St Dominic's Limited

St Dominic's Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service:
St Dominic's Nursing Home provides nursing and personal care for up to 91 people with nursing needs, such as Parkinson's, diabetes, and heart failure, many of whom were also living with dementia. The home was divided into six units, over three floors, Fern, Crocus, Dahlia, Aster, Bluebell and Elderflower. Fern and Elderflower units remain closed currently. There were 43 people living at the home on the days of our inspection.

People's experience of using this service and what we found:
The governance systems had not supported the service to consistently improve and sustain improvement. Audit systems and processes had failed to identify risks to people's safety and other aspects of the service that required improvement.
Improvements had not been sustained since their last inspection and additional concerns were identified during this inspection in relation to staffing and person-centred care.
There was a lack of clear and accurate records regarding some people's care and support. For example, oral care, nutrition and fluid support, and peoples' mental health. Some people's care records were inaccurate and did not reflect their actual needs. There was a lack of oversight by the provider and management team.

Risk management was an area identified as needing improvement to ensure peoples' health and well-being was protected and promoted. We identified shortfalls in respect of the risk of choking, management of dehydration, mental health guidance and the management of specific health problems. Staff practices regarding medicines needed to be further developed to ensure that staff follow the organisational policy for safe administration and recording of medicines. Peoples' oral health was not consistently monitored to ensure good practice was consistently followed.

Staffing levels were not sufficient at this time to meet people's individual needs to keep them safe and ensure their well-being.

We have made a recommendation about the mental capacity assessments for people who live at St Dominic's Nursing Home.

People received care and support from staff who had been appropriately recruited and trained to recognise signs of abuse or risk and understood what to do to safely support people. People were supported to take positive risks, to ensure they had as much choice and control of their lives as possible.

There were COVID-19 policies in place for visiting that was in line with government guidance. Families told us that they were welcomed into the home and followed the guidance currently in place. We signposted the provider to resources to develop their approach.

Referrals were made appropriately to outside agencies when required. For example, GPs, community nurses

and speech and language therapists (SALT). Notifications had been completed to inform CQC and other outside organisations when events occurred.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update:
The last rating for this service was Requires Improvement (published 17 December 2021)

Why we inspected
This inspection was prompted due to information of risk and concern in relation to staffing levels, communication and safeguarding concerns which had impacted on care delivery. We also used this opportunity to look at the breaches of Regulation 12 and 17 from the last inspection in November 2021. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.
For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained requires improvement. This is based on the findings at this inspection.

The concerns raised were looked at during this inspection and have been reflected in the report.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led questions of this full report.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement
We have identified continued breaches in relation to safe care and treatment, staffing and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up:
We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received, we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Details are in our Safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

St Dominic's Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by 2 inspectors.

Service and service type
St Dominic's Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. St Dominic's Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 12 December 2022 and ended on 19 December 2022. We visited the home on 12, 13 and 16 December 2022.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR) dated 11 February 2022. This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spent time with people that lived at the home. We spoke to people throughout the inspection and received feedback on living at the home from 9 people. Some people were not able to tell us their views, so we used the Short Observational Framework for Inspection (SOFI) during the morning of day 1 and 2 of our inspection. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke to 3 people's relatives and received feedback from 4 professionals that regularly worked with the service. We spoke to 10 members of staff which included the registered manager, deputy manager, nominated individual, nurses, senior carers and carers. We looked at 8 people's care plans and multiple medicine records. We looked at documents relating to quality assurance and feedback the home had received from people and relatives.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
At the last inspection care and treatment had not always been provided in a safe way. Risk of harm to people had not always been mitigated. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst improvements were seen, not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Risks to people had not always been assessed and their safety had not always been monitored and managed safely. Improvements to risk assessments and risk management seen at the last inspection had not been sustained, and this had placed people at risk of harm.
● There were people who had been assessed as being at high risk of developing pressure damage and preventative measures such as pressure relieving mattresses were in use. However not all were set correctly for the individual person's weight despite it being documented daily that it was correct. For example, one person had recently moved rooms and the pressure relieving mattress was set and labelled for the previous person and was set at double their weight. This had the potential of causing skin damage rather than preventing skin damage.
● There were people at risk of choking due to swallowing problems. There was evidence of consultation with the speech and language therapists (SaLT) that had advised a modified texture diet to reduce the risk of choking and added nutritional supplements via a percutaneous endoscopic gastrostomy (PEG). However, there was no risk assessment in place for choking or any instructions for staff to follow should the person choke whilst eating.
● There was a lack of risk assessments for people who lived with specific health problems such as cirrhosis (liver disease), there was no risk assessments as to the potential related health risks such as ascites. Ascites is a collection of fluid in the abdomen which causes additional health problems such as breathing difficulties, pain and swelling to lower limbs making walking difficulty. None of these had been noted or planned for within the care documentation.
● During the inspection there was a high number of people who remained on continuous bedrest, without any rationale or best interest discussion documented. For example, one family who's loved one had been in bed for four continuous days in the past week were told it was because of the hoist sling needing repair. However, on discussion with the registered manager, there were appropriate spare slings and there was no reason for this to occur. The impact of the person being kept in bed was an increase risk of skin damage and

incontinence.
● Food and fluid records were not completed consistently and there was no evidence that staff always took appropriate action for people who were not drinking enough. For example, 1 person on three consecutive days (13, 14 and 15 December 2022) had drunk less than 500mls – this information was added by night staff to the handover sheet, but no further action taken or recorded. This person had a medical history that included urosepsis (untreated urinary tract infection) which can be linked to dehydration.
● For some people who lived with dementia or a mental health illness, there was no risk assessment or care plan to guide staff in managing them safely. For 1 person who experienced emotional distress their care plan stated for staff to use de -escalation techniques, however there was no further guidance or any documentation that supported any methods that had been successful. Not all staff spoken with had knowledge of peoples' mental health needs and how to manage them safely.
● A person had had 38 falls from 3 October 2022 to the 12 December 2022. The risk assessment stated '121 supervision was required' but this was not possible with the current staffing levels. The falls team visited on the 13 December 2022, but the senior care staff member had not recorded any advice received or actions to take. The person then had further falls following the professional visit. Whilst the advice may not have prevented the falls, the staff may have been able to take steps to mitigate risk.
● We found during the inspection that some people on continuous bed rest did not have access to a call bell. For example, on 2 occasions on the 13 December we found 1 person climbing over their bed rails to go to the toilet. We called staff for them as they did not have access to their call bell.

The provider failed to provide safe care and treatment to people, including failing to assess and mitigate risks. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were detailed fire risk assessments, which covered all areas in the home. People had Personal Emergency Evacuation Plans (PEEPs) to ensure they were supported in the event of a fire. These were specific to people and their needs.
● Premises risk assessments and health and safety assessments continued to be reviewed on an annual basis, which included gas, electrical safety, legionella and fire equipment. The risk assessments also included contingency plans in the event of a major incident such as fire, power loss or flood.

Using medicines safely
At the last inspection, the provider had failed to ensure medicines were given safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst improvements were seen, not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Medicines were not always being ordered in a timely way, this meant that people did not always receive their prescribed medicines. For example, one persons' medicine prescribed twice a day had been out of stock for six days. Another person had missed two days of their heart medication as it was out of stock.
● The codes used by staff for non-administration were not always correct, for example when one medicine was out of stock staff had used M (make available) rather that F (other reason). This was not picked up on the audits.
● There were hand written medicine administration records for people who had come to live at St Dominic's Nursing home from the hospital and staff had not always ensured a second staff member was checking and countersigning the medicine administration record to ensure the dosage, and times were correctly transcribed. It had been identified by an external medicine audit that staff were not always

checking discharge letters with the medicines sent from hospital, which links in to the need for two staff to check medicines in accurately to avoid errors.
● Protocols for 'as required' (PRN) medicines such as pain relief medicines described the circumstances and symptoms when the person may require this medicine. However, not all were in place. This had been identified on a recent audit.
● Staff were not consistently checking the temperatures of medicine rooms and fridges to ensure that medicines were stored safely at the correct temperature.

The provider failed to ensure medicines were managed safely. This is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Medicines were stored, administered and disposed of safely.
● Staff who administered medicines had relevant training and competency checks that ensured medicines were handled safely. When poor practice was identified, a performance review was held with the staff involved and a plan put in place to monitor to improve practice.

Staffing and recruitment
● Comments from people about staffing included, "Good staff, kind," and "Not enough staff." Visitors told us they had concerns about staffing levels, comments included, "I sometimes visit and don't see any staff," and "They are definitely short staffed. It's got really noticeable in the past three months." "Staff are nice and caring but not enough of them." Staff told us that there weren't enough staff to give the care required to people. One senior staff said, "That's why there are people in bed, its quicker," and "It's difficult to give the right care when we are struggling with staff not turning up."
● Rota's confirmed staffing levels were consistent, with the use of agency staff when required. During the inspection process, there were staff shortages on the 12 and 13 December 2022 that could not be filled by agency staff. This had an impact on people's care. Records told us that oral health had not been undertaken for 5 days, records for showers were minimal and people told us they weren't offered the choice of a bath or shower. The communal bathrooms on bluebell and crocus were used for storage and therefore not used. Two staff members said, "People are supported to have a wash in their bedrooms or in bed."
● Staff had not always received the appropriate training to meet the needs of people currently living in the home. For example, de-escalation techniques, management of substance addiction and mental health illnesses. Staff confirmed that they had not received guidance or training on how to manage emotive behaviours.
● Accident and incident records highlighted that there had been unwitnessed falls. The risk assessment for the person who had 38 falls from 3 October 2022 to the 12 December 2022 required 121 supervision for their safety, but this was not possible with the current staffing levels. Staff told us that they could not provide the monitoring needed to mitigate risk for this person.
● We used the SOFI tool over two mornings and we found there were times when staffing levels were not enough to give support to people as required. For example, One person was trying to get out of bed, over the cot sides and despite searching for staff and ringing the persons call bell, it was 20 minutes before staff responded. People in the communal areas were also unsupervised and there was minimal interaction until the activity person arrived. Only 1 person was up and in the communal lounge/dining room on Bluebell unit and 5 people in the dining room/lounge on the second floor. This meant less than a quarter of people were either in bed or remained in their room.

● The nominated individual and registered manager acknowledged staffing had continued to be challenging but felt that the recruitment drive had been positive, and they were in a good place now. However, during the inspection process, we received information from residents, visitors and health

professionals that two registered nurses and the registered manager were leaving in the coming week.

The provider had not ensured that there were enough numbers of suitably qualified, competent, skilled and experienced persons deployed to meet peoples' needs. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● There was an agency file that contained information in respect of their training and Disclosure and Barring Service (DBS). DBS checks, identify if prospective staff had a criminal record or were barred from working with children or adults. This ensured only suitable people worked at the service. The registered manager told us "We don't use much agency anymore but if we do need them, we try to get the same ones for continuity."
● There was a robust recruitment programme. All potential staff were required to complete an application form and attend an interview online, so their knowledge, skills and values could be assessed.
● New staff were safely recruited. All staff files included key documents such as a full employment history, at least 2 references and a DBS check.

Preventing and controlling infection
● The overall cleanliness of the home was difficult for the house keepers to manage as the older part of the building needed repair and renewal. Particularly carpets and communal shower/ bathrooms. Communal areas however were clean and comfortable. We spoke with the registered manager and area manager regarding the rolling plan of renewal and repair, which we have received..
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. Cleaning records reflected that frequently touched areas were being cleaned on a regular basis. However communal bath/shower rooms, some peoples' bedrooms and stairs cases were not seen to be clean. These were identified to the registered manager and immediate action taken.
● We were assured that the provider was preventing visitors from catching and spreading infections. There were systems in place for visitors and agency staff to follow.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely. Staff were wearing PPE in line with government guidance. Staff had received training in how to safely put on and take off PPE and management staff completed competency checks to ensure that staff were doing this correctly. PPE stations were found throughout the premises.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed. Staff had received training in infection prevention and control. People had risk assessments in place to assess whether they would be at increased risk from COVID-19.
● We were assured that the provider's infection prevention and control (IPC) policy was up to date. Staff had risk assessments in place to determine whether they would be at increased risk from COVID-19. Infection control audits were completed regularly, and actions taken as a result were clearly recorded.

We have also signposted the provider to resources to develop their approach.

At the time of the inspection there were no restrictions for relatives and loved ones visiting people.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe. Comments included, "The staff know me and my problems, I do feel safe" "Staff are kind," and "I think more staff would make me feel safer, but otherwise its good here."
● Staff were aware of their responsibilities to safeguard people from abuse and any discrimination. Staff

were aware of the signs of abuse and how to report safeguarding concerns. They were confident the management team would address any concerns regarding people's safety and well-being and make the required referrals to the local authority.
● A staff member said, "We all get safeguarding training, and there are numbers in our office of phone numbers and procedures, if we need them." Another staff member said, "I would definitely raise it with the nurse in charge."
● There was a safeguarding and whistleblowing policy which set out the types of abuse, how to raise concerns and when to refer to the local authority. Staff confirmed that they had read the policies as part of their induction and training.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. For example, locked doors to prevent people leaving the premises without support. However, we found that the documentation was sometimes incomplete and not reflective of their mental health diagnosis. This was fully discussed with the registered manager and reflected in the well-led question.

Learning lessons when things go wrong:
● Accidents and incidents were documented and recorded as they occurred. Reports were concise and descriptive but lacked follow through regarding dates when relatives and any GP was informed and any responses or recommendations from the GP, for example, a medication review. There were numerous references to 'refer to falls team' but no documentation or date to evidence this had occurred. Two senior staff were able to tell us of what the incident/accident had taught them and what they were doing to prevent a re-occurrence, but this was not evidenced or documented. This has been further reflected in depth in the well led question
● Any serious incidents were escalated to other organisations such as safeguarding teams and CQC.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care.

At the last inspection the provider had not ensured that there were effective systems to assess and quality assure the service and had failed to maintain accurate, complete and contemporaneous record in respect of each service user. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that improvements had not been made and the provider remained in breach of Regulation 17.

● The provider had failed to sustain improvements over the last 3 inspections where a rating was given and had not achieved an overall rating of good during this time.
● Following the last inspection, the provider submitted an action plan to tell us how they would meet the regulations. At this inspection we found that the provider had not met the regulations and further issues were found.
● Quality assurance processes were not effective and did not identify risks to people's safety. The management team had developed a service improvement plan following the last inspection to identify and track issues and concerns at the service. The registered manager sent us the action plan that they were working from, however the plan received by CQC was incomplete and showed that concerns had not been actioned. For example, there was no completion date or update as to progress. This meant that issues identified at the last inspection and in the service improvement plan had not been addressed and many of the same issues were found at this inspection. This included issues with oral hygiene, person specific care plans, poor risk management and accurate record keeping.
● There was a wide range of audits, however we found that some were not accurate as we found shortfalls which should have been picked up by the audits. For example, missing recruitment documents, which were later found elsewhere, the audit had said all were in place. The DoLS folder had records for people that were no longer living in the service. There was a maintenance contingency plan in place, but this had not been updated since 2017. The maintenance folder was disorganised, and difficult to negotiate. Some shortfalls were found, for example, hot water temperature checks had not been completed in November 2022 and weekly fire drills were not consistently undertaken over the last three months.
● Whilst there were systems in place to monitor and measure whether care plans were effective and relevant

to people's needs, these were not effective as we found some care plans did not contain important information about the support people needed and the risks they may experience. For example, mental health illness, choking, addiction and related health needs.

● People's records did not accurately reflect the support they received. Care staff were allocated people to support and completed computerised daily care records and paper room files for the duration of their shift. Entries for oral health and personal care in room files had not been completed since the 5 December 2022.

● Recording processes and handover communication sheets were not efficient or effective. The day nurse completed a report and identified poor intake of food and drink, but no further action was documented. This was not carried forward to guide staff to encourage fluids or food. For example, for three continuous days for 2 specific people it stated 'poor intake', but no update or guidance as to action taken. For 1 person who was prone to urinary tract infections and urosepsis, this had the potential to impact on their health and wellbeing.

● People's records did not show that risks to people were being safely managed. For example, for a person who lived with multiple serious health conditions, there was minimal information to guide staff of how to manage the risks associated with these conditions. This care plan was immediately reviewed and updated.

● We had been informed that a person was not supported to attend a recent hospital appointment, which has the potential to impact greatly on this persons' health. This had not been raised internally as a safeguarding concern by staff or documented within the care documentation. The nominated individual said they would investigate and take appropriate action.

● Staff had not received regular supervision, the supervision programme showed that some staff had not had any supervisions in 2022, and others not since February 2022. Lack of meaningful supervision had the potential to impact on staff performance, poor work relationships and work burnout/tensions.

The provider had not maintained accurate, complete and contemporaneous record in respect of each person. The provider did not have effective systems to assess, monitor and improve the quality and safety of the services provided. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The nominated individual informed us that they had recruited a new manager, and a quality assurance lead who would work together to get the service back on track. The nominated individual shared their vision for the service and hoped fresh eyes and ideas would move the home forward and move to a good rating.

● The provider is required to submit statutory notifications to CQC about events in the service. These had been appropriately submitted.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● We received mixed feedback from people, and their relatives. Comments included, "It's difficult sometimes to get information about my relative, sometimes staff seem too busy to stop and talk, overall I think they get the care, but I'm not happy about them being kept in bed," and "Most staff are really kind, but I get the impression they have staffing problems, sometimes when I visit, there is no one around," and "The manager is good, I have had some issues. They are short staffed, it's got noticeable in the past three months. Staff are nice and caring but not enough of them."

● People we spoke to were positive about living at the home. One person told us, "The staff are very nice, very polite. I have no real complaints, food is alright, boredom is the biggest moan," and "It's warm and clean. The meals are ok, and staff are pretty good, just not enough of them"

● When staff were with people, they were supportive and showed respect and humour. The activity person was seen to be popular with people and we saw some lovely interactions.

● The registered manager understood their responsibilities around duty of candour and the importance of being open and honest.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● People were invited to attend resident meetings to give their views and opinions. Staff recorded how people had responded during these meetings and what people had said.

● Surveys were due to have been sent out to staff and relatives in November 2022, but this had not happened yet. We were not provided with a reason but assured that they would be sent soon, the last survey had been sent out in early 2021. Relatives we spoke to confirmed they had not received an opportunity for formal feedback recently and so did bring things to the staffs' attention when visiting. However, not all visitors felt listened to. One visitor told us that they had approached the registered manager on numerous occasions, but the issues were not resolved, "I felt ignored, nothing changed and no-one listened."

● The management team told us that they felt relationships with external health professionals had improved. The feedback we received from 4 health professionals was mixed. All 4 said that communication needed to be improved. Comments included, "The staff are polite and know their residents fairly well, but sometimes things are missed because communication has failed to be disseminated to all staff," "From the visits I have made the staff appear to know people well and have the understanding of their needs, perhaps new members of staff may need more support with education," and "I believe that they care but there has been a deterioration in communication and using systems over the past few months, which is a shame because we saw improvements earlier in the year."

● Staff meetings took place regularly to speak to staff about good practices and areas to be improved.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured the safety of service users by assessing the risks to their health and safety and doing all that is reasonably practicable to mitigate any such risks. Regulation 12 (1) (2) (a) (b) HSCA RA Regulations 2014 Safe care and treatment.

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 The provider had not ensured that there were effective systems to assess and quality assure the service. Regulation (17) (1) (2) (a). The provider had failed to maintain accurate, complete and contemporaneous record in respect of each service user. Regulation 17 (2) (c).