Malhotra Care Homes Limited

Addison Court

Inspection report

Wesley Grove
Crawcrook
Ryton
Tyne and Wear
NE40 4EP
Tel: 0191 413 3333
Website: www.heathefieldcaregroup.com

Date of inspection visit: 22 October, 6 and 9 November 2015
Date of publication: 11/01/2016

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires improvement

Overall summary

The inspection took place on 22 October, 6 and 9 November 2015 and was unannounced. This means the provider did not know we were coming. We last inspected Addison Court in September 2014. At that inspection we found the service was meeting the legal requirements in force at that time.

Addison Court provides nursing and personal care for up to 70 people, including people living with dementia. Nursing care is provided at the home. At the time of our inspection there were 48 people living at the home.

The service did not have a registered manager. The manager, who had been in post for a year, submitted an application to become registered at the time of our inspection. 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.

Summary of findings

People said they felt safe at Addison Court. Staff were trained in and understood the importance of their duty of care to safeguard people against the risk of abuse.

There was a formal mechanism to help calculate staffing levels based on people's needs. New staff were suitably checked and vetted before they were employed.

The home was clean. Safety checks were conducted to ensure people received care in a safe environment. People were not always protected from the risks of being pushed in their wheelchairs without the use of foot rests. This practice can lead to foot entrapment under the chair.

On the whole, medicines were managed safely to promote people's health and well-being. Arrangements for managing external (topical) medicines were not sufficiently robust to demonstrate people received these medicines as prescribed.

Staff were supported in their roles to meet people's needs. They received training relevant to their roles and although their performance had been appraised recently, formal staff supervision meetings had been carried out infrequently.

People's nutritional needs and risks were monitored and people were supported with eating and drinking where necessary. People were supported to meet their health needs and access health care professionals, including specialist support.

People were consulted about and were able to direct their care and support. Formal processes were followed to uphold the rights of those people unable to make important decisions about their care, or who needed to be deprived of their liberty to receive the care they required.

Staff knew people well and the ways they preferred their care to be given. People and their relatives told us the staff were kind, caring and respectful in their approach. Our observations confirmed this. Alarm bells sounded infrequently and were responded to promptly.

A range of methods were used that enabled people and their families to express their views about their care and the service they received. This included formal care reviews, 'residents and relatives' meetings, quality surveys and a complaints system. Complaints were logged and documented, but investigation and outcome records were not consistently recorded and retained.

Staff assessed people's needs and risks before they moved in and periodically thereafter. Staff ensured care plans were in place and regularly reviewed. A variety of activities were made available to encourage stimulation and help people meet their social needs.

The management arrangements ensured clear lines of accountability. Systems to monitor and develop the quality of the service were in place, but required further refinement to ensure standards of care and safety were more consistently assured. Quality monitoring arrangements included seeking and acting on feedback from the people using the service and their relatives.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to the management of medicines, the safety of service users and good governance. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not consistently safe.

Appropriate arrangements were in place to minimise risks and on the whole people were cared for safely. Foot rests were not always used when staff helped people in their wheelchairs. Work and storage areas were locked to minimise unauthorised access. The home and equipment was kept clean.

Staff had a good understanding of safeguarding people from harm and abuse and how to report any concerns. A thorough recruitment process was followed when new staff were employed. A system to assess and monitor safe staffing levels was in place.

People were supported in taking most of their prescribed medicines at the times they needed them. Records for the administration of external (topical) medicines showed long gaps between administrations.

Is the service effective?

Good

The service was effective.

Staff provided effective care that met people's needs. Arrangements for training staff helped them to understand their roles and meet people's needs effectively.

The service acted in accordance with mental capacity legislation to ensure people's rights were upheld.

People accessed health care services and were supported to maintain their health and welfare. Risks to good nutrition were assessed and people were supported with their eating and drinking needs.

Is the service caring?

Good

The service was caring.

People and their families had positive relationships with the staff team.

Staff understood people's needs and preferences and treated people with dignity and respect.

People were encouraged to express their views and be involved in making decisions about their care and support.

Is the service responsive?

Good

The service was responsive.

People's care needs were regularly assessed and recorded in care plans which were kept under review. Staff provided personalised care and were responsive to people's changing needs.

Summary of findings

Various social activities were offered and people were supported to access and engage in their local community.

There was a clear complaints procedure which people using the service and their relatives were aware of.

Is the service well-led?

Requires improvement

The service was not consistently well led.

A manager was in post but they had not yet become registered with CQC as a fit and proper person.

The manager provided visible leadership and was committed to developing the service.

The manager was responsive to feedback from people and this was acknowledged and acted upon. Quality monitoring processes were in place, although findings from these and complaints needed to be acted upon and improvements embedded in practice. The home was subject to further scrutiny from an experienced operations manager.

Addison Court

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 22 October, 6 and 9 November 2015 and was unannounced. The inspection team consisted of one adult social care inspector.

We reviewed information we held about the home prior to our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We spoke with the local authority's safeguarding and commissioning teams before the inspection, who expressed no significant concerns about the service.

During the inspection we talked with five people living at the home and three relatives. We spoke with an operations manager, the manager, an activities co-ordinator and with nine nursing, care and ancillary staff. We spoke with a visiting professional. We observed how staff interacted with and supported people, including during a mealtime. 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 looked at five people's care records, people's medicine records, staff recruitment and training records and a range of other records related to the management of the service.

Requires improvement

Is the service safe?

Our findings

People said to us they felt safe and comfortable at Addison Court. One person explained how they liked the way their room was set out and how it meant they could safely get around. Another person said, "I feel comfortable and safe here. I have a buzzer and there's one in the lounge. They come quickly, but sometimes not as quickly as you would like." A visiting relative said, "I know my relative's safe here." They continued by telling us, "If I press the alarm the staff come quick; they come running." Another relative commented to us, "I do feel they are safe here." People using the service and their relatives expressed confidence in the manager and their line manager and felt that if they raised a concern this would be acknowledged and acted upon.

Staff were able to explain how they would protect people from harm and deal with any concerns they might have. They were familiar with the provider's safeguarding adults' procedures and told us they had been trained in abuse awareness. This was confirmed by the training records we looked at. Staff told us they would report any safeguarding concerns to the manager, or if necessary to the local safeguarding team or to the Care Quality Commission (CQC).

To support the training staff had received, there were procedures and guidance documents available for staff to refer to. These provided explanations of the steps staff would need to follow should an allegation be made or concern witnessed. The manager was aware of when they needed to report concerns to the local safeguarding adults' team. There was evidence of safeguarding concerns having been reported to the local authority and investigated appropriately, although these had not been notified to CQC. Where necessary, procedures and updated plans of care were put in place to protect people from further harm.

A monitored dosage system was used to store and manage the majority of medicines. This is a storage system designed to simplify the administration of medication by placing the medicines in separate compartments according to the time of day. These medicines were stored safely and securely in locked treatment rooms. During the medicines round we saw a nurse ensured the medicines trolley used was locked when they attended to each person. They offered gentle encouragement to people and waited to check they had taken their medicine before signing the administration records.

Medicines arrangements were subject to periodic audits and the competency of staff to administer medicines was checked periodically. Where shortfalls were identified, actions to be taken were highlighted within the audit and an overall action plan compiled. However, there was no record of follow-up to check the actions had been completed.

Administration records for tablet and liquid form medicines were completed appropriately and stocks corresponded accurately to those documented. This included controlled medicines, which required specific storage arrangements and detailed recording procedures. Medicines with a limited shelf life, such as eye drops, were in most cases dated on opening to ensure they were not used for longer than recommended. Those requiring cold storage were kept in a designated fridge, the temperature of which was monitored to ensure it was within a safe range.

The majority of medicines were administered by nursing staff. Some medicines applied to people's skin, such as barrier creams and emollients (moisturising and soap substitute creams) were administered by care workers, with separate records kept. These are called topical medicines. We sampled three people's topical administration records and saw there were long gaps between administrations with no explanations given. The corresponding charts provided by the supplying pharmacist also had limited instructions, which were recorded as 'use as directed'. Hand written entries on these forms were not signed or counter signed by staff to confirm their accuracy. Medicines care plans did not detail how, or where, topical medicines were to be administered and care plans or risk assessments relating to skin care needs provided only limited guidance for staff, such as where these were to be applied and how frequently. We could therefore not be confident that these medicines were being administered as prescribed. We also saw this area of care had been subject to a previous complaint but not kept under close scrutiny by senior staff and managers in the service.

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

Requires improvement

Is the service safe?

Arrangements for identifying and managing risks in relation to the building were in place. Gas and electrical safety certificates were available and up to date. As a modern, purpose built care home Addison Court had been designed with consideration to safe access. Corridor areas were wide and airy, with level access and well-lit corridors. Working and service areas, such as the laundry, sluices and electrical cupboards were locked to ensure access to these potentially hazardous areas was limited. People's bedroom en-suites had night lights to help people use these facilities safely during the night.

Baths had fixed hoists to allow for safe manual handling and there were walk in showers, which meant wheeled shower chairs could be easily used. Other manual handling equipment, such as mobile hoists and stand aids were available on each floor. This equipment was regularly serviced to ensure it remained safe to use. During lunch time staff helped some people into and out of the dining room. Staff assisted some people in wheelchairs. We saw two people did not have foot rests fitted on their wheelchairs when they were being moved by staff. This practice can place people at greater risk of serious injury (such as fractures and soft tissue damage to feet, ankles and the lower leg) should their feet get caught under the chair while being moved forward. The nurse in charge told us a risk assessment had been put in place for one person to help promote their independence due to the way they mobilised; self-propelling themselves with their feet. They were able to show us records to confirm this. However, the risk remained present when staff pushed the chair forward. For the second person we were told immediate action would be taken to obtain new foot rests from the local wheelchair service.

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

Staff assessed and documented risks to people covering areas of care such as pressure area care, nutrition, mobility and behaviour that might challenge the service. Where appropriate, these had been done using recognised assessment documents, such as BAPEN MUST (Malnutrition Universal Screening Tool) for malnutrition and Braden for pressure ulcer risk. Where a risk was identified, there was clear guidance included in people's care plans to help staff support them in a safe manner. Staff introduced and updated risk assessments promptly. For example we saw a person had experienced a choking episode the day prior to our inspection. Staff had completed the risk assessment and updated the care plan to provide staff with appropriate guidance on keeping the person safe. Staff we spoke with were able to explain how they would help support individual people in a safe manner.

Staff were safely recruited. We looked at the recruitment records for five staff members and the documentation and checks required by regulation were in place for these members of staff. Before staff were confirmed in post the manager ensured an application form with a detailed employment history was completed. Other checks were carried out, including the receipt of employment references and a Disclosure and Barring Service (DBS) check. A DBS check provides information to employers about an employee's criminal record and confirms if staff have been barred from working with vulnerable adults and children. This helps support safe recruitment decisions.

The manager explained there was a minimum of ten care and nursing staff employed during the day. A staffing rota was drafted to help plan staffing deployment and record actual shifts worked. We spent time during the inspection observing staff care practice. Although busy, we saw staff had time to chat with and build positive relationships with people, in addition to carrying out other care tasks and duties. Call alarms sounded infrequently and were answered quickly. Those staff we spoke with expressed mixed views about staffing levels. One staff member who had worked in other care settings said, "I'm really impressed; there are ample staff on." Other staff commented about agency staff often being used during night shifts. Another noted that there were many people who needed support from two staff at a time, stating "We can only work with what we have."

The manager's view was that current staffing was sufficient to meet people's needs. They indicated that when using agency workers, and in particular nursing staff, they would attempt to use the same staff to help with continuity of care. The manager also compiled monthly dependency ratings for people, aggregating these to form an overall dependency rating for the home. This was used to determine safe staff levels, and the assessed level was matched by the numbers deployed on each shift. We

Requires improvement

Is the service safe?

observed the dependency tool did not account for distressed or challenging behaviour, and highlighted this to the manager and the operations manager for their attention.

Good

Is the service effective?

Our findings

People using the service confirmed that staff were caring, supportive and helpful. One person told us, "The staff's very good; I've no concerns about their conduct." Another person said, "The staff on the whole are good." People were complimentary about the food. One person said, "The cook's excellent." A relative commented to us, "I've got nothing but admiration for them, the way they deal with people. They recognise the signs." In respect of their relative they noted, "There's been a big improvement since my relative moved in here." Another relative said, "The mix for the team is good with skills and training. There's always someone who knows."

Staff told us about the training they had received and this was confirmed by the records we examined. Staff told us they felt supported and attended formal supervision meetings. Staff's comments included, "It's good the training", and, "I'm always supported by the manager." All staff whose records we examined had attended a performance appraisal meeting recently, although supervision meetings had been inconsistent throughout the year. A detailed training matrix was available and updated to track progress in staff attending key safety and care related training.

The training staff had attended included fire safety, food hygiene, adult protection, infection control and first aid. Dementia awareness and supporting people with distressed behaviour were also covered. The manger was aware of gaps in individual staff members training which required updating. Training or awareness raising sessions on some health related conditions, such as diabetes or Parkinson's disease were also not evident.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure decisions are made in people's best interests. DoLS are part of this legislation and they ensure where someone may be deprived of their liberty, the least restrictive option is taken.

Staff we spoke with were aware of the MCA and DoLS. Records showed the majority of staff had received training in this area.

Staff recorded people's decision making capacity within care plans and capacity and decision making was considered as part of a formal assessment. These assessments were recorded on documentation supplied by the authorising authority (Gateshead Council). Where people were subject to a DoLS the manager had begun to notify CQC of the outcome of the application.

People told us that staff sought their permission before carrying out any treatment or when providing support, for example with mobilising (getting around) or with personal care.

The people we spoke with told us they liked the food provided. People had a nutritional assessment carried out using a nationally recognised assessment tool. This was reviewed periodically and people's weight and body mass index was regularly monitored. We saw advice had been sought from a speech and language therapist about what foods were appropriate for people, for example when they needed a soft diet. The input of a dietitian had also been arranged where people were at risk of malnutrition.

Catering staff helped serve the lunch, enabling care staff to provide appropriate assistance, support and encouragement to people. The meals during lunch looked appetising and a choice of main meal and pudding was offered. There was a choice of hot or cold drinks. Washable aprons were available for those who wished to wear them. People told us they had enjoyed their meal.

People using the service and their relatives confirmed that GP's, dentists, nurses, chiropodists and opticians could all be accessed as and when required by making a request via staff or the manager. Records we looked at confirmed people were registered with a GP and received care and support from other professionals, such as the chiropodist, dentist and optician. Links with other health care professionals and specialists to help make sure people received appropriate healthcare had been documented. For example the input of speech and language therapy (SALT) services had been documented and their advice was incorporated into care plans. This confirmed people's healthcare needs were considered within the care planning process. A further example included where people were at risk of developing pressure ulcers. Appropriate plans of care were developed and care interventions and the

Good

Is the service effective?

person's condition were regularly monitored. We noted assessments had been completed on both physical and mental health needs such as dementia, skin care and continence.

Care plans were up to date and completed appropriately. Medical history information was gathered and some people had advanced health care plans which detailed their wishes and the care and treatment to be provided in certain situations, such as when they became seriously ill.

Good

Is the service caring?

Our findings

People told us the staff were caring. One person said, "I'm quite happy here. They let you do what you want. They're all friendly." Another person said, "It's lovely. It's very free and easy. They're always there if you need them." A relative commented, "Most of the staff are genuinely caring."

People using the service confirmed that staff knocked on the door or called out, awaiting a response before entering the room. We observed staff doing this in practice. People also told us that staff asked their permission before providing care or assistance. People using the service and their relatives said visits could be made to Addison Court at any time and that visitors were made to feel welcome. One visitor told us how they would share a meal with their relative at the home and that staff ensured their privacy.

During lunch staff interacted well with people, providing support when asked or required and regularly checking if people required more food and drink and encouraging others to eat more. Several people required and received prompt help. Staff were attentive to people's dietary needs and people were given sensitive and patient assistance to eat their food. One to one support was carried out by some staff, who engaged with people at the table, making the meal time a social experience. Time was taken to provide explanation when people were assisted with eating. Drinks were offered to all. The dining room was bright and airy and diners and staff were chatting together. Staff and people using the service appeared comfortable and happy in one another's company and staff were friendly, supportive and attentive.

People using the service and staff were very comfortable in each other's company. We observed staff to be caring. For example, a nurse we observed spoke kindly and gently to the people they had contact with. They enquired as to people's well being and explained their proposed actions clearly before intervening with care.

Staff we spoke with understood their roles in providing people with effective, caring and compassionate care and support. Staff were knowledgeable about people's individual needs, backgrounds and personalities and were able to explain how they involved people in making decisions. We observed people being asked for their opinions on matters, such as drink choices and they were routinely involved in day to day decisions within the service.

People we spoke with were aware of their care plans, as were their relatives. Where people lacked capacity, relatives confirmed they were involved in care decisions and kept up to date about their relative's needs. Information about advocacy (services helping people to express their views and protect their rights) was available for people should they require this support.

People said their privacy and dignity were respected. We did not observe any instances of people receiving personal care within public areas. Staff we spoke with and the manager were able to clearly explain the practical steps they would take to preserve people's privacy. Examples they gave included knocking and awaiting a reply before entering a person's room.and closing doors, blinds or curtains when providing personal care. This was observed in practice. We did however observe some discussion about people's needs between staff during a mealtime, in front of other people, including a visitor. This was raised with the manager, who acknowledged our concerns and undertook to raise this matter with staff.

Good

Is the service responsive?

Our findings

People and their relatives said they were listened to and they had confidence in the way staff responded to concerns and complaints. People confirmed activities were offered. One person said, "Yes there's enough to do, I get my paper every day." We observed various activities taking place, including help with crafts, a quiz and staff simply taking time to chat with people.

Relatives confirmed that they were aware of regular 'resident and relative' meetings where they and their loved ones could express their views or make suggestions about the service. This was confirmed by the meeting minutes we looked at. Topics covered included suggestions, quality issues and general feedback.

We observed several instances of staff being responsive to people's various requests, such as when using their call alarms and when they were mobilising (moving around). Such alarms were answered promptly and sounded infrequently.

People's care plans included needs assessments being carried out before a service was provided. From the information outlined in these assessments individual care plans were developed. These were put in place to ensure staff had the correct information to respond to people's health needs, well-being and individual identity.

Care plans covered a range of areas including diet and nutrition, psychological health, personal care, managing medicines and mobility. We saw if new areas of support were identified then care plans were developed to address these. Care plans were reviewed regularly and were sufficiently detailed to guide staffs care practice. The input of other care professionals had also been reflected in individual care plans and these documents were generally well ordered.

To monitor people's needs, and evidence the support provided, staff kept individual progress notes. These offered an ongoing record of people's well-being and outlined what care was provided. Staff also completed a daily handover record, so oncoming staff were aware of people's health and immediate needs and any forthcoming appointments. Staff periodically reviewed care plans, documented people's changing needs and progress and these documents were up to date. The language used in care records was factual and respectful. Records also focussed on people's strengths and were positively worded.

When talking about personalised care, staff had a good knowledge of the people using the service and how they provided care that was important to the person. The staff we spoke with were able to answer the queries we had about people's preferences and needs.

We saw visitors coming and going freely and an activities worker offered a range of activities and encouraged participation in events on offer. Examples included quizzes and competitions, balloon therapy and reminiscence. Staff spent time socialising with people as well as providing care. For example we saw staff take time to sit and talk with people using the service.

People using the service and their relatives told us they were aware of who to complain to and expressed confidence that issues raised would be resolved. Most said they would speak to the manager or a nurse if they had any concerns. A copy of the complaints procedure was available in a public space. We reviewed the records of complaints received since April 2015 and saw there were 17 logged and a range of themes were apparent. These included care practice issues. There was evidence of some complaints having been investigated, although records were not consistently clear. For example, some had no evidence of how the complaint was investigated, the outcome and how it was communicated to the complainant. We raised this matter with the manager and operations manager, who acknowledged our concerns and undertook to ensure complaints records were appropriately collated to enable more effective tracking of complaints, their investigation and outcome.

Requires improvement

Is the service well-led?

Our findings

People we spoke with told us they were happy at the home and with the leadership there. They told us that staff interacted well with people using the service and that they were caring, supportive and helpful. One relative said, "My relative's happy here, so I'm happy." People and their relatives confirmed that they knew who the manager was and felt that Addison Court was well run. Staff told us they felt supported. One said "I'm always supported by the manager." Another said, "Things get sorted, they're better than some we've had." Another comment was, "They're approachable and sort things out."

The management arrangements ensured clear lines of accountability. The manager held overall responsibility for the day to day operation of the home, and they were supported by nursing staff, responsible for leading the staff allocated to the different floors. Care staff were aware of who the manager was and confirmed they had a visible presence in the home. Staff said they would recommend the home to a friend or relative.

At the time of our inspection there was no registered manager in place. The manager informed us that they had submitted an application in February 2015, then again in March or April. As their registration had not been progressed they submitted a further application in October after we prompted them to do so.

The manager was present and assisted us with the inspection. They walked round with us for part of the inspection and appeared to know the people using the service, their relatives and the staff well. Records we requested were produced for us promptly. The manager was able to highlight their priorities for developing the service and was open to working with us in a co-operative and transparent way. They were clear about the need to send CQC notifications for notifiable events on behalf of the registered provider. Although they had submitted notifications for some events, those relating to allegations or incidents of abuse had not been submitted.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We will take further action regarding this and will report on the outcome when this is concluded.

The manager's stated philosophy for the home was, "Making sure residents are at the forefront of everything staff do." Furthermore, "To ensure residents are safe, protected and to create a home from home, or as close to that as possible." The manager was able to highlight some key improvements made, successes achieved and areas that required further improvement.

There were arrangements in place for assessing and monitoring the quality of care, which included scrutiny and oversight from an experienced operations manager. Quality checks covered areas such as infection control, medicines and fire safety. Audits and other quality checking systems were completed thoroughly, however there was evidence that the system did not always result in sustained improvements. We saw the audits for infection control had identified repeated issues relating to the length of staff's finger nails on three separate occasions (March, May and September 2015), indicating action taken was inadequate or ineffective. We also saw that although medicines audits had identified areas for improvement, there were no documented follow-up steps taken to check ongoing compliance with the provider's own standards. Furthermore we tracked a medicines management issue identified through a complaint and saw the issue had not been satisfactorily resolved. Likewise, at previous inspections we had identified failures in sending statutory notifications to CQC and delays in a previous manager making proper application to become registered.

Quality monitoring arrangements included seeking and acting on feedback from the people using the service and their relatives. A satisfaction survey was carried out and this had highlighted strengths in the service, with comments such as, "Staff always go that extra mile"; "Good bunch of staff"; "Pleased with the care standards"; and, "I am glad I made the choice to place my relative at Addison Court." However, where areas for potential improvement were highlighted the actions arising section of the overall report had not been completed.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes had not effectively assessed, monitored and improved the quality and safety of the service provided. Regulation 17(1)&17(2)(a)&(b)

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had not assessed the risks to the health and safety of service users of receiving care and treatment and doing all that is reasonably practicable to mitigate any such risks. Regulation 12(1) and 12(2)(a)&(b). The registered person had not ensured the proper and safe management of medicines. Regulation 12(1) and 12(2)(g).