Summerfield Medical Limited

Summerfield Nursing Unit

Inspection report

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Ratings

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

Overall summary

This inspection took place on 1 and 2 June 2015 and was unannounced.

Summerfield Nursing Unit provides accommodation and nursing care for up to 66 people who have nursing needs. At the time of our inspection there were 31 people living in the home across two floors. The home is a four floor, purpose built building. Each floor had a lounge, dining room and small kitchen. A cinema, library, hairdresser's salon and gardens were available to people who live in the home. A registered manager was not in place as required by their conditions of registration. 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 provider had commissioned a care management company to help improve the quality of the service. An 'improvement lead' from the care management company acted on behalf of the provider and supported us with our inspection.

People and their relatives were mainly positive about the care they received from staff. However, people's safety

Summary of findings

and well-being continued to be compromised in a number of areas. The care of people with complex medical needs were not always supported and treated effectively. People's care records did not always provide staff with enough personalised information and guidance on how best to support them. The management and assessment of some people's risks had not been recorded accurately. Action taken when people became unwell had not always been recorded or managed in line with their care records or recommendations by other health care professionals. Whilst people were supported to have a nutritious diet those with specific needs such as being at risk of weight loss were not being managed well. Staff did not fully understand the princples of gaining people's consent to their care if they lacked mental capacity. Activities in the home were limited and some people were socially isolated. There were adequate numbers of staff to meet people's needs.

Systems to recruit suitable staff were in place but not as thorough as they should be. The reasons why staff had left their previous employment were not always investigated. Some improvements had been made in the planning and delivery of staff training which was deemed as mandatory by the provider. However the clinical skills and knowledge of staff had not been assessed or updated. A plan was in place to ensure that staff were regularly supported and mentored. Staff meetings had been implemented so staff could share information about people and the running of the home. The home had an established staff team who were familiar with people who lived in the home.

The provider had put systems in place to understand the views and experiences of people and their relatives. The improvement lead had started to implement systems to monitor and check the quality of the service. Actions plans were being produced to address the identified shortfalls. The provider was actively recruiting a manager to run the home.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what actions we told the provider to take at the back of the full version of this report.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The risks of people with complex clinical needs were not being assessed, managed or treated in line with their needs or recommendations. The clinical knowledge of staff had not been assessed or updated.

Some people took their medicines on an 'as needed' basis; these were not always being managed and administered correctly. The medicines policy did not reflect the practices of the administration of people's medicines in the home.

People were not always cared for by suitably recruited staff. The systems to check the reasons why people had left their previous employment had not always been checked.

Staffing levels in the home were sufficient to meet people's needs.

Is the service effective?

Requires improvement

The service was not as effective as it should be.

Staff didn't have a good understanding about gaining people's consent to their care and treatment in a lawful way.

People's dietary needs and choices were catered for. People were concerned about the quality and timings of their meals. The food and fluid intakes for some people who were at risk of not eating and drinking were not always recorded. Guidance on how to support people who required a soft diet was not clear.

A plan to support staff in their personal development and mandatory training was now being implemented to ensure people were cared for by competent staff.

Is the service caring?

Good

The service was caring.

People and their relatives were positive about the care they received. Staff respected people's dignity and privacy when supporting them with their personal care. People's care records provided staff with information about their individual backgrounds.

People were supported by an established team who knew people well. Communication between all staff and people was caring and compassionate.

Is the service responsive?

Inadequate

The service was not responsive.

Summary of findings

People's care records did not reflect their individual needs, risks and emotional needs. There were limited opportunities for people to carry out activities or socialise with other people.

Opportunities were made available for people and their families to raise concerns.

Is the service well-led?

Requires improvement 

The service had not always been well led.

Systems had not been put into place to manage and run the home effectively until the recent input from a care management company.

The checking of the quality of the service being provided had now started to be implemented.

People's views and experiences of living in the home were now being sought.

Summerfield Nursing Unit

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 1 and 2 June 2015 and was unannounced. The inspection was led by one inspector who was accompanied by two other inspectors on 1 June 2015 and also a pharmacist inspector on 2 June 2015.

Before the inspection, we examined other information that we held about the provider, including previous inspection reports and statutory notifications. Statutory notifications are information which the provider is required to send us about significant events and incidents.

We spent time walking around the home and observing how staff interacted with people. We spoke with four people, two relatives and eight members of staff. We also spoke to the general manager as well as the improvement lead from a care management company who had been commissioned by the provider to oversee the running of the home and to drive improvement in the quality of the service.

We looked at staff files including recruitment procedures and the training and development of staff. We checked the latest records concerning complaints and concerns, safeguarding incidents, accident and incident reports and the management of the home.

Inadequate

Is the service safe?

Our findings

At our last inspection, people's individual care, treatment and medicines were not being managed and delivered in line with their needs. We found some improvements had been made during this inspection; however people continued to be at risk as their care, treatment and medicines were not always provided in a safe way.

Some people's complex clinical needs and risks were not always thoroughly assessed and monitored. People's care and treatment was not always delivered appropriately and tailored to their individual needs. There were three people with safeguarding concerns who had been referred to the local authority and others who had been assessed as being at risk due to their medical needs. The management of these people's risks had not been clearly assessed, recorded and managed appropriately. For example the management and treatment of their pressure areas was not consistent.

Staff had requested health care professional's guidance for some people. However, recommendations made by healthcare professionals had not been followed. In the case of one person, their pain management, dressing changes and ongoing assessment of the progress of their pressure wound had not been monitored and recorded in line with professional guidance. Also the description and the progress of their pressure wound was not being correctly recorded. This had resulted in poor improvement in the healing of the wound.

Staff had not requested professional guidance for another person who was at risk of choking on their food. Staff had introduced a soft diet for this person but the detail of the consistency of the food was not recorded or known by all staff. Another person told us they had been given small pieces of toast with a poached egg although their care records stated they required a soft diet. This action put this person at risk of choking.

The management and positioning of people's bed rails was not always correct and in line with safety guidance. Some risk assessments had not been accurately completed and therefore did not indicate the correct level of risk and actions to mitigate these risks. For example, the risk assessment for one person's pressure care had been completed incorrectly and identified them as high risk instead of very high risk. This meant the staff could potentially not support and treat this person correctly to further reduce the risk of harm.

Some people who had been identified and assessed as being at risk were being regularly monitored. For example the weight of one person was being specifically monitored due to their weight loss and another person was being monitored due to poor oxygen levels. Whilst staff were checking and recording their findings, there was no guidance on the acceptable range of measurements or actions to be taken if people's readings fell outside this range. The improvement lead had introduced a new protocol to weigh everyone in the home weekly for four weeks to establish a benchmark for everyone's weight. People who were identified as at risk of losing weight after this period would be subsequently monitored and supported to maintain a stable weight.

People were cared for by staff who may not have all the necessary skills and competencies to do so safely. The clinical skills of the nurses who supported people with complex needs had not been assessed to ensure that their practices were safe, current and suitable to meet the medical needs of people. The provider had relied on the nurses to use their previous clinical knowledge and experience from other care settings to support and care for people. A senior nurse had highlighted they required additional training at their interview but this had not been addressed. Nurses told us they gained knowledge from visiting health care professionals or shared knowledge between nursing colleagues. For example, knowledge had been shared amongst nurses on how to manage the diet of people who required their nutrition via a tube direct into their stomach. One staff member told us they had received no formal training in this procedure which meant their practices may not be current.

People were cared for by suitable numbers of staff. There were sufficient nurses and care staff to meet people's physical needs. However some people who remained in their bedrooms told us they sometimes had to wait for staff to attend to them. One person said, "Sometimes I have to wait but the staff are nice." Most people who could use a call bell to alert staff were left with a call bell within easy reach of them. However, there was no clear system in place for staff to check people who were unable to use the call bells or check on people who sat unsupervised in the

Inadequate

Is the service safe?

lounge. Staff told us they checked on people every hour but this was not recorded. The care records of one person who was unable to communicate did not provide staff with adequate guidance on how regularly they should be checked.

Generally people were given their regular medicines as prescribed to them. Records of when people had taken their medication were mainly accurate. Their medicines were ordered, stored and managed by nursing staff. The improvement lead informed us that the home was negotiating a new contract with a local pharmacist. The improvement lead said, "I believe having the new pharmacist on board will help us tighten up our medication systems and will help to reduce any errors in the ordering and storing of the residents medicines." As a result of our last inspection, a decision had been made by the provider that people would not store or be given any over the counter medicines for minor ailments. All medicines would be prescribed by the person's GP.

Whilst people's regular medicines were mainly managed well, improvements were needed in the process for people who were prescribed PRN medicines. PRN are medicines that are only given if and when required by the person such as for pain relief. Records relating to PRN medicines were not always clear. For example some people required medicines when they became anxious. However their records did not always provide the necessary guidance for staff. Possible alternative treatments or strategies to be used before medicines were administered were not explored or documented.

One person had been prescribed medicines to be administered every three months. No clear plan was in place to ensure that their next dosage of medicine would be administered at the correct time. Another person had been prescribed medicines for pain relief for a specific area of their body; however records showed that the pain relief had been administered for different reasons other than the original purpose and this change in the person's needs had not been reviewed.

A recent medicines audit carried out by the deputy manager had identified improvements were required in the management of people's medicines as well as a review of the protocols and medicines policy. An action plan had been put into place to address the short falls but this had not yet been implemented.

The clinical risks, treatment and medicines of people with complex medical and communication needs were not always assessed and managed by adequately trained staff in a safe way. **This was a breach of Regulation 12, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Generally there were safe recruitment systems in place to ensure that suitable staff were employed to support people. Employment and criminal checks had been carried out on all new staff. References had been sought from previous health care employers to ensure they were suitable to support people with complex needs. However, the reason for staff leaving their previous employment had not been recorded in two out of the five staff recruitment files that we inspected. There were no records that verified employment and criminal checks had been carried out on agency staff who worked in the home when unplanned staff absences had occurred.

Staff were knowledgeable about recognising the signs of abuse. The majority of staff had received recent training in protecting people. They were able tell us the actions they would take if they suspected a person was being harmed or abused. Notice boards displayed 'Say no to abuse' posters around the home to inform people and their relatives. Staff were aware of where to report their concerns and how to find contact details of outside safeguarding agencies. However information about relevant national safeguarding agencies was not correct in the safeguarding policy.

Requires improvement

Is the service effective?

Our findings

At our last inspection, people's consent to their care and treatment was not sought in line with legislation and guidance. During this inspection we found some improvement had been made in this area, however the implementation of obtaining and recording people's consent lawfully was not fully understood by all staff. Therefore people's rights were not always protected by the correct use of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make certain specific decisions for themselves. The DoLS protect people in care homes from inappropriate or unnecessary restrictions on their freedom.

Some people who were able to make decisions for themselves had consented and had been involved in the planning of their care although this was not always recorded. For other people, their families had been involved in making decisions about their care and support. However, staff were not fully aware which family members or significant people had the legal authority to make a decision on their behalf, people such as a Lasting Power of Attorney or an advocate. The improvement lead was gathering this information about people, to ensure staff were supporting people within their legal rights.

Some staff had completed training in MCA and DoLS, however they were not fully clear on how this applied to their care practices especially when recording people's ability to consent to specific decisions or how they may be restricting people in their freedom. We were told that an application to the local authority had been made to authorise the restriction of one person. The outcome of the application had not yet been confirmed by the local authority.

Where people required support with their personal care or day to day activities, staff supported them to make choices and be as independent as possible, although this was not recorded. Since our last inspection, staff had started to assess the mental capacity of people using local authority MCA assessment forms. The completed mental capacity assessments forms indicated that it had been assumed all people who lived in the home lacked capacity. Some people's mental capacity assessments had not specifically addressed their capacity to make a particular decision and staff had recorded their mental capacity assessment in general terms. This therefore indicated that although staff had been trained in MCA and they had started to record people's consent to their care, they did not fully understand the principles of MCA. We were told by the improvement lead that a plan was in place to review and update the completed assessment forms to ensure they reflected people's mental capacity to make specific decision about their care and treatment.

Whilst improvements had been made to gain people's consent to their care and treatment, there were still some improvements needed to ensure staff were familiar with the principles of the Mental Capacity Act 2005 and how to apply them appropriately.

This was a breach of Regulation 11, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where people's needs had changed the service had not always made appropriate referrals to other health and social care professionals for advice and support. Records of health care professional visits varied in detail and their recommendations were not always reflected across the relevant parts of people's care records. For example, we are told that a GP had visited a person but their treatment and advice had not been documented. There was also no recorded evidence that the referrals to health care professionals for two people had been followed up when there had been no response from the service.

At our last inspection, staff were not being fully supported and trained to meet people's needs. During this inspection we found some improvement had been made in this area and there were plans in place to implement further improvements. One staff member was designated to manage the personal development of staff in the home. Each staff member had been asked to complete a personal action plan and identify their strengths and weaknesses in their health and care knowledge. A new training plan was now in place which monitored staff training. Most staff had now completed training considered as mandatory by the provider, such as safeguarding people and health and safety training. Staff were positive about the training they had recently received. One staff member said, "We have received a lot of training and support recently. It has been good." Whilst staff had been asked to complete an action

Requires improvement

Is the service effective?

plan to identify how they would implement their new knowledge after attending a course, the impact and observation of their new knowledge in their care practices was not evidenced and recorded.

A three day induction course had now been developed which addressed subjects such as infection control and fire awareness. New staff were given a period of time to shadow an experienced member of staff and get to know the people in the home. The staff member designated to training had an understanding of the new care certificate which helps providers to monitor the competences of staff against expected standards of care. This staff member was attending a care certificate assessor's course to become qualified in assessing and monitoring the key health care skills of staff.

The improvement lead had started to implement a plan to ensure all staff were regularly supervised and would receive an annual appraisal to evaluate their personal development. Staff were encouraged by this process and told us they now had the opportunity to express their views about their role in a constructive and supportive environment. A plan for various staff meetings to be held had also been implemented so staff could share knowledge about people and the running of the home.

People were generally supported to maintain a healthy and well balanced diet. Staff knew people well and knew people's preferences and choices in their meals. People were offered a choice of two hot meals, although one person told us there was often no choice in the meals provided. Portion sizes were flexible and dependent on people's appetites. Pre-cooked meals were bought in frozen and heated up. The nutritional values for each meal were provided.

Other parts of this report have addressed concerns about the inadequate risk management of people who have been identified as losing weight or risk of choking.

Families who had attended a recent 'Resident and Families Meeting' had raised the subject of the quality and timings of the meals in the home as well as the provision of snacks and drinks throughout the night. The improvement lead said this would be investigated and actioned. A 'dining experience audit' had been carried out by several staff over a few days to ascertain people's experience of the quality, variety of food and their general views of mealtimes in the home. Shortfalls in the quality and timing of people's meals had been identified and an action plan was being produced as a result of the audit. We were told that the arrangement of the planning and producing of meals in the home was to be reviewed.

Good

Is the service caring?

Our findings

People who lived in Summerfield Nursing Unit had complex medical needs. Therefore many people spent a large part of their day in bed or sat in their own individual bedrooms. Personal care was delivered in a dignified and unrushed manner enabling staff to spend quality time with people.

The home now had an established team of staff who knew people well and were familiar with their needs and preferences. Staff spoke to people using their preferred names. They knew people's individual communication skills, adjusted their pace and type of communication accordingly. Some improvements in people's care records gave staff a better understanding of people's backgrounds and their personal histories. We were told that junior care staff did not always have access to people's care records to read this information. However the improvement lead told us that this was being addressed so all staff could access information that was gathered about people.

People who were able to speak to us said they were mainly positive about the care and support they received from staff. One person, "They (staff) are lovely here. I can't complain." We observed staff interact with people and found them both respectful and caring. People's families were invited to visit their loved one at any time. Relatives praised the kindness of the staff. One relative said, "Staff are wonderful. So kind." Another relative who visited the home daily said, "We are very happy here. I can't praise them enough." Staff helped people to remain in contact with their families despite having complex nursing needs. We saw staff from all departments of the home speaking to people and their relatives courteously and politely.

People's dignity and privacy was respected by staff. Staff knocked on people's doors and waited to be invited in. Staff shut doors and covered people with towels and clothing when supporting them with their personal hygiene. People were supported in a dignified manner if they required assistance with their eating and drinking. Staff explained how they were about to support them and made respectful suggestions on they could support themselves.

Since our last inspection the provider had put systems in place to gain an understanding of people's experiences of living in the home. People and their relatives had the option to complete comment cards available in their bedrooms. There were plans in place to have regular resident and family meetings and also to send out bi-yearly quality questionnaires. We were told the provider's and manager's door were always open and the new manager would be expected to hold monthly 'Home manager surgeries' to provide additional opportunities for people and their relatives to express their views and opinions.

Inadequate

Is the service responsive?

Our findings

At our last inspection, people's individual care and treatment plan was not being recorded and delivered in line with their needs. Whilst we found some improvements had been made to the detail of people's care records during this inspection, we also found that people continued to be at risk of poor care as their care and treatment was not being recorded effectively to give staff clear guidance.

The provider had implemented a new paper copy format of people's care records which had been divided into clear categories to enable staff access the relevant information about a person quickly. Nurses carried out the initial assessment of people and frequently updated their care needs. However the records of the care and treatment of people with complex needs was not adequate and did not give staff clear guidance on how to respond to people's personalised needs. For example, the details of the management and type of catheter being used for one person were not clear. The monitoring and photographing of the pressure wound of another person who had a pressure ulcer had not be consistently recorded as requested by a health care professional. There was little detail about the pain management of another person who experienced a lot of pain during the dressing changes of their wound. There was insufficient guidance for staff to support people who had specific medical needs such diabetes or seizures. Parts of people's care records had not all been dated and signed by staff or where possible authorised and signed by people.

People's wishes, opinions and goals were not recorded. There were no records and guidance on how to support people with emotional and mental health needs where appropriate. There was an inconsistent approach to supporting people to complete an end of life care plan.

Staff recorded details about people's day in their daily notes. These notes were often brief or gave little or no explanation about any actions taken. For example one person's daily notes stated they were 'drowsy'. There was no other information provided such as the possible cause of their drowsiness or any actions taken.

People's involvement, assessment and monitoring of their individual health and social care needs were not adequately recorded to give staff sufficient guidance on how people were required to be cared for and treated.

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

Daily handovers were taking place between staff to ensure all staff were aware of any changes to people's care needs and to ensure a consistent approach. Staff told us they relied on the handover to keep up to date about people as their care records were not clear. A new key worker system was being put into place. A key worker is a named member of staff that was responsible for ensuring people's care needs were met. This would help to ensure information about people was shared with other staff and relevant health care professionals.

There had been one formal complaint since our last inspection There was recorded evidence that this complaint had been investigated and used as an opportunity to improve the service. We were unable find out if people and their relatives were satisfied with their response as they no longer lived at the home.

There were limited activities for people to be involved in. Most people were very isolated in their bedrooms. A film was shown every afternoon in the cinema but very few people joined in this activity. Posters around the home advertised the film which would be shown each day. The improvement lead had informed people at the residents and families meeting that a social activities coordinators post would be advertised in the near future which would enhance the day of people who lived at Summerfield nursing Unit.

People were socially isolated and did not have the support to follow their interests and take part in social activities that interested them.

This was a breach of Regulation 9, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service well-led?

Our findings

Since our last comprehensive inspection in November 2014, the provider had explored various routes to improve the service which had delayed their progress in ensuring people are receiving quality care which is safe and effective and meets people's needs. There was no registered manager currently in post. This meant that the service had not been well led since our last comprehensive inspection and there had been no significant improvement made in the managing and monitoring of the service.

However, two weeks prior to this inspection, the provider had commissioned a care management organisation to help 'turn around' and drive improvement across all aspects of the service. Whilst there was little evidence of any improvements prior to the management company, there was indications of the positive developments since they had been in position.

The care management company deployed an improvement lead to run and manage Summerfield Nursing Unit and to help lead and implement the improvement plan. The improvement lead and provider were actively recruiting for a new manager to be responsible and accountable for the running and management of the home. We were told that the improvement lead would ensure the new manager would be fully embedded and inducted into their role before they would withdraw from their management position, however they would continue to visit the home regularly to carry out monitoring and quality audits.

A plan was in place to initially audit different aspects of the service to identify the scale of the development required.

For example an infection control audit had been carried out to identify any shortfalls in the quality of infection control. An action plan was in place to address the gaps and enforce improvements in infection control. A senior member of the management staff was about to undertake a health and safety course and would become the lead in all matters relating to the health and safety of people, staff and the premises and grounds. Records showed that regular servicing and maintenance was carried out to the building and its utilities as well as to equipment relating to people's care such as hoists.

The provider and senior management team were responsive to new ideas from the improvement lead. They had engaged with other organisations to seek further guidance and training for staff. They were exploring ways of networking with other providers and expanding their knowledge to keep themselves current and up to date with the latest legislation and guidance. Plans were in place to review and update all the policies of the home as they did not reflect the home's practices and national guidance.

Staff were mainly positive about working in the home. Staff told us they were dedicated to looking after people well but they had not always had the skills and resources to do this. One staff member told us the provider and senior management team had a more proactive approach towards the care of people who lived in the home.

Although the auditing and monitoring of the service had started to be implemented, we were unable to ascertain the impact on the quality of care provided as the findings had not yet been evaluated and an action plan produced.

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	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: People who use services did not always receive care and treatment which were appropriate, met their needs and reflect their preferences, especially their social preferences and needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: The care and treatment of people who use services were not always provided with the consent of relevant people.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: People who use services did not always have accurate and complete care records which reflected their needs.

The enforcement action we took:
We have issued an enforcement action and asked the provider to take immediate action and comply with Regulation 17, HSCA 2008 (Regulated Activities) Regulations 2014 by 30 July 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: People who use services did not always have accurate and complete care records which reflected their needs.

The enforcement action we took:
We have issued an enforcement action and asked the provider to take immediate action and comply with Regulation 17, HSCA 2008 (Regulated Activities) Regulations 2014 by 30 July 2015.