Fieldside Care Limited

Fieldside Care Limited t/a Fieldside Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out this unannounced inspection on 22 May 2018. At our last inspection in March 2017 we rated this service 'good'. At this inspection we have rated this service 'requires improvement'.

Fieldside Care Home provides care and support for up to 34 older people and people living with dementia. The building includes a large lounge and dining area, garden with laundry facilities and a quiet lounge on the ground floor. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had 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.

We carried out this inspection, in part, as there had been a high number of falls in the service. The provider was working with the local authority to improve falls management measures, but falls prevention plans lacked detail on what actions staff should take to protect people from falls. Safer moving and handling measures were not always followed, and some staff lacked training in this area. There was an extensive training programme in place for care workers, including specialist training on dementia awareness. However, records of this were not well maintained, and sometimes care workers were overdue for essential training.

The provider worked closely with local services to deliver improvements and try out new ways of working. We found that care plans were not designed in a way people could follow and were not always clear about how to support people. The provider had recognised this and was working with the local health service to develop new plans. Plans sometimes lacked detail about people's life stories and needs and preferences, but people received support from a stable staff team who knew them well. People told us they were treated with dignity and respect and were listened to. We observed positive interactions from caring staff.

The building was kept clean and had a pleasant environment, but aspects of its design did not meet the needs of people living with dementia or limited mobility. We have made a recommendation about this. At times confidential information could be viewed by people using the service or visitors to the service. New laundry and office facilities were being developed. The provider protected people's rights by obtaining consent to care and assessing people's capacity to make decisions. People received good support to eat and drink well and maintain good health.

Staffing levels were sufficient to meet people's needs, and people told us they were satisfied with the number of staff available and the consistency of staff. We found most care workers had worked in the service for a long period of time and understood people's needs and wishes well. There was an activities

programme in place which was designed in a way to promote reminiscence and community involvement, but exercise programmes were not always effective.

Staff were working in line with safer recruitment measures. Staff understood how to safeguard people from abuse and their responsibilities to report this.

The provider worked with local health services to ensure people's medicines were reviewed regularly and managed safely. Managers carried out regular checks to ensure that medicines procedures were followed. The provider carried out regular checks to ensure that premises were safe. People were confident about making complaints, and when these were made these were addressed and outcomes recorded. Managers held staff meetings in order to address particular concerns and promote good communication and teamwork.

We found breaches of regulations relating to safe care and staff training. You can see what action we told the provider to take at the back of the full version of this report.

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 safe in all respects.

We found that sometimes there were not sufficient plans in place to prevent falls and ensure safe moving and handling, and some staff lacked up to date training in this area.

There were sufficient levels of staffing to meet people's needs and the provider followed safer recruitment measures.

Medicines were safely managed and stored, with regular checks to ensure this continued.

Is the service effective?

Requires Improvement

Aspects of the service were not effective.

Staff received training and supervision to carry out their roles, but sometimes records were incomplete in this area and some care workers were overdue for some training.

The environment did not always meet the needs of people with dementia and limited mobility.

People received good support to eat and drink and to stay well. People had consented to their care and people's capacity to make decisions had been assessed and reviewed.

Is the service caring?

Good

The service was caring.

We observed positive and respectful interactions with people.

People told us they felt listened to and treated with respect. People's communication needs were assessed and reviewed regularly.

Care plans lacked details on people's likes and dislikes, but there was a stable staff team who demonstrated a good understanding of this.

Is the service responsive?

Requires Improvement

Aspects of the service were not responsive.

People told us that care workers met their needs and supported their choices.

Care plans were reviewed monthly and noted changes to people's needs. However they were not always clear about what people's support needs were and were not laid out in a way people could easily understand.

There were systems in place to respond to complaints and people told us they felt confident reporting concerns to the provider.

Is the service well-led?

Requires Improvement

Aspects of the service were not well led.

The provider had identified shortfalls in areas such as care planning and falls prevention and was working well with the local authority in order to address these.

Some audits were effective, but in some areas did not detect issues with risk assessments and staff training.

People's views on the service were sought and there were systems in place to maintain good communication.

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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.

The inspection was prompted in part by information received about a high number of injuries sustained as a result of falls. This indicated potential concerns about the management of risk related to the management of falls. We had also received information of concern from relatives of people using the service, which we had shared with the local authority.

This inspection took place on 22 May 2018 and was unannounced. The inspection team consisted of two adult social care inspectors, a specialist professional advisor who was an occupational therapist 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. The inspection team was shadowed by a member of staff from the Care Quality Commission (CQC).

Prior to the inspection we reviewed information we held on the service, such as notifications of serious events that the service is required by law to tell us about. We contacted representatives of the local authority for their views on the service.

In carrying out this inspection we spoke with seven people who used the service and seven relatives of people using the service. We spoke with the home's owner, the registered manager, deputy manager, a senior care worker and three care workers. We spoke with four visiting professionals who were in the service at the time of the inspection. We looked at records of care and support for four people, records of medicines management for seven people and six risk assessments relating to falls or moving and handling. We also looked at three staff files and records relating to training, supervision and the management of the service.

Requires Improvement

Is the service safe?

Our findings

People were not always protected from injury as there were not suitable measures in place to ensure safer moving and handling and falls prevention.

The provider was working with the local authority and Clinical Commissioning Group (CCG) in order to develop risk management plans relating to falls. This included having a falls champion appointed in the staff team. However, risk management plans frequently did not assess the severity of the risks relating to falls and lacked clear action plans on how falls could be prevented. Similarly, although there was a process to follow in the days following a person falling, at times this form was used to record injuries only. The procedure required care workers to make and document the checks they carried out on the person which was not taking place, and staff did not always document what action had been taken to prevent a recurrence.

The registered manager told us "if someone falls we get them off the floor by lifting and never with a hoist." There were no clear guidelines in place for completing this task, although the provider's policy stated, "A risk assessment must be carried out on any moving and handling task where a risk is identified". People had care plans in place regarding their mobility needs, including the level of support they required to mobilise around the building, but these lacked details on how to safely lift people and support them to make transfers.

The provider's policy stated that, 'Where workers move people, workers must have initial training which has a theoretical and practical assessment, plus have an annual assessment.' We did not see any evidence of theoretical and practical assessments being carried out. We found that although the provider required annual training in safe moving and handling, seven care workers were overdue for this, including three staff who had last received this in 2014. We saw some examples of poor practice. In one case, we saw that a person was lifted from a chair in an unsafe manner by being held under the arms. We observed one person who required a hoist to make transfers had an unsuitable sling attached to their hoist. Some care workers told us they did not feel confident supporting people using hoists, and some complained they had developed bad backs.

This constituted a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were safeguarded from abuse. People we spoke with told us they felt safe using the service. Comments included "I feel safe here" and "They're very pleasant and they keep me safe." Care workers received training in safeguarding adults, and staff we spoke with demonstrated a good understanding of their responsibilities to report abuse. A care worker told us ""In terms of safeguarding, it is important that we protect people from any dangers but also prevent them from having any accidents. If I report concerns I feel listened to." The registered manager told us "I've always said report, report, report, there's a huge change and improvement in reporting." Records showed that when abuse had been suspected, this had been reported to the local authority and appropriate action taken to address this.

The provider acted to ensure the premises were safe. This included carrying out checks of firefighting equipment, fire detectors and call points, and carrying out regular fire drills where people's response was recorded so that any issues could be addressed. There were personal emergency evacuation plans in place, which recorded any factors that would affect a safe evacuation and the level of support people would require to evacuate. An inspection by the London Fire Brigade had shown no significant concerns. However, risk assessments for the premises had not been recently reviewed, and we could not be certain that diagrams of equipment were still correct, as some had not been reviewed since 2015.

People told us that staffing levels were suitable to meet their needs. Comments included "there are enough staff and I never feel rushed", "There are a lot of people about but I do occasionally feel rushed" and a relative told us "There are plenty and they are lovely, we feel very lucky that our [family member] is here." A rota system was mounted on the wall outside the staff office, which made it easy to see who was on duty at any time. Staffing levels were consistent and in line with what the provider told us, and there was usually a manager on duty, including at evenings and weekends. A staff member told us "I feel we have enough staff and in the morning we have four staff and a senior. There are times when we have six as well which helps".

Allocation sheets were produced daily by the deputy manager, for the morning and afternoon staff, highlighting responsibilities. These included which group of people they were responsible for supporting in the morning with personal care, helping with breakfast, supervising people in the lounge, providing fluids and snacks. They were also responsible for housekeeping duties, including checking commodes, stripping beds and checking toilets.

Safer recruitment measures were in place to ensure staff were suitable for their roles. This included obtaining proof of identification, references from previous employers and carrying out a check with the Disclosure and Barring Service (DBS). The DBS provides information on people's background, including convictions, to help employers make safer recruitment decisions. The provider had a recruitment checklist in place to ensure these steps were followed.

Medicines were safely managed in the service. The service was working with the CCG's medicines optimisation service to ensure good practice. A visiting professional told us "We have no concerns, they've got support and there's a good network in Lewisham." Comments from people included, "there have been no problems with my medicines" and "They have cut [my relative's] medicines down which is much better." Where people had medicines administered, there was a medicines care plan in place outlining people's needs. Care workers recorded the medicines people had taken on a medicines administration recording (MAR) chart. We reviewed charts for seven people, and found that these were correctly completed. A monthly audit was also carried out to ensure stock levels were correct and records were correctly completed. Medicines were safely stored in a locked cabinet. We noted that where medicines needed to be refrigerated this was taking place, and the temperature of the fridge was also checked. There was a thermometer in the medicines cabinet for checking the temperature of this, however we could not be certain this was taking place regularly as staff were not keeping records of this.

There were measures in place to learn from incidents. Where an incident had taken place, the provider recorded what the incident was, and what actions had taken place, although in some cases it was not always clear what had been done in response to the incident or to prevent repeat events. In response to a safeguarding incident which had taken place, the provider showed us additional training they had carried out for staff, and how they had revised their procedures with regards to managing pressure sores. The registered manager told us "Staff do report and it's more in depth".

Requires Improvement

Is the service effective?

Our findings

People using the service told us that they felt staff were effective. Comments included, "They are very knowledgeable" and "They know what they are doing". Staff were also positive about the training that they received. A staff member told us "I have had all the training and it is good. The trainers are fantastic and explain it clearly for us to understand." However, record keeping in relation to staff training was incomplete and sometimes staff did not keep up to date with training.

It was not clear from record keeping what was considered mandatory training for care workers, but an administrator explained that this included yearly training in first aid, safeguarding adults, fire safety, infection control, two-yearly training in medicines and three-yearly training in health and safety. This was in addition to the yearly requirement for moving and handling training. Although care workers sometimes received certificates for training, attendance at these was not always logged. The provider's training matrix had not been updated for over a year. This meant the provider's record could not be relied on to give an accurate overview of the level of training that was currently in place, which was acknowledged by the registered manager.

Seven care workers were overdue for moving and handling training, including three staff who had last received this in 2014. Some care workers had other gaps in their training. Two care workers had not received infection control training and one had not received infection control, health and safety and first aid training.

After the inspection the provider told us they would arrange for this training to take place as soon as possible.

There was a framework for induction of new care workers, which included spending a week shadowing and working with experienced staff and an explanation of procedures and the layout of the building. However, for two care workers who had started within the past three years this was not completed, and a review of their probation had not taken place to ensure that they were competent to carry out their roles.

This constituted a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was evidence the provider had worked closely with Lewisham NHS and staff had received training modules to support people living with dementia. This included some specialist training around nutrition and behaviour that challenged for people living with dementia. A care worker told us "The dementia training was very helpful and taught us how to cope with challenges that come along and how to handle them." There was information on key points from dementia training displayed in the staff office.

Other training received by care workers included dignity and respect, effective communication and an introduction to palliative care. Training had been booked in for the upcoming year which included medicines, mental capacity, autism awareness, safeguarding, palliative care and malnutrition. There was

also training for senior staff, including the owner on pre-assessments and care planning.

Care workers told us that supervision took place regularly but records of this were incomplete. Some staff records contained evidence of bimonthly supervisions. However, for one care worker, records were not available since November 2017, and for another worker there were no supervision records available at all. A staff member told us "We have it at least every few months and we talk about the residents, their preferences, things we don't understand. I feel well supported and that they explain everything to me clearly."

Aspects of the design of the building did not always meet the needs of people with dementia and limited mobility. We saw some good practice, for example there was a smaller lounge for people who preferred a quieter environment, and the building was attractive and clean throughout. However, some areas of the building were quite cluttered and difficult to navigate, such as between tables in the dining area. People's doors all looked the same, and there was a lack of dementia friendly design such as the use of colours, navigation aids or personal items to help people orientate themselves. At times the design of the building did not maintain confidentiality. For example, the kitchen had boards which contained information on people's dietary and health needs and some information about people's behaviour. These boards faced out towards a communal area where they could be seen by people using the service and visitors.

We recommend the provider take advice from a reputable source in maintaining a dementia friendly environment in a way which meets people's needs and preferences.

People were supported to eat and drink well. People had nutritional care plans and these were reviewed monthly, which included reviewing the person's weight and malnutrition risk. Where people were losing weight or at risk of malnutrition the provider had referred people to dietitians and had followed their recommendations.

People received good support at mealtimes. People using the service were able to eat independently. We saw that food was served promptly and people received large portions which they were able to finish. Care workers were attentive and encouraged people to eat and offered drinks. Where people were at risk of choking there were guidelines in place to mitigate this risk which we saw care workers followed.

There was a menu for the day displayed in the dining area. There was no choice of meals displayed, but we saw that care workers tailored people's meals to their needs, including offering rice or mashed potatoes based on people's preferences and soft foods for people who required them. Care workers demonstrated a good understanding of what people liked to eat and how, including when people preferred gravy or to eat much later.

There was evidence of joint working with other services to meet people's needs. This included occupational therapists, GPs, nurses and other local health and social care teams. The registered manager told us "We work with multi agencies such as nurses and doctors and assess people's needs and how they like to approach." The provider had worked with the local NHS to introduce a new, more detailed assessment including assessing people's functioning in a wide range of areas, and any relevant information on health conditions, diagnosed conditions and information relating to personal care needs.

People and their relatives told us the service supported people to stay healthy. Comments included "I think the food is healthy and they monitor health so that they can get treated early" and "I am well so I suppose they must." There was extensive support to maintain good health. This included detailed monthly reviews of people's health and wellbeing care plans with information on how health conditions had changed over the

past month and regular checks with a visiting GP. When the service was concerned about people's health conditions, people had been referred to specialist services and records were maintained of when people had been supported to attend appointments.

The provider had worked with the local NHS to implement a 'red bag' system. This was a new initiative for helping people who were going into hospital. Care workers packed a bag for the person including clothes, pyjamas, glasses, dentures and toiletries. There was also a form completed by staff with baseline observations and any information that hospital staff should know about the persons needs and health conditions, along with a checklist of what items the person had taken with them. This was designed to prevent delays in discharging the person and reduce the risk of glasses and dentures being lost.

People told us staff asked them for permission before providing care. Comments included "They always talk to me before doing anything" and "They always say is it alright?" The provider was working in line with the Mental Capacity Act (2005) (MCA). The Act 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. Where people had capacity to do so they had signed their plans. Where a person did not have capacity to make a decision this had been assessed in relation to specific decisions, and we saw that people's decision making abilities had been reviewed on a monthly basis. However, in some cases where people were not able to sign their plans due to poor eyesight but had capacity, the provider had not always recorded whether people had consented to their care verbally.

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). Where people were at risk of being deprived of their liberty, the provider had made an application to the local authority to do so. Authorisations to deprive people of their liberty were monitored by managers, who ensured that renewal applications were sent to make sure the application did not lapse.

Good

Is the service caring?

Our findings

People told us that staff were caring. Comments included, "They are very respectful" and "They always listen. I would say that if you have to be in a care home this is a really good one."

Care workers had a good rapport with people and seemed to know them well. This included managers. Care workers we spoke with spoke passionately about caring for people and wanting to provide a good level of care to them and support them to the best of their abilities. Interactions were positive, and we saw that people were greeted by care workers and addressed by their preferred names. One person told us "They even call me by my nickname because it is what I like." A relative told us "[my relative] tells everyone off and the staff continue to treat him respectfully."

People's plans contained information on how they preferred to communicate and helpful information for staff about how people's moods could change and how they should respond to this. This included information on whether people needed communication aids such as glasses and these were reviewed for changes monthly.

People's choices for their care and daily routines were respected. People told us they were able to tell staff their views and that they were listened to. People told us they were able to stay in their room if they preferred and a relative told us that their family member had moved to a different room as they preferred to overlook the neighbouring cricket fields. A relative said "When [my relative] first came the owner asked us to write a page or so about him and his likes and dislikes."

We found that care plans often lacked detail about people's preferences and life story. However, the staff team was stable and consistent and demonstrated a good knowledge and understanding of who people were and what they liked. Comments included, "They know me and I know them, makes everything so much easier" and "[My relative's] needs are known, the staff seem to stay a long time."

People's independence was promoted. As part of the assessment process, the provider had assessed what people could do for themselves and the support people required to stay independent. This information was included in care plans, and included information such as whether a person could wash their own face or shave for themselves, and the items that care workers should provide for the person to do this for themselves. Comments included "They encourage me to do anything I can" and "They allow me to be independent."

We observed that staff protected people's dignity. This included knocking on people's doors before entering. People told us they felt staff promoted their dignity. One person said, "They always make sure my dress is down and I get washed and dress in private". Other comments included "They always knock and wait for an answer" and "They make sure I am decent!"

Requires Improvement

Is the service responsive?

Our findings

People told us they received care which responded to their needs but care planning was not always carried out in a way which was effective.

People and their relatives talked about how they received care which met their needs and preferences. Comments included "I choose when to get up and what to wear and what I want to do in the day", " [My relative] gets plenty of choices, they are very flexible, she is her own person and she doesn't suffer fools gladly" and "If things go wrong they help, if someone falls they all help."

Plans were handwritten on an index system. This was organised to cover key aspects of care such as decision making, hearing and eyesight, personal hygiene and grooming, continence and skin care and views and consent. Care workers had written a paragraph under each heading to show how the person's needs had changed in the past month and what staff needed to do differently as a result. This included health conditions, changes in people's abilities and interaction with family and professionals. However, there were limitations to this approach. Plans lacked key information on what people's preferences were, for example with regard to food, how they liked hot drinks and the preferred gender of staff supporting them. Although people's religions were recorded, there was often a lack of information on what people's cultural needs were and how care workers could meet these. We found that in practice care workers met people's needs by relying on their shared knowledge of the person.

Although plans were reviewed monthly, there was not an overarching care plan for each person. This meant that it was easy to see what had changed by the month in each area of need, but not what the person's long-term needs were. Staff needed to write a paragraph in each area even if this had not changed, which was not always the most effective way of reviewing the plan. This was also not supported by an allocation system which indicated when care workers were responsible for supervising a person, but provided no other information on particular tasks they may need to carry out to meet the person's care plan.

People's communication needs were not always met as there was not an assessment of how people needed information presented to them, and the care plan format was not designed in a way which met the Accessible Information Standard (AIS). The AIS was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. It is now the law for the NHS and adult social care services to comply with the AIS. The registered manager recognised this, and said "Some people found our care plans a bit confusing…one or two may be able to look at the care plan but some get very confused." The provider was working with the local health team to implement a new, more detailed care plan. Records showed that people received care in line with their plans in a way which met their needs.

There was an activity programme in place for people using the service, but this was not designed in a way which met people's health needs. The majority of relatives we spoke with were satisfied with the levels of activity provided, and when people chose not to take part were confident that this was the person's choice, and that care workers attempted to engage people. The activities programme included visits from a local

nursery and from an opera singer, and outings to parks or museums once or twice a week. There were also regular parties and events taking place, including a party for the royal wedding which had taken place the previous weekend. We observed an exercise activity. This was well attended and people appeared to enjoy it, but staff appeared to struggle to offer a meaningful graded exercise activity in a way which may promote improved mobility. There was a positive reminiscence programme in place, which was suitable for meeting the needs of people living with dementia.

At the time of the inspection nobody was receiving end of life care. However, staff had undergone training in palliative care. For some people, there were advanced care plans in place for meeting their needs at the end of their lives. This included information on things people would like to do before they die, where they would like to be cared for and their wishes for after their deaths, including any religious aspects to their funeral.

People told us they felt confident making complaints about the service. Comments included "I talk to them and they listen and act, I know the difference between lip service and real concern" and "[The manager] has sorted out some minor issues, like laundry not being collected." However, the majority of people we spoke with told us that they had no cause for complaint. Complaints were recorded, and the registered manager recorded what action they had taken to address a complaint and ensure the person was satisfied with the outcome.

Requires Improvement

Is the service well-led?

Our findings

People using the service told us they were happy with the manager and the provider and that they found them approachable. A staff member told us "I certainly have no issues or concerns. We are all like one big family, all the residents and the staff team, including the manager, we all work closely together and feel there is a good sense of teamwork here."

Where audits were in place, such as with regards to medicines, these had been effective, but audits of staff training were limited and had not picked up on some shortfalls in these areas. There was a lack of a clear overview for risk assessments, both individual and those relating to the entire service which could highlight when these were due for review.

People told us they did not feel involved in the running of the service. However, relatives we spoke with told us that their views were sought about the quality of the service. Comments included "We have completed several questionnaires and views with the local authorities" and "We have been asked our opinions and they have listened especially over clothing."

We reviewed a sample of relatives questionnaires, which were broken down into three sections – about the home, the people using the service and the staff. It also included 21 statements that could be rated from strongly agree to strongly disagree. This included areas such as the cleanliness of the home, kindness of staff, attitude of staff, activities, personal care, management and if there was a warm atmosphere. 14 relatives had responded, and all were positive, with no issues of concern highlighted.

We spoke with several visiting professionals from local services. This included visitors from the NHS who were involved in driving improvements in residential care settings. All told us that the service had been heavily involved in local improvement initiatives. These included medicines optimisation and implementing the 'red bag' system for improving people's experience of hospital admission. In some areas where we had identified shortfalls, such as falls management procedures and care planning, the provider was aware of these and had been working with local organisations to start to implement improvements in these areas. This included identifying frameworks for these areas, but lacked a clear timescale for implementing these at this time. A visiting professional said, "They've worked very hard with me, they're certainly quite thirsty for knowledge and are heading in the right direction."

Policies and procedures were maintained in key areas such as safeguarding adults, staff training and moving and handling. Staff meetings were taking place on a regular basis. These were often held in order to explain requirements for staff or to respond to particular concerns. For example, a meeting in May had been held in order to explain the provider's policy on the use of mobile phones. In October, managers had held a meeting with cleaning staff as they had found that standards of cleanliness were unacceptable. Meetings had also discussed areas such as care planning and review, recording of care and the use of infection control equipment.

The provider was meeting requirements to display the rating of their previous inspection and had informed

the Care Quality Commission (CQC) of significant events such as when people had died, suffered falls or when they had applied to deprive people of their liberty.

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 registered person did not assess the risks to the health and safety of service users of receiving care or do all that was reasonably practicable to mitigate any such risks, or ensure that persons providing care or treatment have the competence, skills and experience to do so safely 12(2)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Persons employed by the service provider in the provision of a regulated activity did not receive such appropriate support, training and professional development as was necessary to enable them to carry out the duties they were employed to perform 18(2)(a)