

Czajka Properties Limited Brookfield Care Home

Inspection report

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Ratings

Overall rating for this service

Requires improvement



Is the service safe?

Inadequate



Is the service effective?

Good



Is the service caring?

Good



Is the service responsive?

Good



Is the service well-led?

Requires improvement



Overall summary

We inspected Brookfield Care Home on 10 & 20 November 2015 and the visit was unannounced.

Our last inspection took place on 2 July 2013 and, at that time, we found the regulations we looked at were being met.

Brookfield Care Home is located in Nabwood, Shipley on the outskirts of Bradford and is registered to personal care for up to 40 people. However, as the two double

bedrooms were being used as single bedrooms this had reduced the number to 38. At the time of our visit there were 37 people using the service. Nursing care is not provided.

Brookfield Care Home is an extended building and the accommodation is arranged over two floors. All of the bedrooms have either an en-suite toilet and shower or en-suite bath and toilet. There are communal sitting areas on both floors and a passenger lift is available. Outside there is car parking to the side and gardens.

Summary of findings

There is a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Recruitment processes were robust and thorough checks were always completed before staff started work to make sure they were safe and suitable to work in the care sector. Staff told us they felt supported by the registered manager and that training was on offer. People told us they liked the staff and found them kind and caring. On the day of our visit we saw people looked well cared for. We saw staff speaking calmly and respectfully to people who used the service.

There were not always enough staff on duty to meet people's needs. The registered manager had identified they needed an additional care worker on duty during the day as there were 18 people using the service who required two staff to assist them with their moving and handling needs. The provider agreed to increase the staffing levels in the evening but not during the morning.

We found nurse call bells could be sounding for up to 12 minutes before staff attended to assist people. This delay meant people's needs were not being met in a timely way.

We found the lack of response by the provider to some issues was leaving people using the service at risk. We

found the hot water to some bedrooms and en-suite bathrooms was excessively hot and could have caused a burn or scald. We saw this had been reported but no action had been taken to resolve the problem. We found the loft was being used to store combustible materials, we asked the fire officer to visit because we were concerned about this.

People told us they felt safe at Brookfield Care Home. We saw there were policies and procedures in place to safeguard adults at risk.

We found people had access to healthcare services and these were accessed in a timely way to make sure people's health care needs were met. The medication system was well managed and people received their medicines at the right times.

We found the service was meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS).

People told us meals at the home were good offering choice and variety.

We found there were quality assurance systems in place, however, these were not always up to date and were not effective in ensuring the provider addressed the issues identified in a timely way. Some of people's personal care and treatment records were not up to date.

We found three breaches of regulations and you can see what action we told the provider to take at the back of the full version of the 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?

The service was not safe. There were not enough staff on duty to provide care and support in a timely way.

Actions were not taken to mitigate risks identified by the provider. For example, when issues with high hot water temperatures, nurse call bells and fire precautions had been identified, action had not been taken to rectify the problems in a timely way.

Medicines were managed safely which meant people received their medicines when they needed them. However, care records did not always demonstrate how staff were meeting people's specific nutrition and hydration needs.

Inadequate



Is the service effective?

The service was effective. We saw from the records staff had a programme of training and were trained to care and support people who used the service.

The service was meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS).

The menus we saw offered variety and choice and provided a well-balanced diet for people who used the service.

Records showed people had regular access to healthcare professionals, such as GPs, opticians, district nurses and podiatrists.

Good



Is the service caring?

The service was caring.

People using the services told us they liked the staff and found them patient and kind. We saw staff treating people in a dignified and compassionate way.

People's privacy and dignity was respected and maintained.

Good



Is the service responsive?

The service was responsive.

People's health, care and support needs were assessed and individual care plans were in place to ensure people received the care and support they needed.

There were activities and outings on offer to keep people occupied.

People told us they would tell the manager or deputy manager if they had a complaint.

Good



Is the service well-led?

The service was not always well-led.

Requires improvement



Summary of findings

There was a registered manager who provided leadership and direction to the staff team.

Quality assurance systems were in place but checks were not always up to date. In some instances when areas had been identified as needed improvement, action had not been taken. Some of the records of people's care and treatment were not up to date.

Brookfield Care Home

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 10 and 20 November 2015 and was unannounced.

The inspection team consisted of two inspectors and an expert by experience in care of older people and people living with dementia. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We spent time observing care in the lounges and dining rooms and used the Short Observational Framework for

Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not express their views to us. We looked around some areas of the building including bedrooms, en-suite bathrooms and communal areas. We also spent time looking at records, which included five people's care records, four staff recruitment records and records relating to the management of the service.

On the days of our inspection we spoke with seventeen people who lived at Brookfield Care Home, five visitors, seven care workers, the deputy manager, the chef, the registered manager, a senior manager, the proprietor and two district nurses.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed all information we held about the provider.

Is the service safe?

Our findings

People using the service told us there were not always enough staff on duty to meet their needs in a timely way. Relatives also confirmed this was the case for example, one relative said, “There aren’t enough staff the ‘buzzers’ are always busy.”

On the first day of our visit we talked to the registered manager about staffing levels in the home. They told us in the mornings there was one senior care worker in charge, a senior carer and five care assistants on duty and in the evenings there was one senior carer in charge, a senior carer and three care assistants. At night there was one senior carer and two care assistants. We looked at the dependency levels of the people living at Brookfield and found 18 people all needed the assistance from two carers to meet their moving and handling needs and seven people required assistance with their meals.

We saw staff were constantly busy in the morning attending to people’s needs and the nurse call bells were sounding throughout the morning. We asked to see the printouts from the nurse call system for the day of our visit and the two days prior. These showed us it could take staff up to 12 minutes to respond to the call bell. This meant people received delays which could impact on their safety. The registered manager and the other senior manager agreed this was not acceptable.

The registered manager told us they did not think the current staffing levels were suitable to meet people’s needs. They told us a meeting with the provider had been arranged for 13 November 2015 to discuss this.

On the second day of our visit we saw the minutes of that meeting and saw the provider had agreed to increase the staffing levels on a late shift by one care staff, but had not increased the number of staff on the morning shift. We spoke to the provider about this and they were clear they did not think the staffing levels needed to be increased. This clearly went against the registered manager’s assessment of the numbers of staff which were needed.

On the second day of our visit we saw one person had a falls mat in place because they were at high risk of falling. This is a special mat which is connected to the nurse call bell to alert staff when the person was moving. We saw they had got up from their chair and walked to their en-suite bathroom. We saw they were very unsteady and one of the

inspectors intervened to stop them from falling, before staff arrived. For the falls mats to be effective staff need to be able to respond very quickly when the buzzer sounds. If this does not happen the measures put in place to reduce the risk of falls would not be effective.

This breached Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We looked in one person’s en-suite bathroom and found the hot water temperature to the bath and wash hand basin was 62 degrees Centigrade. We asked the handyperson about this and they told us there were other rooms which had excessively high water temperatures. We asked for the water to be turned off to the bath as the hot water posed a risk to people. When we asked for a water thermometer the registered manager and other staff told us there was one in each bathroom, however, one could not be produced. When we looked at the handyperson’s test records for the hot water we saw since August 2015 they had identified there were ten hot water outlets which required new thermostatic mixing valves in order to ensure hot water was delivered at a safe temperature. This work had not been done which meant hot water in some rooms was excessively hot and posed a risk of scalding. This meant the risk had been identified but not mitigated.

We saw from the maintenance book that the loft was being used for storage. The registered manager and handy person confirmed this was the case. We were concerned about this and following the inspection contacted West Yorkshire Fire and Rescue Service to ask them to visit as experts in fire safety. The fire officer visited on 19 November 2015 and told the provider the loft needed to be cleared of all storage. We saw the handyperson had started to do this on the second day of our visit. This meant the loft had been used inappropriately for storage and increased the fire load in this area. This also further demonstrated where a risk had been previously been identified with the provider, they had not acted to mitigate the risk. Since our visit the provider informed us, following discussion with the fire officer, a decision had been made that the loft could be used for limited storage so the amount of storage had been reduced accordingly.

The minutes of residents meeting showed us there had been problems with the nurse bell system since January 2015. When we looked at the complaints book we saw a complaint had been made in March 2015 about the nurse call bell system not working properly. One person had used

Is the service safe?

it but the call was not showing outside of their bedroom. On 14 October 2015 we received a notification that one person had sustained a fracture as they had pressed their nurse call bell, when no one had responded they had tried to transfer themselves and had fallen. The registered managers' investigation showed the buzzer had indicated a person in a different room required assistance. Additional checks were put in place until the system was replaced on 26 October 2015. We asked the provider about the longstanding problems with the nurse call bell system. They told us, prior to the new system being installed, they kept getting the electrician who fitted the previous system back in to make repairs, but the faults kept reoccurring. We consider the provider did not resolve the problems with the nurse call bells in a timely manner to keep people safe. We consider the incident on the 14 October 2015 could possibly have been avoided if the problems with the nurse call bell system had been properly resolved when issues were first identified in January 2015. This showed us another example of risks not being properly mitigated once they had been identified.

On the first day of our inspection we found people who required falls mats in place to alert staff when they were moving. No falls mats were available as the ones which had previously been in place were not compatible with the new nurse call system. We saw one person, who had been assessed as requiring a falls mat, had fallen three times since the new system had been installed. This meant measures were not being put in place to manage risks in a timely way.

We looked at the service certificates for hoists and found these were up to date. We saw the electrical installation certificate had expired on 4 March 2015. We spoke to the registered manager who told us the electrician was in the process of completing this check.

We saw nutritional risk assessments were completed on admission and people's weight was monitored. The staff we spoke with told us they monitored individual people's food and fluid intake if they had concerns and involved other healthcare professionals if appropriate.

However, we looked at the weight record for one person and found they had lost 5kg in weight between June and October 2015. The person was not on a food and fluid balance chart, was not taking a diet supplement and there was no documentary evidence to show they had been seen

by their GP or a dietician about their weight loss. We also found that at times people's weights were being recorded in three different places with the care documentation which increased the chance of mistakes being made.

In addition, we were told twelve people were on food and fluid charts because staff were concerned about their intake. However, we found the food and fluid charts we looked at were not always completed correctly and therefore it was difficult to establish if people received sufficient to eat and drink. For example, the fluid chart for one person showed they had only drunk 190mls of fluid between 7am on the 2 November 2015 and 6am on the 3 November 2015. The fluid chart for the same person showed that on the 4 November 2015 they had only drunk 125mls of fluid between 8am and 8pm after which no further entries had been made.

We found the food intake chart for another person showed that on the 2 November 2015 they had nothing to eat after their lunchtime meal and had only drunk 590mls of fluid between 7am and 6am the next day.

For a third person we saw staff had totalled their fluid intake over the previous four days which was between 300ml – 450ml each day and very little diet had been recorded. The Royal College of Nursing hydration best practice toolkit recommends, as a conservative estimate for older adults, the daily intake of fluids should not be less than 1.6 litres per day.

This was discussed with the registered manager who told us that people did receive sufficient to eat and drink but acknowledged staff had failed to complete the charts to evidence this. The lack of documentation around people's nutrition and hydration meant there was no assurance staff were mitigating risks to those individuals.

This breached Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We saw there was a recruitment and selection policy in place which showed all applicants were required to complete a job application form and attend a formal interview as part of the recruitment process. The registered manager told us during recruitment they obtained two references and carried out Disclosure and Barring Service (DBS) checks for all staff before they commenced work. These checks identified whether staff had any convictions or cautions which may have prevented them from working in the care sector.

Is the service safe?

We looked at four staff employment files and found all the appropriate checks had been made prior to employment. However, we found in one instance the application form was poorly completed and there were significant gaps in person's employment history which had not been explored at the time of their interview. This was discussed with the registered manager who confirmed that in future they would ensure recruitment procedure was more robust.

The staff we spoke with told us the recruitment process was thorough and done fairly. They said they were not allowed to work until all relevant checks on their suitability to work with vulnerable adults had been made. They also said they felt well supported by the registered manager and senior management team and enjoyed working at Brookfield.

We saw there was a disciplinary procedure in place. One person who used the service told us a member of staff had been abrupt with them and told them not to use their emergency call bell. We asked the registered manager about this. They told us arrangements had been made for the individual member of staff to be supervised on shift to check their care practice. This meant the registered manager was using the procedures to challenge any poor practice.

People who used the service told us they felt safe at Brookfield Care Home. We saw the service had policies and procedures in place to safeguard adults at risk. However, while the training matrix showed staff had received appropriate training the four staff we spoke with

at the handover between the morning and afternoon shift had a poor understanding of what might constitute abuse or who they could contact if they were concerned people were being abused. This was discussed with the registered manager who told us they were confident staff were aware of the procedures to follow but had been reluctant to engage with the Inspector during the group discussion. They assured us they would follow this up in individual supervision sessions to check staff members' understanding. We found other staff members we spoke with had a good understanding of how to keep people in their care safe and how to report any safeguarding concerns.

During our visit we looked at the systems that were in place for the receipt, storage and administration of medicines. We saw a monitored dosage system was used for the majority of medicines with others supplied in boxes or bottles. We found medicines were stored safely and only administered by staff who had been appropriately trained. Medication administration records were up to date with no gaps in recording, we noted medicines were recorded when received and when administered or refused. This gave a clear audit trail for us to see. We checked a random sample of stock balances for medicines and these corresponded with the records maintained. We observed people were given their medicines in an efficient yet caring way and those who required more encouragement and support received it. This demonstrated people were receiving their medicines in line with their doctors' instructions.

Is the service effective?

Our findings

The registered manager told us that all new staff completed induction training on employment and staff who had not previously worked in the caring profession completed the care certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life.

The registered manager also told us new staff always shadowed a more experienced member of staff until they felt confident and competent to carry out their roles effectively and unsupervised.

The registered manager confirmed that following induction training all staff completed a programme of mandatory training which covered topics such as moving and handling, infection control, food hygiene, health and safety and safe guarding.

We saw the organisation employed a training manager who worked closely with a designated training officer based in the home to ensure staff received the training and support they required to carry out their roles effectively.

We looked at the training matrix and saw mandatory training had been completed by staff within the recommended time frames for each training course. We saw training was provided in a number of different ways including distant learning, E-learning and staff attending courses at the organisations training unit, which was based in the local area. We saw training courses on pressure ulcer prevention and palliative care were planned for December 2015.

The registered manager told us individual staff training and personal development needs were identified during their formal one to one supervision meetings with their line manager and their annual appraisal. We saw the internal quality assurance tool had identified improvements needed to be made in relation to staff development and had given timescales for these to be completed of between six weeks and three months. For example, one of these improvements involved the training department developing a training plan for all levels of staff.

The staff we spoke with told us that they received the training and support they required to meet people's needs and for their own personal development.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We spoke with the registered manager and found there was no one using the service who required DoLS.

We saw staff gained consent from people before any care tasks were undertaken. For example, before people were assisted to move and before assisting people with food and drinks. This showed staff were making sure people were in agreement before any care was delivered.

In the main people were positive about the quality of the food and told us they got plenty to eat and drink throughout the day. People said they were offered a choice of menu and were offered alternatives. One person said, "The food is brilliant, you can have what you like." Another person told us, "I can't eat some foods, the chef is very accommodating and comes every day to see what I want to eat." A third person said, "The food is fine" and a fourth person said, "The food is alright, not as good as it was, smaller portions, but always cooked nice." A relative told us they thought the food was, "Excellent."

We observed the lunchtime meal and saw people were offered choices and the atmosphere was informal and relaxed. We saw if people required staff to assist or prompt them to eat their meal this was done discreetly and even though staff were very busy they were patient and did not rush them or leave them until they had finished their meal.

We spoke with the chef and it was apparent that they were aware of people's dietary needs and individual preferences. We saw menus were displayed and people were offered at least two choices at main mealtimes.

In addition, we saw people were offered an alternative if they did not like what was on the main menu.

Is the service effective?

One person who used the service told us, “If I’m not well they don’t mess about they get me to the hospital.” A visitor said their relatives’s ankle had swelled and a doctor had been called straight away. On another occasion she had been ill and had been taken to hospital accompanied by one of the carers.

In the five care plans we looked at we saw people had been seen by a range of health care professionals, including, GPs, district nurses, opticians, and podiatrists. We spoke with

two of the district nurses who told us care staff made appropriate referrals and followed any instructions they were given. We saw short term care plans were developed to inform staff of any changes to people’s support needs. For example, if someone developed a urinary tract infection a plan was developed to inform staff about the treatment. This helped ensure people’s health care needs were being met.

Is the service caring?

Our findings

People were positive about the staff who they said were kind, caring and gentle. One person said, "I'm quite happy here, warm, staff look after me pretty good. If you want anything they do it for you." Another person told us, "I like it very much, took me a while to settle down, staff are kind and polite." A third person said, "Staff are gentle and kind and very helpful." A fourth person told us, "I'm comfortable, there's nothing they could do better." A fifth person said, "I decided to live here because it had a good reputation in the local community and I have not been disappointed. The staff are lovely and the food is excellent."

A visitor told us their relative could be rude to the staff and very demanding. They said they thought the home provided, "A good standard of care, staff are pushed but do the best they can and handle difficult situations with humour." Another relative said the home was "Excellent, no complaints whatsoever."

We saw there was information in people's bedroom about their lives and personal preferences. We found staff knew the people they were caring for well and knew about individuals likes and dislikes. Staff responded to people's requests and offered them choices. Staff knew what people

were able to do for themselves and supported them to remain independent. We saw staff addressed people by their preferred name and always asked for their consent when they offered support or help with personal care.

We saw staff were caring and patient in their approach and had a good rapport with people. Staff supported people in a calm and relaxed manner. They stopped to chat with people and listened, answered questions and showed interest in what they were saying.

We observed staff initiating conversations with people in a friendly, sociable manner. We saw people's personal information was treated confidentially and their personal records were stored securely.

Some people who had complex needs were unable to tell us about their experiences of the service. We spent time observing the interactions between the staff and the people they cared for. We saw staff approached people with respect and support was offered in a sensitive way. We saw staff were kind and caring. However, we noted staff did not always have time to spend with people unless they were attending to their direct care needs.

Visitors told us they were made to feel welcome and found the staff helpful.

Is the service responsive?

Our findings

We looked at the care documentation for three people who used the service and found the care plans in place provided sufficient information about people's care and treatment. The registered manager told us they were in the process of implementing a new improved care planning system.

We saw care plans were reviewed monthly or sooner if people's needs changed significantly and there was evidence that wherever possible people who used the service and/or their relatives were involved in reviewing their care plan.

Where specific needs had been identified care plans and risk assessments were in place and provided detailed information about how best to support the person including how to meet people's communication, mobility, personal care and dietary needs.

We saw the pre-admission assessment used by the service which showed family members had been involved in the assessment process. The assessment identified how the person liked to be addressed; identified their needs and what was important to them.

The care staff we spoke with told us the care plans provided them with clear information and guidance on how to meet people's needs. Throughout the time of our inspection we saw staff responded appropriately if people requested assistance or support. We saw people were involved in their care and staff always explained what they wanted to do and asked for people's consent before carrying out care or giving support.

We observed the handover between the morning and afternoon staff and found information about people's care and treatment was discussed in a professional manner and staff had a good understanding of people's needs

We spoke with the activities co-ordinator who told us they worked four afternoons a week plus one extra every month. They told there were a range of activities on offer such as games crafts and outings and said that music was probably the most popular.

On the first day of our visit we saw there was a craft session was taking place in the upstairs lounge. About six people attended and enjoyed the session. On the second day we saw a small group of people involved in an exercise class.

The home is part of a wider complex which included a nursing home and independent flats. There is also a club house which provides meals and entertainment and which some of the people we spoke with said they attended.

One person we spoke with told us they led a, "Lonely life" and would like the opportunity to mix with others and enjoy a chat. They said the downstairs lounge where most people sat only had five chairs and the people who were generally sat there were unwilling or unable to have a conversation.

People we spoke with told us they had not had reason to complain but would feel comfortable in raising any matters if needed either by talking to one of the carers, the registered manager or the deputy manager.

Is the service well-led?

Our findings

The registered manager told us that from September 2014 until recently they had managed another home owned by the same provider. They confirmed that during this period another senior manager employed by the provider and the deputy manager had managed the service. The registered manager and provider confirmed they had not informed CQC of this arrangement as was required.

We saw three 'residents meetings' had been held this year. We saw in January 2015 people using the service had raised concerns about the nurse call bell system malfunctioning and again at the meetings in April and July 2015. We saw the provider had been present at two of these meetings. We asked the provider why it had taken until October 2015 to make sure the nurse call bells were fully functional. The provider told us they kept getting the electrician back to repair the previous system but that the faults kept re-occurring.

We found the provider was not always responding appropriately when issues had been identified, For example, the malfunctioning nurse call bells, hot water temperatures, fire safety and staffing levels. The lack of appropriate response demonstrated that risks were not being appropriately mitigated and was leaving people at risk from unsafe premises and insufficient staff to care for them.

We found people's diet and fluid charts had not been fully completed. We saw from the staff meeting minutes this had been raised on 13 November 2015 by one of the senior managers. However, on the second day of our visit, 20 November 2015 we found these records were still incomplete. This demonstrated a lack of acting on feedback to address risks.

We found there were audits in place but not all of these were up to date. For example, we saw monthly checks of profiling beds and bedrails were required, however, these had last been checked in August 2015. Equally, the last monthly check of the specialist air flow mattresses had not been completed since September 2015.

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

The staff we spoke with told us that the registered manager operated an open door policy and were confident that any issues they raised would be dealt with promptly.

We found the registered manager was open and honest with the inspectors about where they recognised improvements were still required.

We saw an annual quality audit tool had been introduced which assessed the service against the CQC's key lines of enquiry. This had been completed in January 2015 and had highlighted areas where improvements needed to be made and timescales within which these improvements had to be made. For example, some issues with the management of medicines had been identified. We found these had been addressed as we found the management of medicines to be satisfactory.

We saw at the 'residents' meetings' people were asked about meals, activities, cleanliness and laundry. We saw people's requests were responded to for example, someone wanted strawberries more often. We spoke with this person who told us they now got strawberries everyday. This showed people's views about how the service was managed were being taken into account.

We saw 'residents' and relatives' surveys' had been sent out in May 2015 and we looked at some of the 26 forms which had been returned. We saw generally people were satisfied with the service. Some people had mentioned some things they would like to change; for example, having the tea time later than 4:30pm, chefs to try Afro-Caribbean food and people who stay in their bedrooms to have more companionship. One person felt the information available about how to make a complaint was poor and four people only found the information satisfactory. We asked the registered manager if a report detailing the findings had been produced and what response had been made to individual suggestions. We found no report of the findings had been made. This meant people had not been given any formal feedback on the outcomes of the survey

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed. Regulation 18 (1) (a).
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Service users were not provided with care and treatment in a safe way as action to mitigate identified risks had not been taken. There were areas of the premises which were unsafe. Regulation 12 (2) (a) (b) (d)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not operated effectively to assess, monitor and improve the quality of the services provided or to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Accurate, complete and contemporaneous records were not maintained in respect of each service user, including a record of the care and treatment provided to the service user. Regulation 17 (1) (2) (a) (b) (c)