respected.

Good

Is the service responsive?
The service was not always responsive.

Care plans were not all up to date and one person did not have a care plan in place.

The registered manager sought feedback from people and visitors about their experience and there was a complaints procedure in place.

Requires improvement

Is the service well-led?
The service was not always consistently well led.

The audit system did not identify the concerns we have raised in this report.

However, there was a system to monitor the quality of the service. There was a positive culture in the home and the registered manager was well thought of.

Requires improvement

Home Park Nursing 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.

This inspection took place on 14, 16 and 21 July 2015 and was unannounced. The inspection team consisted of two inspectors and a specialist advisor. A specialist advisor is someone who has clinical experience and knowledge of working with people who are living with dementia.

Before the inspection, we reviewed the information we held about the service. This included notifications about important events which the home is required to send us by law and our previous inspection report.

During the inspection we looked around the premises, observed people eating their lunch and sitting in communal areas. As part of our observations we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke in detail with one person living in the home, three visitors, five staff and the registered manager. We looked at a range of records regarding the management of the service and people's care records, including five care plans.

Requires improvement

Is the service safe?

Our findings

At our previous inspection we identified a breach of four regulations relating to staffing, medicines, safeguarding and infection control. We set compliance actions and the provider sent us an action plan stating how they would meet the requirements of the regulations. At this inspection we found the concerns relating to staffing, safeguarding and infection control had been addressed. Concerns relating to care planning for medicines had not been addressed and we identified a new concern relating to risks on the ground floor of the home.

We found people did not always have effective care plans in place for medicines which were prescribed as 'when needed' (PRN), such as pain relief. Care plans stated the medicine was to be taken "for pain" but only one included the signs staff should look for to see if an individual person might be experiencing pain. Two people had been prescribed medicines for pain relief, which differed in their strengths. The care plans did not show when the stronger medicine should be given. One person had been prescribed a controlled medicine without any written guidelines for staff to decide when it should be administered. Two people had a PRN protocol in place which stated, "give for anxiety". There was not any written information to support staff in their decision making regarding how individuals may display their anxiety.

The continued failure to ensure there were care plans in place for medicines prescribed as "when needed" was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were stored appropriately and safely, except a bottle of liquid medicine which should have been kept in a specific part of the cupboard, which is higher security. However, the liquid was locked away in the medicines cabinet. The temperature of the medicine rooms were recorded once a day in the morning, together with the temperature of the refrigerator. We noted that the temperature in the topical medicines and food supplements room had been recorded on one morning as 25 degrees. It was possible that the temperature in the room could rise during the day and some medicines should not be stored above this temperature. We raised this concern with a nurse who told us they would ensure the temperatures were recorded twice a day.

Nursing staff were knowledgeable about medicines, their uses and side effects. They received training in the administration of medicines and their competency was assessed annually. Nurses approached people in a professional and caring manner and explained what the medicine was for and asked for people's consent before dispensing the medicine. They did not rush people and appeared to have a good rapport with them.

There were areas of the home where risks had not been identified. Two ground floor bathroom windows opened out directly onto the road and did not have restrictors. We saw the windows open during our inspection. There was a risk that people could leave the building or enter the building, undetected. A sluice room used for cleaning soiled equipment was unlocked even though there was a lock on the door. A bottle of toilet cleaner was on the worktop in the sluice room. A piece of equipment had been left in front of an open fire door which may have restricted the effectiveness of the door should the fire alarm have gone off.

The failure to identify and minimise risks in the environment was a breach of Regulation was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our previous inspection found there had been a safeguarding incident which had not been referred to the local authority under safeguarding procedures or reported to us. The issue was subsequently reported. The registered manager had taken action to ensure correct procedures were followed if decisions needed to be made in people's best interests. The provider had a safeguarding policy and procedure in place as well as a whistle blowing procedure. Staff received training in safeguarding. Staff were aware of the different types of abuse and knew what procedures to follow, including whistle blowing, if concerns were raised

At our previous inspection, we found the recruitment procedure was not robust which had resulted in two staff not having the relevant references in place. This inspection found the provider's recruitment procedure included seeking references and completing checks through the Disclosure and Barring Service (DBS) before employing new staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. We found the checks had been undertaken before new staff

Requires improvement

Is the service safe?

started work. Recruitment files contained other information such as an application form which showed a full employment history as well as a medical questionnaire to ensure staff were fit to work.

We previously found there were not enough staff to meet people's needs in a timely manner. During this inspection we saw staff responded quickly to call bells and attended to people quickly if they asked for support. A visitor said they could not "fault the care, there is a good number of staff around". However, staffing levels were calculated based on the number of people living in the home rather than on assessed needs. Staff told us most people needed support with eating and many needed two staff to support them with moving and personal care. Two staff said they felt one more member of staff on shift would enable them to spend more time talking with people.

The registered manager ensured there were two nurses on duty each shift and the provider employed enough nurses for this to happen. However, although there had been a recent recruitment drive, there were not enough care staff employed to fulfil the planned staffing level of seven care staff on each shift. The shortfall was made up from the staff team where possible and the registered manager said agency use amounted to "about one full time post a week". Where possible, agency staff had worked in the home before and knew people living there. Since our last inspection the registered manager had changed the rota to enable a staff member from the afternoon shift to come on duty at 12 noon so they could support people with eating. This had improved people's experience at lunch time.

Our previous inspection report set a compliance action regarding the cleanliness of the home. During this inspection, the home appeared clean and a visitor told us they thought the home was clean. There were cleaning rotas in place which included daily cleaning tasks as well as deep cleaning schedules. These were completed and up to date. The registered manager told us they conducted regular audits to ensure the people living at the home were protected from infection. The home had identified an Infection Control Lead who had completed the appropriate training and staff knew who was responsible for issues around infection control. There was a copy of the Department of Health's infection control guidelines in the office and staff said there was always plenty of disposable aprons and gloves to protect them. However, we found some equipment and fittings were worn and not easily cleanable, such as some commode seats and light pull cords in toilets. This meant it would not have been possible to clean appropriately. The registered manager told us the commode seats were likely to be out of use and waiting to be replaced. An order had been placed for new ones and during our third visit, we saw new commodes being delivered.

Staff were aware of risks to people, such as using the hoist to support people to move. They knew about people's moving and handling care plans which detailed what equipment people needed to ensure they were supported safely. We saw staff supporting people to move between chairs using hoists and slings. Staff did this competently and with concern for the person being moved. Staff constantly talked to the person, telling them what was happening at each stage and reassuring them that they were safe and making good progress. When one person told the staff they were not comfortable in the wheelchair the staff corrected the person's position quickly.

Requires improvement

Is the service effective?

Our findings

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. At our previous inspection found the registered manager had not submitted applications, where needed, under the Deprivation of Liberty Safeguards (DoLS). We set a compliance action and the provider sent us an action plan stating how they would meet the requirements of the regulation.

The registered manager had subsequently submitted the relevant paperwork to the local authority, where necessary. The local authority was in the process of reviewing the applications and no-one was currently the subject of a DoLS.

Where people lacked the mental capacity to make decisions the home was guided by the principles of the Mental Capacity Act 2005 to ensure any decisions were made in the person's best interests.The Mental Capacity Act 2005 (MCA) provides a legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision should be made involving people who know the person well and other professionals, where relevant. The registered manager was aware that many people lacked the "capacity to plan for care but on a day to day basis can make choices, such as what to drink and what to wear. People can show a lack of consent with body language, such as shouting, or becoming resistive. Care planning is done in their best interests". Staff told us about particular people they supported and how they made individual choices, for example, by pointing to or saying what they wanted to wear. The home had information available regarding advocacy services if this was needed.

The majority of people needed support with eating their meal and some were supported by their visitors. Staff called people by their names, sat next to them and stayed with them until they finished. One staff member had to move away from assisting someone to eat to support someone who was eating independently as they were about to tip their plate on themselves. The staff member apologised to the person they had been supporting. One person began to cough or choke but staff immediately went to help. Staff asked permission to do things such as cleaning the person's face. However, in another dining room we saw a person being supported to eat inappropriately by an agency worker who was on their first shift in the home. They were putting large amounts of food in to the person's mouth, not giving them time to finish before putting the next spoonful near their mouth. They were also given a drink before they had swallowed the food. This meant the person was at risk of choking. We advised the registered manager who took appropriate action straight away.

On the second day we saw that one person did not want to eat a main meal and a staff member suggested to a colleague they might like a banana. The person did eat a banana followed by two puddings. This showed staff knew individual's preferences. However, we also observed one person who had been assessed as able to eat independently. They used their knife to eat, and the plate and food started to gradually slide from the table, onto the person's lap and then between their leg and the arm of the chair. Staff later removed the plate and brought a dessert. The person tried to eat this but tipped almost all of it onto the table and into their lap. They picked a lot of it up with their fingers to eat it. We spoke to the registered manager about this who said they clearly needed to re-assess the person's abilities. By our next visit this had been undertaken and the person had been given extra support.

The registered manager told us since the previous inspection, they had bought new dinner plates which were "dementia friendly" colours. They also said this approach had worked well and a visitor had commented to them that their relative was eating better as they could see the food better on the plate. We spoke with two visitors about mealtimes and they confirmed people were given a choice of food and drink. People were frequently offered another drink after they had finished one.

One visitor confirmed their relative was given food which was presented in a way which met their needs. Where appropriate, people were weighed monthly or sooner if there was a concern about their weight. If necessary, the GP was contacted and this could be followed up by the dietician. Fortified food was provided for people where this was needed to maintain their weight.

There was a system in place for all staff to receive formal supervision. The registered manager told us there was a system in place to record which staff had received supervision and to send reminders to the supervisors. The registered manager was responsible for supervising the

Is the service effective?

nursing and ancillary staff. The records showed staff had not received the number of supervision sessions detailed in the provider's policy. Two staff had received four sessions in the last year, but nine had three sessions in the last year. The registered manager said when discussing this with supervisors, there was a view that they did not have any issues to raise with staff. However, this view contradicted the provider's policy, which stated supervision should cover 'all aspects of practice, philosophy of care and career development'. The registered manager said they met and talked informally with staff.

New staff completed a period of induction, with those new to the caring profession working towards the Care Certificate, which is a nationally recognised set of standards staff are expected to work to. Part of the induction included shadowing the nursing assistants and completing a 'performance criteria' induction checklist. From this, a personal learning plan was devised individually and discussed with their supervisors. All the resources used for training, including the newly available Care Certificate modules were available to all staff. Staff received an annual appraisal, as was in the provider's policy.

The provider had a training programme in place and a named staff member had the responsibility to manage the programme to ensure all staff members were up to date with their training. We spoke with this staff member about the training programme and they said they were aware that individuals learn in different ways so they accessed different training formats to match individual staff needs, for example, group learning. Training was appropriate to staff roles and included infection control, nutrition, dignity and dementia care. There was a "training board" in place which showed who was up to date with their training and when training was due. The staff member supplemented training with annual "quizzes" for some topics such as safeguarding. They marked the answers and supervisors were asked to focus on any issues raised. Specialist training was accessed when needed to meet people's individual needs. Some staff had attended a conference which looked at topics such as dining with dignity. The registered manager ensured staff were aware of best practice through training and reading articles in professional publications.

People were supported to have access to healthcare services and received ongoing treatment. Healthcare professionals such as GPs, district nurses, dentists, opticians and speech and language therapists visited the home when needed. Healthcare visits took place in people's bedrooms for privacy, except the optician who set up their equipment in a small communal room.

Good

Is the service caring?

Our findings

At our previous inspection we found people's dignity was not promoted when eating because the equipment provided did not meet their needs. We set a compliance action and the provider sent us an action plan stating how they would meet the requirements of the regulation. We found during this inspection that the registered manager had bought more dinner plates and specialist equipment as well as promoting dining with dignity as a dignity issue one month.

Staff respected people's privacy and dignity. There were a number of shared rooms in the home but we saw these rooms had privacy screens. Staff confirmed they used these when undertaking personal care for people. We saw that all the bedroom doors were kept open, which meant anyone walking along the hallways could see people in bed. People had not chosen to have their doors open and it was not detailed in care plans. Staff and the registered manager explained doors were open so that staff could see people without disturbing them by opening and closing doors. We saw that people were dressed and their dignity was not compromised. Staff explained how they ensured people's privacy and dignity was respected whilst undertaking personal care. Usual practice was to close curtains, shut doors, and put a sign on the outside of the door to ensure no-body walked in.

The registered manager ensured dignity was a key focus at the home. A named staff member was the designated Dignity Champion. The role of a dignity champion is to challenge poor care practice, act as a role model and educate and inform staff working with them. The Dignity Champion identified resources to explore a different aspect of dignity each month and posted information on a board in the staff room. There was also a scheme in place whereby one staff member was given the title of "employee of the month", recognised for the positive ways they supported people's dignity.

Staff formed positive caring relationships with people. One person told us that staff "respected" them. Comments from visitors included "staff seem genuinely interested in the residents" and "[my relative] seems more happy and contented than when they were at home."

Staff spoke about people in a caring and compassionate way. They listened to relatives when they relayed stories about people's life stories. We heard staff talking nicely to people and showing concern for their welfare, for example, a nurse asked somebody if they were comfortable after they had supported them to put their feet on foot plates of the wheelchair. One person was concerned as to how they would pay for their lunch, but the staff member reassured them in a patient and kind way. The registered manager told us they listened to what was going on in the home as they walked around. They observed how staff approached people and asked visitors for feedback about staff attitudes to people.

Most people were not able to be actively or visibly involved in making decisions about their care and support. Staff therefore ensured they got "to know people" and relatives provided information about individual preferences. Whilst most people could not "plan for their care", they might say, for example, "I don't like it done like that." Staff would try to engage with them further and observe their body language, changing the way they were doing something until the person appeared happy. One staff member used an example where a person could appear exhausted and be irritable, but look happy when they went to bed. Staff said people could sit in any of the lounges, but some did not like noise so they ensured they sat in a quieter lounge. Staff ensured they respected people's choices and one person confirmed it was "up to" them whether they went to the main lounge or stayed in bed during the day.

Requires improvement

Is the service responsive?

Our findings

At our previous inspection we identified a breach of two regulations relating to care planning and a lack of activities. We set compliance actions and the provider sent us an action plan stating how they would meet the requirements of the regulations. At this inspection we found the concerns relating to activities had been addressed. However, we found continuing concerns relating to care planning.

Some care plans were not up to date. One person had epileptic seizures and their care plan had been updated to show "No more fits". However, the records showed the person subsequently had a serious seizure, but the care plan was not updated to include this incident. Another person had a diagnosed urine infection in June. No short term care plan had been implemented to guide staff on how to provide appropriate support to manage this change in their health. A third care plan had been reviewed but did not include the details of an injury to the person's skin. When a person has experienced a skin injury, they are much more vulnerable to further similar skin damage in the future. It is an "early warning" sign that should trigger a review of skin care and what the staff can do to provide additional protection against future skin damage.

Most people were unable to be involved in planning their care because of their level of dementia. People had care plans in place which detailed their assessed needs and personal preferences, except one person who had recently moved into the home. Their care plan only covered nutrition and hydration and a specific health care need. The registered manager said they expected care plans to be completed within a month of admission and that it was still within the month. However, there was a significant lack of information to assist staff to support the person consistently.

The continued failure to ensure every person had an up to date care plan was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All but one person had a care plan in place which described what care and support they needed. Where people had been referred to health care specialists, guidance was available, for example, regarding how to prevent the person from choking. Moving and handling care plans were also in place. Care staff passed information about people's changing needs or preferences to the nurses who were responsible for writing the care plans. A staff member said, "I ask relatives to look at care plans and ask is there anything else I can include". They observed people's responses to the care and support they were receiving. For example, if someone was not drinking well, staff found people would often drink more if sugar was added to the drink.

Since the previous inspection, the provider had employed an activities co-ordinator two days a week. The staff member was qualified in various types of activities, was knowledgeable and described how they undertook different activities with different people, dependent on their needs. Activities were based on knowledge about people's personal history, for example, one person had worked in a factory, counting items. We saw they were enjoying manipulating a set of numbers and the registered manager confirmed they liked numbers based activities. Another person liked to shuffle cards and dominos to make patterns. Others like to sing or be sung to. The activities co-ordinator was aware that some people might like them to be "bright and bubbly" whereas others would not. They changed the way they facilitated activities accordingly. One person told us they liked to sing to music played in their room as they spent most of their time in bed. A visitor told us they had spoken directly with the activities co-ordinator about their relative who had never been a "joiner in" but was happy to not be "entertained". More general activities included music, visiting theatre groups and church groups. A monthly leaflet was displayed showing what was happening that month.

The provider had a complaints procedure in place which was made available to people and visitors. A visitor told us, "I would complain to the manager, she is often around". The registered manager kept a record of complaints made and how they had been investigated. The investigation was timely and included an apology as well as the offer of a face to face meeting. A summary was competed annually to monitor the complaints and how they had been managed. Staff understood that people had a right to complain and knew what to do if they did.

Requires improvement

Is the service well-led?

Our findings

At our previous inspection we identified a breach of regulation as audits were not being effective in

driving improvements. We set a compliance action and the provider sent us an action plan stating how they would meet the requirements of the regulation.

Following our previous inspection report, the registered manager had worked towards improving the quality of the service as outlined in their action plan. We found the quality of care overall had improved. However, the quality assurance process did not identify the concerns we found. Whilst the provider's action plan stated care plans would be audited to ensure any changes in the person's health care needs would be reflected in the care plans. Care plans had been audited but the process had not been sufficiently robust to ensure all the care plans reflected people's current needs and included information about medicine prescribed as "when needed".

The provider had completed a thorough quality assurance check in January 2015. This covered a range of issues, such as whether weekly fire checks had been completed, if there was protective clothing was in place and whether various records had been completed. Any issues identified formed part of an action plan. The registered manager had a system of auditing which covered various aspects of care provision. They had also undertaken a number of spot checks at night and given feedback to the staff on shift. The accident book was monitored on a monthly basis and discussed at the nurses meetings to see if anything could be changed to improve people's mobility. The registered manager had recently completed some observations at meal times and records showed issues had been noted and addressed with staff as well as speaking with relatives about the findings. The audit process found that an incident had occurred but the records were not completed. The registered manager took action to ensure staff could learn from this.

The registered manager promoted a positive culture in the home. One visitor told us the home was, "relaxed, resident orientated, they are at the centre of everything." Another visitor said the home was, "cosy, comfortable, not regimented". A staff member said "It is very friendly, it feels like a home, staff are helpful to each other, they work together as a team. Staff work for the benefit of people living here." The registered manager said relatives received a monthly newsletter advising them of changes being considered and could raise any issues directly with them.

The provider had undertaken a quality assurance questionnaire for relatives in October 2014. Seventeen had been completed and returned, from thirty three sent. The results were positive. Relatives felt consulted about changes in the home and were involved in the planning of care for the people they visited. One relative had stated on their questionnaire that, "all staff are friendly and welcoming". The registered manager said following the survey, they had spoken to relatives where necessary and had displayed the survey results where people could see them.

The culture of the home was open and honest. Our last inspection resulted in the home being given a rating and we saw the rating was displayed prominently in the hallway. Following our previous inspection report, the registered manager held a team meeting to discuss the report and action plan which were also made available for all staff to read. Staff confirmed they had read the report.

There was a board in the hallway which displayed staff photos and names, so people and staff could understand who was who. There was also a book where people could write comments if they wished to bring something to the attention of staff or the registered manager.

Visitors spoke highly of the registered manager. Comments included, "very co-operative and understanding", "approachable" and "the manager's door is always open. She comes to chat to me." Staff echoed this view. One said, "they are good, tasks get done, the place has improved". Another said "since [the manager] has been here, she has totally transformed the place, we've got the best staff we've ever had." Staff also found the provider to be "very approachable" and they visited the home three times a week.

Staff were involved in the running of the home. The registered manager was in the process of consulting with staff regarding the shift times, as it was thought people's needs could be better met. A staff member said "if anything's changed, we are consulted, we let them know if

Requires improvement

Is the service well-led?

changes are working or not. The manager has made changes which have worked, for example, breakfast was late, now some people have breakfast in their room before getting up".

The registered manager did not access supervision for their role. However, an external company visited twice a year to undertake a quality assurance audit. The registered manager found these visits useful to talk through issues and ideas. We saw the latest audit which had highlighted some areas for improvement. The registered manager had taken action and addressed these areas and suggestions. The registered manager attended a 'manager's forum' in Hampshire, which is currently working on a project across a number of services to improve how information is provided when people go to hospital.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 (2) (d) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe care and treatment.** **There were areas of the home where risks had not been identified and action taken to minimise risks.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9 (3) (b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Person centred care.** **There was not a care plan in place for everyone using the service. Some care plans were not up to date.** **People did not have care plans in place regarding the use of medicines prescribed as “when required”.**