Platinum Nursing Care Ltd

Platinum Nursing Care

Inspection report

McDonnell Drive
Coventry
CV7 9GA

Tel: 02477103374

Date of inspection visit:
19 May 2021

Date of publication:
08 July 2021

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Platinum Nursing Care Limited is a residential care home providing personal and nursing care to 26 people aged 65 and over at the time of the inspection. The care home accommodates 32 people across three wings, each of which has separate adapted facilities. One of the wings specialises in providing care to people living with dementia. People with nursing needs were supported on other units. Not everyone in the home was receiving nursing care.

People's experience of this service and what we found
A lack of governance systems and clinical oversight meant that issues identified during our inspection were not picked up by the provider. There was no system to regularly analyse falls or other incidents in the home to mitigate the risk of them happening again. We identified a number of falls which had occurred at the home which had not been identified by the provider. We also identified where people had wounds and/or pressure injuries which the provider was not aware of. Quality assurance systems of care records had failed to identify gaps in records found during our inspection.

Staff gave positive feedback about the registered manager and provider and said they felt well supported. However, there was no formal system in place to regularly gather feedback from people, their relatives, staff or professionals and some relatives told us that communication between them and the service was poor.

Risks to people's safety were assessed but not consistently reviewed following changes in their health or falls. We found records did not routinely include recommended information to help staff mitigate risks to people such as daily monitoring of catheters, or how to spot complications related to specialist feeding tubes. Records relating to the management of people's skin did not always evidence repositioning was being done in accordance with people's care plans. Although there were enough staff on the day to provide care safely, we received mixed feedback about staffing levels.

People did not always receive enough encouragement and prompting to eat and drink, and a lack of social interaction at mealtimes meant many people ate alone in their bedrooms. Staff were provided with training the provider considered mandatory and staff spoken with could tell us how they monitored people's health for any changes and would report those changes to senior staff or management. However, training records showed that a number of staff required their training to be refreshed and some had not completed training considered mandatory by the provider.

We observed some caring interactions between staff and people, and people spoke positively about care staff. Communication from staff was warm and friendly and people were supported in a dignified way.

Staff told us they enjoyed speaking with people about their past lives, families and interests and used the information contained in people's care plans to support these conversations. However, there was little opportunity to engage people in meaningful activity to encourage stimulation and prevent boredom. The

dementia wing lacked objects of interest or décor that could provide a more stimulating environment to prevent boredom and restlessness. The provider had recognised improvements were required to offer people more stimulus and social interaction and had employed an activities co-ordinator.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. People's views regarding their care and treatment were identified and included in assessments.

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

Rating at the last inspection
This service was registered with us on 16 January 2020 and this is the first time the home had been inspected.

Why we inspected
This was a planned inspection because the service was unrated. 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.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well-Led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches in relation to regulation 12 (Safe Care and Treatment) and regulation 17 (Good Governance) at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow Up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information 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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Platinum Nursing Care

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 Care Act 2014.

Inspection team
The inspection team consisted of three inspectors, a Specialist Advisor 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.

Service and service type
Platinum Nursing Care Limited is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since it was registered and sought feedback from commissioners. We used all this information to plan for our inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with five people who used the service and six relatives about their experience of the care provided. We spoke with 14 members of staff including the provider, registered manager, deputy manager,

maintenance person, housekeeper, six care workers, one senior care worker, one nurse and the nurse in charge. We carried out observations of people's experience of receiving care and reviewed a range of records. This included five people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

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

This was the first inspection for this newly registered service. This key question has been rated Requires Improvement. 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; Using medicines safely; Learning lessons when things go wrong

- Some risks to people's health had been identified and plans implemented to manage those risks. However, there were insufficient records to support the management of risks related to skin damage.
- The provider was not aware of all recorded pressure injuries or wounds to people's skin. We found that 11 people were recorded as having wounds and four people with pressure injuries. This meant timely action was not always taken to investigate the cause or implement measures to minimise the risk of them happening again. We raised this with the provider who took action to investigate following the inspection.
- Where people had injuries or damage to their skin there was no measurement of the wound to assess how well it responded to treatment.
- Some people needed to be repositioned regularly because they were at high risk of developing pressure sores. Records did not always evidence when repositioning was being done in accordance with people's care plans.
- Information regarding safe catheter care was not routinely included in people's care plans and did not follow NICE guidelines on how to clean and monitor a catheter for signs of complication. The daily care records did not evidence that recommended monitoring and cleaning took place. This put people at risk of infection.
- One person had a specialist feeding device to support them with their nutrition. However, their care plan lacked detail regarding the safe monitoring and management of this device or how to spot signs of complications.
- Each person had a personal emergency evacuation plan detailing the support they would require if the building needed to be evacuated. However, these were not readily available to hand and the fire 'grab bag' did not contain a register of all the people who lived at the home to enable a safe and effective evacuation in an emergency. There were gaps of around two inches under some fire doors which meant they would not seal correctly to minimise the risks of smoke inhalation. We raised this with the provider who took immediate action to ensure that fire doors complied with fire regulations.
- Processes to ensure the safe storage and administration medication were not always followed.
- Medication was stored in three separate areas but the temperature was only monitored in one of those areas. Temperatures should be monitored to ensure medication is not exposed to temperatures outside of the manufacturer's recommended range, as this can compromise how well the medication works.
- Thickener and sharps were not stored safely in line with guidance. This put people at risk of injury if they accessed the equipment inappropriately.
- Some people were prescribed patch medications as a pain relief but medication records did not provide

details of how often the patch should be rotated to ensure it was administered safely, or daily checks that it was still in place. This is important because patch medications placed in the same area can cause the skin to become thin and increase the rate of absorption. Patch medications are prone to falling off or being removed accidentally, so daily checks to ensure they remain in place reduce the risk of a person experiencing unnecessary pain and skin irritation.
● Staff were not consistently following the provider's policies and procedures for recording incidents and accidents and there was no system to regularly analyse falls or other incidents in the home to mitigate the risk of them happening again.
● We found that one person at high risk of falls experienced four falls in May 2021 but their falls risk assessment had not been reviewed following these falls. This person was recommended to be referred to the falls team but records did not evidence this referral had been made.
● Another person at very high risk of falls had experienced eight falls since March 2021 but had no falls care plan to demonstrate actions taken to minimise the risk of falls.

Systems were not robust enough to demonstrate safety was effectively managed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff spoken with could tell us how they monitored people with certain health conditions such as diabetes. One care plan viewed for a person with diabetes contained detailed information about how to treat this person if they experienced a hyperglycaemic or hypoglycaemic attack.
● Some people were prescribed time critical medication to manage the symptoms of Parkinson's disease. Records showed that these people had individual medication regimes recorded and received their medications within the therapeutic time period.
● Staff could explain to us how they managed the risk of damage to people's skin or people with pressure injuries. One staff member spoken with said, "we're good at monitoring and healing pressure areas. We keep [people] off their bottoms and rotate gently. Some [people] with delicate skin, (need to be careful) especially removing clothes. Any dressings are dealt with by the nurse and will be recorded and monitored."

Staffing and recruitment
● There were enough staff on the day of our visit to provide safe care. However, we identified several occasions through the day when people in a communal lounge were left unattended because staff were supporting people elsewhere. Some of these people were assessed as being at high risk of falls.
● Staff gave mixed feedback about staffing levels. Some staff told us staffing levels had improved over recent months which meant they were able to spend time with people. However, others told us care was 'task based' because of pressures on their time. One staff member told us, "You have to be quick and then move on to the next person."
● Staff were recruited safely. The provider had completed checks to ensure staff working at the service were of suitable character.

Systems and processes to safeguard people from the risk of abuse
● Staff told us they would not hesitate to escalate their concerns externally if they felt appropriate action had not been taken by managers to safeguard people from harm. The provider had ensured the contact numbers for the local safeguarding team were readily available to staff.
● Staff told us they would report any poor practice by other staff such as poor moving and handling techniques.

Preventing and controlling infection

● We were assured the provider was preventing visitors from catching and spreading infections.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.
● We were assured the provider was meeting shielding and social distancing rules.
● We were assured the provider was admitting people safely to the service.
● We were assured the provider was accessing testing for people using the service and staff.
● We were assured the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured the provider's infection prevention and control policy was up to date.
● We were somewhat assured that the provider was using PPE effectively and safely. This is because some staff members did not wear their masks according to guidelines. We have signposted the provider to develop their approach.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet

- There were gaps in some food and fluid charts which meant it was not clear whether food and fluid had been offered. Care plans did not demonstrate how nutritional and fluid intake was being encouraged based on oversight and analysis of people's intake and preferences. For example, one person would often eat very little of their main and all of their pudding but their care plan did not demonstrate how this was used to maximise how much they ate.
- We found improvements could be made to make lunch time a positive experience that encouraged people to socialise and eat more. Most people chose to eat in their bedrooms and some people who were in communal areas were either alone or did not have any staff presence for 25 minutes. This meant some people ate nothing at all and others were not always encouraged or offered alternatives.
- On one unit, lunch was served in the sitting area. Two people sat at a dining table which was positioned under the television screen which was on throughout the meal. Four people remained in their lounge chairs, two of them balancing plates on their laps. Tables had not been laid to encourage those people to move from their chairs which would also have had the added benefit of providing pressure relief and supporting mobility.
- One person had cleared their plate. Staff did not offer the person anything else to eat before asking to take their plate away.
- On another unit, one person was served their lunch in their lounge chair. There was nobody else in the room and there was no staff presence for 25 minutes. The person did not eat any of their meal. When a staff member offered the person assistance, the meal was cold, and the person spat out their mouthful of food. The person did not eat any of the meal, but checks later confirmed they had been given an extra serving of pudding.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Assessments were carried out to identify people's needs, choices and wishes regarding their care.
- The registered manager recognised the importance of gathering information about people's past histories and encouraged relatives to contribute information.

Staff support: induction, training, skills and experience

- Mandatory training was provided and staff were encouraged to undertake qualifications in health and social care. However, the training records showed some staff were either yet to complete some of the mandatory training expected or that it was out of date and needed to be refreshed to ensure staff worked consistently with best practice.

● One staff member told us, "I have done all my on-line training, I did that before I started. I have not long done manual handling training and we are doing fire training at the minute. There are always the on-line courses we can do."
● New staff received an induction which included working alongside experienced staff for a number of days. As staff progressed into their role, they had opportunities to obtain nationally recognised vocational qualifications.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Records showed that referrals were made to external health professionals including the G.P, Speech and Language Therapist and Dieticians to ensure people had access to the support they needed.
● However, we found that some people recommended for referrals to the continence service to trial them without indwelling catheters were not referred until a month after this recommendation. Indwelling catheters increase the risk of developing a urinary tract infection, so the delay posed unnecessary risk to this person.
● People's oral healthcare needs were assessed and included within care planning.
● Staff spoken with told us that key information about people was shared during staff handovers.

Adapting service, design, decoration to meet people's needs
● Some areas of the home had been redecorated to make it a cleaner and fresher environment for people.
● The provider had developed a sensory garden but acknowledged the garden was not used very often. The provider needed to consider ways of encouraging people to use the facility to increase their access to fresh air and exercise.
● The provider had made changes to the environment to provide some cues and clues to assist people living with dementia to orientate to their surroundings. However, many people spent a large amount of time in their bedrooms and communal lounges and dining rooms were rarely used. Action was needed to identify why this was, so every effort could be made to provide a dementia friendly environment that was stimulating and comforting to people and their relatives.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act 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 particular 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 MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● There was CCTV in communal areas of the home. There were no records of seeking people's consent for the use of CCTV and if they were unable to provide consent, there was no evidence a decision had been made in people's best interests within the provisions of the MCA. We raised this with the provider who implemented consent forms after our inspection and told us that in future CCTV would only be used to review incidents in the home when needed.
● Where people were unable to make decisions for themselves, mental capacity assessments had been completed. However, the assessments did not consistently demonstrate how people had been supported to understand information relating to the decision.

● Care plans recorded information about powers of attorney, relatives and appropriate others who could support staff in making best interest decisions on behalf of people.

● Staff worked within the principles of the MCA. They sought people's consent before providing personal care and assistance.

●Staff told us they would respect people's right to decline assistance with personal care but would work with other staff to ensure people received the care they needed to keep them well. One staff member told us, "We document it (when people decline personal care) and keep trying through the day and ask other staff to ask them."

● DoLS applications had been made to the Local Authority where it had been identified people were being deprived of their liberty.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care
● Improvements were needed to ensure that important people in service user's lives were made to feel welcome and their contributions valued.
● We received mixed feedback from relatives about their involvement in assessment and care planning. One person told us, "I requested that I could be a part of the doctor's consultation. I felt that I was excluded but I have let it go. They have nursed [person] back to health. I'm happy about this now." Another person told us, "I am not involved in the care plan."
● Assessments showed that people's views and wishes had been gathered regarding decisions about their care.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence
● Staff told us that staffing levels impacted on the time they could spend in meaningful activities or conversation with people. However, staff recognised the value and importance of spending time in conversation with people, talking about their past lives and interests. One staff member said, "It is nice finding out what they used to do. It gets them talking and gets their minds going and it is nice to relive what they have done. If you have an interest similar to what they used to like to do, you can sit for hours talking to them.
● Interactions between staff and people was warm and respectful and people were observed to respond positively to staff interactions. One person spoken with told us, "The staff are wonderful. They know what I like to eat and drink and they bring it automatically." One relative spoken with said, "The staff do like [person]. They come into her room to chat with her. They encourage her to go into the garden. [Person's] also been doing crochet. One of the nurses is having a baby and [person] crocheted a hat for the baby."
● We observed some caring interactions. One person was showing signs of discomfort. A member of staff went over to the person, gently spoke with them and identified the person was suffering pain in their knees. The staff member arranged for the nurse to assess the person.
● Another person spilt some food down the front of their cardigan. The staff member immediately helped the person and cleaned their clothing, promoting the person's dignity.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; Support to follow interests and to take part in activities that are socially and culturally relevant to them

• The service had 'getting to know you' information about people in care plans which contained information about their past lives, hobbies and interests.

• However, improvements were required in understanding and responding to people's interests and need for occupation and engagement on the individual units. We saw few people were engaged in activities that might interest them or give them something to look forward to.

● A new activities coordinator had recently been appointed by the provider. The registered manager told us they wanted to plan activities more around people's own particular interests and hobbies to increase engagement and interaction but acknowledged this was work that needed to be completed.

● NICE and the Kings Fund recommend how dementia friendly environments can help promote independence and social interaction and reduce agitation and distress. However, we found limited examples to demonstrate how the principles of dementia friendly care had been applied. On the unit for people living with dementia, there was little of interest in the décor, such as pictures, photos or tactile objects people could touch and hold to stimulate their minds. There was a lack of materials, such as interactive artefacts relevant to people to capture their interest and enthusiasms, which meant they were mostly reliant on staff for intellectual stimulation.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carer's.

● Care plans contained information about people's preferred methods of communication and described how staff should engage with people to ensure they provided responsive care. This included any equipment people required to support their understanding such as hearing aids or glasses.

● However, improvements were needed to bring key information into the main area of the home to make it more accessible for people living there. For example, there had been no consideration of how to make activities on offer visible which could act as a prompt to encourage more people to engage.

Improving care quality in response to complaints or concerns

● The registered manager told us they had only received one written complaint in the last 12 months. This complaint was being investigated at the time of our inspection visit.

● However, we were made aware of some verbal concerns raised by relatives to staff and the registered

manager which had not been recorded or addressed to the relative's satisfaction. We raised this with the provider following the inspection and they recognised the need to implement a more formal and structured approach to handling and recording actions taken in response to verbal concerns.

End of life care and support

• Where people needed end of life support, the provider had procedures in place to meet people's health needs and their wishes.

• People's choices for their end of life were recorded in their care plan, when they wished to share this with the provider.

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.

This is the first inspection for this newly registered service. This key question has been rated 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Governance and oversight systems to ensure the provider was mitigating risks to people in relation to their care were insufficient. Management audits and checks had not identified service shortfalls and some auditing systems of risks were not in place.
- Some tasks and responsibilities related to clinical care and oversight were delegated to the deputy manager. However, we found that communication between the management and staff team needed improving.
- Systems to ensure oversight of clinical care were not sufficiently developed to enable the registered manager to have insight and understanding of events within the home. We identified, through the provider's electronic recording system, four people with pressure injuries and 11 people with wounds that the registered manager was not aware of. Lack of oversight meant that gaps in repositioning charts for people who needed to be turned, to remove pressure from their skin, had not been identified.
- Quality assurance systems of care records failed. Some care plans relating to catheters and specialist feeding tubes did not contain recommended information on monitoring and cleaning, and care records did not evidence these checks took place. There were gaps in some food and fluid charts which meant there was no assurance that person had been offered food or drink on those occasions.
- Accidents and incidents in the home were not being analysed or audited for trends and patterns to identify ways of reducing risks to people. The registered manager informed us that they did not experience many falls at the service, however, we identified a number of falls had been recorded which the registered manager and provider were not aware of.
- Policies and procedures had not always been effectively communicated. For example, the registered manager told us staff supervision meetings were held once a month but the deputy manager, who was responsible for staff supervisions, told us they took place once every three months. Some staff said they had not received a supervision or could not remember the last time they had a supervision meeting with their manager. A staff member told us, "I have had one (supervision) but I am not sure how often we are supposed to do them, if we do have a problem we just go and see the nurse."
- Staff spoke positively about the management team but one stated they would like them to be more visible. They told us, "They are alright, if you have got a problem you can always go and see them, and they will help you out if needed. It would be nice to see more of them during the day, they just have a wander around."

Engaging and involving people using the service, the public and staff, fully considering their equality

characteristics; Continuous learning and improving care

● Although relatives were encouraged to give feedback on care using online platforms, there was no system in place to regularly gather and review feedback from people, relatives, staff and professionals in to order assess the quality and safety of care and plan for improvements.

● Some relatives told us that communication needed to be improved. One relative said, "I would prefer it if they kept me informed but they just don't. The communication just isn't there so I have to hear from [person]. I do feel listened to, but the home can be long winded trying to sort problems out."

We found systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Relatives could have full online access to the care plans and daily records so they could see the care provided throughout the day.

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

● The registered manager understood their responsibility to notify us about important events that affected people living at Platinum Nursing care.

Working in partnership with others

● The provider worked with other health professionals in response to changes in people's needs.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not taken all practicable steps to assess, monitor and mitigate risks to service users. Falls risk assessments were not consistently reviewed following falls and systems to regularly review accidents and incidents was not robust. Records relating to clinical care did not support effective clinical oversight or management of those risks. Medication was not consistently stored or monitored safely.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes to assess, monitor and improve the quality of service and assess, monitor and mitigate risks relating to the health safety and welfare of service users were not established or operating effectively. There was no formal system to seek and act on feedback to drive improvements. Accidents and incidents were not routinely analysed for trends or patterns to identify actions that could minimise the risk of them happening again. Systems to monitor clinical care and oversight of those risks and ensure an accurate record in respect of each service user including the care and treatment provided failed to identify gaps in care records identified on the inspection

The enforcement action we took:

warning notice