Roseacres Care Home Limited

Roseacres

Inspection report

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Ratings

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

Overall summary

This unannounced inspection took place on 24 March 2015. Our previous inspection of 16 September 2014 found that the service had made improvements to the safety and welfare of people because the service was keeping people's care needs and areas of risk under review, and we saw many positive interactions between staff and people using the service. However, improvements were needed for the support of people against the risks of malnutrition, and for consistent record-keeping. Our inspection before that took place on 16 April 2014 when we found a number of breaches relating to the care and welfare of people.

Roseacres is a care home for up to 35 older people. There were 32 people using the service when we inspected, and we were informed that their maximum practical occupancy is 34. The service's stated specialisms include dementia, physical disability and sensory impairment. The accommodation is an adapted home with passenger lift access to the first floor.

At the time of our visit, the service's manager had been registered for six months. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

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.

We found that Roseacres had a very open and welcoming atmosphere. Staff attended to people in a friendly and unhurried manner, and people's choices were listened to. There was a range of positive feedback about the service.

People received meals that were appetising and freshly prepared. Improvements had been made to people's support with food and drink, as people's weight and support needs were kept under regular review, and actions were taken to address any concerns identified.

Staff underwent a robust procedure to check they were appropriate to work with people before they started work. Staff received good support to deliver care to people appropriately, including through regular training and supervision. The service had enough staff, with little reliance on using agency staff.

The quality and consistency of record keeping had improved, which helped to demonstrate that appropriate care took place.

The registered manager knew the service and people using it well, and was accessible to anyone at the service. There were systems of auditing quality and risk at the service, and we could see that action was taken to address identified shortfalls.

The service took appropriate action if they believed a person needed to be deprived of their liberty for their own safety, including involving community health professional and people's closest contacts. However, further work was needed with ensuring that the principles of the Mental Capacity Act 2005 were consistently applied for everyone using the service.

Medicines were managed appropriately and people received good overall support with health matters. However, the agreed delegation of blood-sugar testing arrangements from a community healthcare team was not suitable to protect the health, safety and welfare of people using the service.

There were adequate systems to infection control. However, the service was not consistently safe because action had not been taken to promptly address some shortfalls identified by professional checks of the premises. This may have put people using the service at unnecessary risk.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have 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. Action had not been taken to promptly address some shortfalls identified by professional checks of the premises, which may have put people using the service at unnecessary risk.

The service had enough staff, with little reliance on using agency staff.

New staff underwent a robust procedure to check they were appropriate to work with people.

People's medicines were adequately managed.

The service had appropriate safeguarding procedures in place, and staff knew what to do if they had concerns about people being abused.

There were adequate systems of infection control and equipment maintenance.

Is the service effective?

Requires Improvement

The service was not consistently effective. The agreed delegation of blood-sugar testing arrangements from a community healthcare team was not suitable to protect the health, safety and welfare of people using the service.

The service took appropriate action if they believed a person needed to be deprived of their liberty for their own safety. However, further work was needed with ensuring that the principles of the Mental Capacity Act 2005 were consistently applied for everyone using the service.

People received meals that were appetising and freshly prepared. Improvements had been made to people's support with food and drink, as people's weight and support needs were kept under regular review, and actions were taken to address any concerns identified.

Staff received good support to deliver care to people appropriately, including through regular training and supervision.

Is the service caring?

Good

The service was caring. There was an open and welcoming atmosphere. Staff attended to people in a friendly manner, people were offered care choices, and people's choices were listened to. People were treated with respect, and the approach to care was unhurried.

Is the service responsive?

Good

The service was responsive. People received care that aimed to meet their individual needs, which were kept under review.

The service provided daily activities led by a designated activities worker. This included occasional community trips.

Summary of findings

The service had an accessible complaints system. Whilst there were low levels of complaints, matters raised were addressed.

Is the service well-led?

Good

The service was well-led. There were systems of auditing quality and risk at the service, and we could see that action was taken to address identified shortfalls.

The registered manager knew the service and people using it well, and was accessible to anyone at the service. Staff benefitted from an open and empowering culture, which helped them to better meet people's needs.

Roseacres

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 24 March 2015 and was unannounced. The inspection team comprised of two inspectors, a specialist advisor on dementia and nutrition, and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at the information we held about the service including notifications they had sent us and information from the local authority. We contacted two community healthcare professionals for their views on the service.

During the visit, we spoke with 13 people using the service, two visiting relatives, a visiting community healthcare professional, eight staff members, the registered manager, and two members of the senior management team.

We observed people throughout the day and used the Short Observational Framework for Inspection (SOFI) during lunch. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also looked at various parts of the accommodation.

We looked at care records of seven people using the service and five staff members, along with various management records such as quality auditing records and staffing rosters. The registered manager sent us further documents on request after the inspection visit.

Requires Improvement

Is the service safe?

Our findings

There were certificates to show that a number of professional safety checks had taken place, for example, for electrical appliances, the passenger lift and fire equipment. However, the check of emergency lighting that was started in December 2014 had not been completed and signed off as safe. The last electric wiring certificate for the premises, dated 19 July 2013, recorded an 'unsatisfactory' outcome with explanation that included, "System in generally poor condition." When we asked for evidence that this outcome had been rectified, the management team told us that all necessary safety actions had been addressed, however, they were unable to provide professional documentation confirming this. This put people using the service and others in the building at unnecessary risk to their safety and welfare. Following our visit, we were sent the appropriate professional documentation demonstrating that professionals had addressed these matters after our visit.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at some people's rooms. We saw some good attention to people's safety, for example, the use of window restrictors and radiator covers to prevent risks of injury. Pressure mats, connected to the staff-call system, were in place at the foot of some people's beds to alert staff to the person getting up where the person was assessed as being in need of support.

There was a system of documenting regular checks of a variety of health and safety matters in the service, with clear guidance on the detail of the check and what safety risks to consider. This meant that reasonable steps had been taken to ensure the safety of, for example, wheelchairs, and that fire evacuation processes had been regularly practiced. However, some checks were not up-to-date. For example, monthly checks of the slings used to hoist people had not been recorded in over two months. The only monthly bed-rail check was over two months old, and did not record a check of the four bed-rails that we were shown to be in current use. We found that bed-rails were being safely used in these rooms, and that there were individual risk assessments for these that were kept under review. Records showed that where equipment concerns had been identified, action was taken to keep people safe and to rectify the concern.

People using the service told us they felt safe. Comments included, "Staff are always there" and "They come if I use my buzzer." We found that staffing levels were assessed and monitored to ensure they were sufficient to meet people's identified needs. The registered manager told us, "Everything depends on the needs of the residents," and that their staffing arrangements were very flexible.

Records showed the service had over fifteen permanent care staff along with a pool of bank staff who worked when needed. The rota showed that six or seven care staff were on duty during the morning, five in the afternoon, and three during the night. Records showed that people's reliance on care was assessed on a monthly basis. The staff had daily meetings to discuss difficulties and to enable the registered manager to adjustment staffing arrangements with regards to the number of staff and skills mix. Staff told us they felt there were enough staff working to meet people's needs.

The service followed safe recruitment practices as staff personnel records showed they had been subject to appropriate and necessary checks prior to employment. Records showed staff had been subject to identity and criminal record checks. There was a job application form for each staff member, which included their employment history. Two references had been obtained to ensure each staff member was of good character, and medical questionnaires were completed to ensure staff were fit for work. This meant the provider had taken appropriate steps to make sure people were safe and their welfare needs were met by staff who were suitably qualified, skilled and experienced.

There were individual risk assessments in place for each person using the service that reflected their current needs and abilities. These covered areas such as supporting people to move or be hoisted, slips and falls, skin integrity, and continence management. These were in line with people's monthly dependency assessments. Care plans were in place as a result of significant risks. This meant that action was taken to minimise the risks to individuals from foreseeable hazards.

The service had appropriate systems of protecting people from the risk of infection. People commented positively

Requires Improvement

Is the service safe?

about the standard of cleanliness, and we saw this to be the case. The service had dedicated cleaning staff working seven days a week. We saw adequate systems of infection control, including personal protective equipment such as disposable gloves being easily available for staff when providing people with personal care. People were supported to clean their hands before lunch. Sharps bins were safely stored and used. We noted a four-star food hygiene rating from the local authority dated March 2014, meaning good standards of infection control were in place for food and drink. There was a contract in place for removal of clinical waste. Records showed that the registered manager had recently audited the service for infection control matters. Whilst it indicated good control levels, there was also action about shortfalls such as removing bed sheets with ingrained stains.

We found that people's medicines were adequately managed. People told us their received their medications correctly and at the right time. Some people mentioned getting pain relief when needed. Medicines records showed that many people had individual as-required medicines protocols in place, to guide staff on appropriate circumstances for supporting people with these medicines. We found that twice a week there was no night staff member assessed as competent to administer as-needed medicines during the night. The registered manager explained that this was a temporary arrangement pending staff recruitment, and showed us documented guidance by which another staff member was available 'on-call' during the night to provide any required medicines.

We found that no medicines were out-of-date, and no prescribed medicines were out-of-stock. Administration records were up-to-date and indicated that people received their medicines as prescribed. This included for complex medicines that had dosage changes on a weekly basis, and where medicines were in monitored dosage packaging. However, we found that records for the separately-boxed medicines for one person had minor discrepancies compared to the number of tablets available. We brought this to the registered manager's attention as it indicated the person may not have consistently received their medicines as prescribed.

The service had appropriate safeguarding procedures in place including a detailed safeguarding policy. It noted, for example, the systems in place at the service to help prevent the possibility of abuse, such as recruitment checks, a culture of listening to and valuing people using the service and their representatives, and the appropriate support of staff to carry out their roles. It also clarified that it was the duty of staff to report safeguarding concerns, how they should do this, and how the service would ensure all appropriate external organisations such as the local safeguarding team were informed of the allegation. Information on safeguarding and whistleblowing processes were available in the service. Staff knew what to do if they had concerns about people being at risk of abuse.

Requires Improvement

Is the service effective?

Our findings

People told us of good support with health matters, for example, "If anyone is suffering from a mental health condition it is the ideal place to be. There's no orders and we soon get better because of it." A visiting relative told us, "[My relative] is clearer and happier since the new management." They also praised the service's response to a recent healthcare emergency situation. The two healthcare professionals we contacted as part of the inspection fedback positively about the service and how it worked in co-operation with them. In particular, the service was praised for their knowledge of individual people using the service.

Despite the feedback we received, we found that an avoidable incident recently occurred in which the health of someone using the service was temporarily compromised as a result of ineffective working arrangements between the service and a community healthcare team. Records and feedback from the registered manager demonstrated that a prompt multi-professional meeting had taken place to consider the incident and set up processes to minimise the risk of reoccurrence. A record showed that three of the service's staff had been trained on the minor nursing procedure of taking people's blood sugar levels in support of monitoring diabetes. The registered manager could not supply us with a formal record that the community healthcare team had provided this training and had formally delegated responsibility for the procedure to the three staff members. Additionally, the staff member who checked the person's blood sugar levels during the above incident had not received the training from the community healthcare team, and so had not been assessed by that team as competent to undertake the procedure effectively and act on the results appropriately. The staff member did not seek medical advice at the time of the incident, which the training would have prompted them to, and which was in contrast to the person's care plan. These arrangements at the service were not suitable to protect the health, safety and welfare of people using the service in circumstances where responsibility for their care and treatment was shared with a community healthcare team.

This was a breach of Regulation 24 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted that the service kept clear records of people's ongoing health needs and advice from community healthcare professionals such as GPs, chiropodists, dieticians and community psychiatric nurses. The last staff meeting included guidance to staff on health supported expectations, for example, that medical advice had to be sought if someone had a fall or was found to have significant weight loss.

People fedback positively about the food and drink provided. Comments included, "It's nice; I eat it" and "The food's lovely." We saw that people received a choice of meals that were appetising and freshly prepared, and that staff provided people with unhurried support to eat and drink where needed. People received soft or blended food as per their care plans.

Improvements had been made with ensuring that people were supported to eat and drink enough. Records were kept of the food and drink provided to people where they were assessed to be at risk of malnutrition or dehydration. The service kept people's weight and nutritional risks under monthly review or weekly where needed. There were recent records of community dietitian input for some people, and we saw that advice from this was being acted on. For example, one person was on a fortified diet. The cook knew this and could explain how the fortification was achieved by adding full fat milk and cream to the diet. We saw that this took place for the person, and they were supported to eat as directed.

The provider supported staff with skills and knowledge development for their roles. Records showed staff had individual supervision meetings with a member of the management team at appropriate intervals. The frequency of supervision had increased in recent months, to provide greater support. Supervisions involved discussion on care practice issues and training needs, and staff were given feedback about their performance.

The registered manager and staff told us that new staff had a three-day induction program to familiarise themselves with the needs of people using the service, management and administration. The staff training matrix showed most

Requires Improvement

Is the service effective?

staff had completed training on essential topics such as manual handling, safeguarding adults from abuse, and dementia. However, some staff needed refresher training in some areas and new staff needed to complete almost all of their training. The registered manager told us they were in the process of commissioning new training, to enable staff to receive training quicker and meet the requirements of the new national Care Certificate that was being implemented from 1 April 2015. The registered manager also demonstrated that half of the staff had national qualifications in Health and Social Care, and that some new staff were being supported to attain these.

The building was not designed to meet the needs of people who have dementia. This challenged the service's ability to effectively meet people's dementia care needs. However, action had been taken to attempt to address this. For example, signs had been placed on doors to help orientate people, many bedroom doors had been repainted in contrasting colours to the walls and had memory boxes next to them, and the dining area had been further redecorated to try to provide a cafeteria appearance.

The Deprivation of Liberty Safeguards (DoLS) provides a legal framework to protect people who need to be deprived of their liberty for their own safety. The service took appropriate action in this respect, including involving community health professional and people's closest contacts. The registered manager explained that formal DoLS applications were made for new people where appropriate, and that applications were also being made for established people in line with local authority expectations. We found the service to be operating in line with approved DoLS applications.

We found that three senior staff had been formally trained on the Mental Capacity Act 2005. Staff showed good awareness of asking people for consent to provide care and respecting refusals. We saw this to occur in practice, for example, staff tried different ways of acquiring consent where they considered the care to be in the person's best interest. The registered manager explained that he had provided informal training to all staff on the practical application of this legislation as part of dignity training, and gave examples such as how a person may lack capacity to consent to their stay in the service but could make choices about their day to day care delivery.

However, further work was needed to ensure that the principles of the Mental Capacity Act 2005 were consistently applied for everyone using the service. People's care records included assessment of their capacity to consent to receiving care and support at the service. Where these established that the person lacked this capacity to consent, the best interests decision-making section of the document was blank for the three people we checked. We also found old capacity and consent documents in some files, such as a 'desired level of medical intervention' that had been superseded by a Do Not Attempt Resuscitation (DNAR) form. These points did not assure us that the service had completed the process of working in line with the principle of the Mental Capacity Act 2005 so as to ensure people's human rights were properly promoted.

Good

Is the service caring?

Our findings

People told us they experienced staff as kind and caring. Comments included, “It’s very good here, staff are friendly, it’s a happy place”, “No shouting or orders, very restful, it’s excellent” and “This is a nice place here. They listen to you. I wouldn’t move out of here.” Another person told us, “They are very kind and do everything for you. It’s not the same as home, but I’m happy.” They said their daughter had helped them choose the care home, and it had been on the recommendation of a friend.

Visiting relatives made positive comments about the care, for example, “I like and trust the core caring staff enormously and they communicate well with me. They are looking after [my relative] really well.” One visiting relative told us that they did not have input into their relative’s care plan because their relative did that themselves. This respected the person’s ability to express their views and make decisions about their care. The registered manager told us that a few people using the service were consistently capable of being involved in reviewing their care plans. He recognised that some other people could at times have insight into this process.

We saw that the service had a very open and welcoming atmosphere. Staff attended to people in a friendly manner, people were offered care choices, and people’s choices were listened to. For example, people could sit where they wanted for lunch. People were asked which of the available meals they wanted, and where verbal communication was difficult, they were shown the options.

The service had a caring approach. When one person started crying, they were quickly attended to in a friendly manner. People were free to move around the service.

When someone got up and used their frame to get around, staff supported them. Staff checked on people regularly, and we saw that the way they interacted with people helped to enhance people’s well-being, for example, because people smiled in response. We saw one person apologise for interrupting the registered manager in his office close to the lounge and dining areas. The registered manager went after them to check what they wanted, which was a caring and affirming approach as we heard the person mentioning being in pain.

Records and feedback about the registered manager showed that he role-modelled and encouraged appropriate behaviour towards people using the service. Minutes of the last meeting for people using the service and their representatives included positive feedback about the caring nature of staff and that the service was a “happy place.”

We saw an unhurried approach to people’s care. For example, staff took time to encourage people with their medicines, keeping them informed of the health benefits. Where one person did not accept the staff support to eat their meal, another staff member tried. We saw the person to respond better to the change of staff member, both in terms of now eating but also smiling more. This indicated a positive relationship was in place with the staff member.

The service’s approach to people promoted their dignity. People were well dressed and presented, indicating appropriate staff support where needed. At lunch, people wore napkins where needed that blended in with the décor of the environment rather than highlighting their care needs. Staff noticed where people needed minor adjustments for lunch, such as with sitting up better or having their plate closer to prevent spilling food.

Good

Is the service responsive?

Our findings

People were enabled to carry out activities in the service. The provider employed a full-time activities coordinator who organised activities on a daily basis including at weekends. Records informed us that they had a national qualification in activities management and they kept up-to-date with training in this area. People provided reasonable feedback about activity and stimulation at the service. One person said, "The activity lady is on holiday. We do exercises and colouring and I help her out sometimes." We saw that the art supplies were age-appropriate. A community healthcare professional told us of frequently seeing activities taking place when they visited. A visiting relative told us, "There's a lady who organises things for them to do. When she's here they play skittles and do crosswords and exercises. [My relative] goes out with them sometimes in the minibus." The registered manager confirmed that the minibus was used to take up to four people out at a time to various places such as a local farm and for clothes shopping. This helped people to maintain a community presence.

Care staff followed the clearly-displayed activities program during our visit. There was about twenty minutes of a ball throwing activity during the morning, and a more substantial tea dance activity in the afternoon that staff seemed familiar with. A number of people using the service joined in with the dancing. Some other people watched and those not wishing to join in were supported to move round the corner to the other lounge where tea and cake was additionally passed around. We noted that the atmosphere in the service lifted as a consequence of the activities provided.

We listened to a staff handover meeting, during which key information about people using the service was communicated to incoming staff along with clear guidance on which people they were responsible for delivering care to. This helped to ensure that people received individualised care that reflected their current needs.

When we looked round people's rooms, we found that call-bells were available to people and were seen to work. This helped to ensure that people could call for staff support when they wanted it.

We saw staff working in different ways to address one person's dementia-influenced anxiety, with varied success. We were shown the work done to document the care strategies for this person, which staff and the registered manager could explain to us, including reference to different strategies working at different times.

All of the care records we looked at showed that people's needs had been regularly reviewed and updated to demonstrate any changes to their care. Staff told us they had access to the care records and were informed when any changes had been made. Care records contained detailed information about the desired care outcome, how staff were to provide support, and what the person's preferences were.

We saw that brief life stories had been developed for many people using the service. This helped staff to be able to interact and respond to people's dementia-influenced behaviours in ways that validated their realities more.

People told us that they could raise concerns and complaints which were addressed. As one person put it, "If anything's not ok, I put my foot down and they help." A visiting relative added that the service "takes criticism well and act on what I say. For instance, these armchairs needed cleaning and they did it."

The service had an accessible complaints policy that was on display in the premises. The policy gave brief information on the process to be followed, including for evaluation to ensure the issue was not repeated. The policy clarified that people would not be discriminated against for raising concerns, and included that the provider would inform us of certain more serious complaints, which helped to assure us of the transparency of the service.

Whilst records showed low levels of complaints, matters raised were addressed. For example, one person had complained that their bedroom door lock did not prevent other people coming into their room. A different lock was installed to rectify the issue. We saw records indicating that the registered manager and provider kept complaints under review.

Good

Is the service well-led?

Our findings

We received positive comments about the registered manager's approach and knowledge of people. For example, one person told us, "The manager is very good." Staff told us, "He's patient and he listens" and "He's trying to improve the quality of care." The registered manager demonstrated that he knew the service and people using it well, and was accessible to anyone at the service.

The provider sought the views of people using the service, relatives and staff in different ways. The minutes of the last quarterly meeting for people using the service and their relatives included updates on staff recruitment, refurbishments and activities, progress with involving families, along with responses to anyone's questions and concerns.

People's representatives had been sent a survey three months before our visit, the results of which showed that the nine respondents had provided almost entirely positive feedback, for example, about the quality of staff. However, the registered manager had set an action plan to address the occasional shortfall, for example, in respect of advertising activities and improving laundry quality.

We found that the management of staff promoted a positive culture that aimed to deliver high quality care to people. We saw senior staff checking the well-being of staff members, and we received feedback such as, "We're getting on well." Staff we spoke with showed enthusiasm for their work, and fedback positively about the management of the service, for example, "We're having daily meetings to discuss any problems," which the registered manager led. Records and our observation of these meetings, along with two-monthly staff meetings, showed that staff could initiate discussions, and received support and guidance on service expectations. For example, the registered manager reminded staff to speak English in front of people using the service as others languages could easily confuse people with dementia. A recent survey of staff provided almost entirely positive feedback about the management of the service, including feeling listened to in their work role, and receiving staffing rosters in good time.

There were systems of auditing quality and risk at the service, and we could see that action was taken to address identified shortfalls. For example, the operations manager recorded outcomes of their regular visits to the service within a monthly document set up to ensure good outcomes for people using the service. It included a set of actions to be addressed, for which we saw a separate record of updates as items on it were completed. This included, for example, various improvements to the environment, the setting up of an agency staff induction folder, and updating health and safety risk assessments. We saw evidence in support of these updates.

The management team provided us with occasional updates of progress at the service. Their records and approach demonstrated a transparency about the service, and showed that action was taken to address quality and risk concerns. We saw during the visit many improvements had been made. For example, there were various quality and risk audits such as for improved care plans, better support of people with eating and drinking, and the approach of staff in how they interacted with people.

The registered manager reviewed accidents and incidents on a monthly basis. Records indicated that learning points from these were promptly shared with the staff team and left available to remind staff. Staff meeting minutes showed the provider's learning from quality checks of their other services was shared, which helped to demonstrate good management of the service.

We saw a record of a recent night check by the management team. It showed that staff were attending to people appropriately, that call-bells were within reach of people, and that records were being appropriately kept. Action was also taken to address a health and safety risk identified during the visit.

We found no overall concerns with the standard of record-keeping at the service. This improved on the findings of our previous inspection. The registered manager told us of much support and encouragement of staff to keep accurate and up-to-date records of people's care, and it was evident that record-keeping was now embedded as part of the service delivery.

The registered manager told us he attended meetings with the local authority's quality improvement team, and that the activities co-ordinator attended designated meetings run by that team for staff in that role. This showed a willingness to be open to new ideas, and work with community partners to improve on service quality.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises The registered person did not ensure that people who use services and others were protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance and operation of the premises. Regulation 15(1)(c) [which corresponds to regulation 15(1)(e) of the HSCA 2008 (Regulated Activities) Regulations 2014]

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 24 HSCA 2008 (Regulated Activities) Regulations 2010 Cooperating with other providers The registered person did not make suitable arrangements to protect the health, safety and welfare of people using the service in circumstances where responsibility for their care and treatment was shared with a community healthcare team. Regulation 24(1)(a)(c) [which corresponds to regulation 12(1)(2)(i) of the HSCA 2008 (Regulated Activities) Regulations 2014]