Four Seasons (Bamford) Limited

Romford Grange Care Home

Inspection report

Romford Grange Care Home
144 Collier Row Lane,
Romford,
Essex,
RM5 3DU
Tel:01708755185
Website: http://www.fshc.co.uk/care-home/romford-grange-care-home/

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Ratings

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

Overall summary

We carried out an unannounced inspection on 19 November 2014. At our last inspection on 4 December 2013 the provider was found to be meeting the regulations we looked at.

Romford Grange Care Home is registered to provide accommodation for 41 people who require nursing or personal care. The home provides services to adults who have a physical disability, people with dementia care needs, older people who are physically frail and those in need of nursing care. On the day of our visit there were 37 people using the service.

Although there was a manager in place, at the time of our visit the manager was still in the process of completing registration with the Care Quality Commission. Following the inspection the manager completed registration.

Summary of findings

'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.'

People told us that they were happy living at the home and that their wishes were respected. We observed staff speaking to people in a courteous manner. Regular meetings were held with people and their relatives in order to listen and respond to their views on issues such as meals, staffing, and activities.

People were safeguarded from harm and cared for by staff who were knowledgeable about how to recognise and report abuse. Medicines were stored and ordered appropriately. However, there were shortfalls in the handling and administration of medicines as staff sometimes found medicines on the floor and the provider had not taken action to address this. Care was assessed and planned and reviewed regularly. We observed that staff were visible and supported people in a polite and professional manner.

We found that people were supported to eat a balanced diet and had access to health care professionals as and when needed. There was choice of a cooked breakfast daily and sandwiches or salads were available if people did not like the meal.

There were systems in place to monitor the quality of care provided, and obtain feedback from people who used the service. However, staff felt that team working between care staff and nurses could be improved. We also saw shortfalls in the training related to Mental Capacity Act 2005 (MCA) specifically for care staff and the effectiveness of the infection control and medicines audits. We found at times that records maintained about the care delivered to people were inaccurate.

At this inspection we found that the provider was not meeting the legal requirements in relation to medicines management, maintaining accurate records of care and assessing and monitoring the quality of service provided. 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?

Inadequate

There were aspects of the service that were not safe.

We found shortfalls with the handling of medicines. Staff told us that they picked up tablets on the floor. On the day of our visit a tablet was picked up in a corridor. We found that carpets, toilets and the cooker were not always clean. Clinical waste bins were not stored securely and could easily be accessible to people using the garden.

People thought they were safe. There were procedures in place to safeguard people from harm. Staff were knowledgeable about how to recognise and report abuse. They said they could raise concerns with the manager and aware of the safeguarding and whistle blowing policy.

There were risk assessments in place to protect people from avoidable harm such as falls and pressure ulcers.

People with the exception of a few relatives thought that there were always enough staff on duty to meet their needs. During the inspection, staff were visible in all areas of the home. We reviewed duty rotas for the home and saw that there were adequate levels of staffing in place to ensure people's care needs were met.

Is the service effective?

Requires Improvement

The service was not always effective.

Consent to care and treatment was sought before care was delivered. Where people lacked capacity appropriate guidance was followed by the nurses and managers. However, not all staff were aware of the deprivation of liberty safeguards (DoLs) and the Mental Capacity Act (2005) despite some of them having completed online training. We recommended that the manager revised the training and reassessed understanding.

People were supported to express their views and were actively involved in making decisions. People told us that staff listened to them and respected their wishes.

People told us that they were supported to maintain good health. They told us that they had access to see a doctor and other healthcare professionals when required.

Is the service caring?

Good

The service was caring.

People were supported to express their views and were actively involved in making decisions. People told us that staff listened to them and respected their wishes.

Summary of findings

People and their relatives told us that they were treated with dignity and respect. Relatives and friends were able to visit without restrictions. Some people chose to stay in communal areas whereas some went with their relatives to their rooms to spend some quality time together.

People we spoke to said staff usually responded promptly to their calls. People in their rooms were left with call bells within reach and had drinks in their rooms to promote hydration.

Is the service responsive?

Requires Improvement

Aspects of the service were not responsive to the needs of the people.

People were encouraged and supported to develop and maintain relationships with people that matter to them and avoid social isolation. We reviewed four care plans and found that people had initial assessments before they arrived. Care plans were then constructed on arrival in conjunction with the person and their relatives where appropriate.

People were listened to on a daily basis, during one to one with the activity coordinator and during annual care reviews where next of kin were invited to take part in reviews. People were supported to make a complaint and complaints were fully investigated.

Is the service well-led?

Requires Improvement

The service was not always well led.

We found shortfalls related to record keeping and teamwork. Although notifications about deaths and other safeguarding concerns, we did not see documentation to support that investigations had been made following staff reporting medicines found on the floor.

People and staff thought the home was a good place to live. There was a system in place for monitoring quality and risk and regular audits were completed and used to improve quality of care provided.

Romford Grange 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 checked 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 19 November 2014 and was unannounced. The inspection team comprised of a lead inspector, a second inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection, we reviewed the information we held about the service. We spoke with the local contracts and commissioning team and the local Healthwatch. We also reviewed notifications and safeguarding alerts. During the inspection we spoke to 13 people using the service and four relatives. We spoke to the manager, deputy manager, the chef, domestic staff, a nurse, six care staff and an activities co-ordinator. We observed care during meal times and medicine rounds. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at four care records including daily care records, risk assessments and care plans. We looked at four DNAR forms and five nurse appraisal records, supervision and training records. We also looked at maintenance records, and quality assurance audits. We also reviewed ten Medicine Administration Record Sheets (MARS) and four best interest decisions relating to covert administration of medicines.

Inadequate

Is the service safe?

Our findings

All the people we spoke with said that they felt safe living at the home. One person said, "I have no reason to feel unsafe. I think the home is quite secure and the staff are kind." Another person said "I like it here. They look after me very well."

We found that medicines were not always handled or administered safely. Although we checked medicines including 10 medicine administration records and saw evidence that medicines were ordered and stored appropriately, we were not assured that they were handled or administered properly. This was because three members of staff we spoke with told us they had picked up medicines in people's rooms on the floor or in people's rooms. One member of staff told us that they found tablets on the floor on a regular basis. They had taken these to the nurses and on one occasion were told to, "throw it in the bin." Two other staff also said they occasionally picked up medicines around the home. They also said they were not aware of any follow up investigations following the findings of the tablets. Management told us that all prior incidents had been investigated. However, we could not find documentary evidence to state whether investigations had been carried out and their outcome. The provider had not taken sufficient action to investigate and address this problem.

On the day of our visit another staff picked up a yellow tablet outside a person's room. We followed this up with the manager who told us that any medicine found on the floor was investigated and if necessary would lead to a best interest decisions relating to covert medicines. We did not find any documented evidence of investigations taking place following to medicine being found on the floor prior to our inspection. After our inspection the manager sent in a safeguarding referral to the local authority relating to the tablet that was picked up during the inspection.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (regulated activities) Regulations 2010.

People were cared for in a clean and hygienic environment with the exception of a few toilets and the cooker. We looked around the home including the communal areas. The main lounge/dining room was well equipped and looked in good, clean order. However, some toilets were not clean and bits of tiles were missing which was an infection control risk. The exterior clinical waste area was not secured from people who lived at the home. The clinical waste bins were in an open access area and were not locked.

We observed that appropriate infection controlled guidance was followed in order to prevent people from cross infection. We noted that during the morning handover, one person who used the service was unwell and required care and treatment in the room throughout the day. We spoke with staff who all outlined a clear procedure for managing the spread of infection. One member of staff said, "We will always try to manage any sickness outbreaks in the person's own room. We monitor them throughout the day and always were protective disposable gloves and aprons to reduce the spread of infection to others."

There were procedures in place to safeguard people from abuse. Staff were aware of how to spot the signs of abuse and were able to tell us what these might be. All of the staff felt comfortable in reporting any concerns they had to the manager. All staff knew how to locate the policies and procedures for safeguarding. We reviewed safeguarding completed investigations and those in progress and saw that appropriate action plans were implemented to avoid or better manage future incidents.

There were risk assessments in place to protect people from avoidable harm such as falls and pressure ulcers. We saw risk assessments in place for people with diabetes. Staff were aware of the signs and symptoms of a high and a low blood sugar how to manage this as outlined in the care plans we saw. Staff were aware of the procedure they would follow in an emergency and in the event of a fire. We found that emergency plans were in place and staff demonstrated knowledge of these procedures and the location of the emergency bag which were in place to ensure continuity of care in the event of a major incident.

The home was accessible by a lift or stairs and was secure as access was via a keypad front door. A fire safety system was in place with fire extinguishers located in different parts of the service. The premises were well maintained with the exception of scuffs to skirting boards in the main corridor. The carpet in the main corridor leading to the lounge was well worn and could do with replacing. Gas safety checks and fire safety checks were up to date in

Inadequate

Is the service safe?

order to protect people from the risks of avoidable harm. Lifts and equipment were serviced with next service dates clearly noted in order to prevent people from avoidable harm.

Most people thought there were always enough staff on duty to look after their needs with the exception of two relatives and one staff member. During the inspection, staff were visible in all areas of the home. We reviewed duty rotas for the home between 29 September and 19 November and saw that staffing levels were in line with what staff had told us. The home used regular bank staff to cover sickness and other absences. Although there were no current vacancies the manager showed us documentation that showed recruitment for a bigger pool of staff who could be used at short notice was in progress. We spoke with the team leader who said, “We always ensure the right number of staff are on duty. Staff are very good at doing extra shifts if required.” The activity co-ordinators, a maintenance man and kitchen staff were all available on the day of inspection and doing their part to meet the needs of the people. This ensured all of the people who lived at the home had access to a range of suitably qualified persons to assist them with their care needs.

We looked at four staff files and we saw there was a robust process in place for recruiting staff that ensured all relevant checks were carried out before someone was employed. These included appropriate written references and proof of identity. Criminal record checks were carried out to confirm that newly recruited staff were suitable to work with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

People were supported by staff who had appropriate skills. All staff interviewed had received an induction. One recent member of staff said, "I had an induction for one week and it was helpful to understand how to do things in this home as I have worked somewhere else before." On the day of our visit a Vocational qualification assessor was at the home and told us that they had two new carers who had just started the diploma in social care and another four who were at different stages of their training. The staff we spoke with had recently completed manual handling and fire training. We noted this had been recorded in the training matrix. Most of the training was delivered by e-learning. The staff could demonstrate what they learnt with the exception of Mental Capacity Act 2005 (MCA) training.

All staff interviewed had supervision sessions every three months. They all told us they found them helpful. We looked at the supervision files and saw that they were complete. Two members of staff were seeking to do further training and felt the home would support them in this so they could deliver better care.

All staff were aware of their responsibilities to report a change in someone's care needs. They said they would report immediately to a team leader. The home had a hand-over every morning. The staff found the information useful to know how to care appropriately for the people who lived at the home. One staff member said the care plans were completed using a tick box method rather than detailing any specific action. This did not always ensure that individual preferences were detailed accurately.

We looked at the team meeting minutes. The staff appreciated the meetings and were able to contribute to them. One staff member said, "It is a good place to raise any concerns and issues so that we all know how to give better care."

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. Consent to care and treatment was sought before care was delivered in order to ensure that people's wishes were respected.

Where people were assessed as not having capacity to make decisions the MCA code of practice was followed by the nurses and managers. There had been previous Dols applications in the past, however, at the time of our visit no one required a DoLS authorisation. The manager and the two nurses we spoke with were aware of changes to the legislation and had sought advice from the local authority. However, none of the six care staff interviewed were aware of how the MCA Act 2005 or DoLS applied to their role despite some of them having completed online training.

We recommended that online training offered to care staff be reviewed in order to ensure care staff understood the Mental Capacity Act (2005) and how it applied to their role.

Care was assessed and delivered according to national guidance. We saw care plans outlining whether people had capacity. There were best interest decisions documented on the use of bed rails and slipper mats for a person at risk of falls. We saw evidence that best interests assessments were in place and written advice had been sought from pharmacists and the GP's before administering medicines covertly. Do Not Attempt Resuscitation (DNAR) forms were in place however one out of the four DNAR forms we, looked at was not completed properly. We had to look further in care records to find evidence of a discussion with the relatives as the section on the form to discuss DNAR with family and next of kin was left blank.

People were supported to maintain a balanced diet. We were told and saw that menus were on a four week cycle and people were supported to choose what they wanted. A cooked breakfast was available daily to those who wanted it and a salad or sandwich option was also available for people who changed their mind at meal times. We observed the lunch time meal in the main lounge. People who required support were given support such as cutting up the food, help with sitting up or assisting to eat at an appropriate pace. One staff member was serving people who chose to stay in their rooms whilst other staff served food to people in the lounge. We observed one incident during lunch where a person who had dropped their cutlery waited for over five minutes for it to be returned to them. By the time staff came with replacement cutlery the food was cold and no alternative was offered to ensure the person ate a hot meal. When we asked the person said they would have liked it warmer but did not want to have to wait again.

Requires Improvement

Is the service effective?

Records were reviewed showed that peoples weight was monitored monthly and risk assessed. Any significant weight loss or gain was documented and referred to the dietician. Staff were aware of people on a diabetic diet, people with specific food allergies and those who needed prompting.

People told us that they were supported to maintain good health. They told us that they had access to see a doctor and other healthcare professionals when required. We saw in the four care files we reviewed that people had a named GP who was responsible for their care and a mini care plan that had been printed by the GP detailing past medical history and current medicines which could be useful if a person was attending hospital. There was evidence that people were reviewed by dieticians, speech and language therapists, chiropody and dentists when they required. Annual flu injections were also offered in conjunction with the district nurses and people's consent.

Good

Is the service caring?

Our findings

People and their relatives told us that they were treated with dignity and respect. Relatives and friends were able to visit without restrictions. Some chose to stay in communal areas whereas some went with their relatives to their rooms to spend some quality time together. People were encouraged to be as independent as they could. We saw staff encourage people to walk or to eat without assistance. We also saw signs in several rooms that had a reminder for staff to encourage independence. One of these notices read "Please remind me to make my bed. I can do it by myself."

We observed that all the people living in the home had been supported with their personal care. Each person was dressed in individual styles and looked well groomed. This helped maintain self-esteem and dignity. Staff told us how they maintained people's privacy at all times by ensuring that the doors and curtains were closed during personal care and by ensuring they respected people's wishes. One member of staff said, "We treat people as if they are a member of our own family. They deserve the best."

People were supported to express their views and were actively involved in making decisions. People told us that staff listened to them and respected their wishes. One person said, "I don't like to mix with the others so staff let me be. They do pop in occasionally during the day and ask if I need anything. They are quite good at listening and responding to my requests. One person told us about their complaints about the food and we saw evidence in their file and in their food questionnaire survey that an attempt had been made to meet their needs. For example, a person wanted their vegetables crunchy and the cook was aware of this and would take ensure the persons vegetables were crunchy.

Nursing staff were aware of advocacy support services that were available in the local area and said they would direct people and their families to these services. Other information relating to funeral plans and wills was also available for people and their relatives to look at. People told us they had a received an information pack when they first came to the service but could not always remember the contents. We saw one of these packs. It included information such as meal choices, activity options and how to make a complaint.

We saw staff responding well to people using the service. For example, staff bent whilst speaking with people. Staff ensured that one person's hearing aid was in place when the person had not put it in properly. They listened and spoke slowly to ensure people could understand them and vice versa. Staff spoke politely and in a pleasant manner. Staff tried to include everyone who wanted to participate in the activities going on in the lounge. Relatives and people called staff by name and were conversing and involved in the sing-along that were taking place. Staff responded to people when they asked questions such as when lunch would be served. If they could have a drink or about the time or the next outing.

Staff we spoke to were aware of people' individual preferences and personal stories. For example staff gave an example of how they supported a person with learning disabilities and how they encouraged them to make their bed. They were aware of the person's history of self harm and said they kept an eye on their mood and encouraged them to come out to the communal areas as they usually self-harmed when let alone for prolonged periods of time. We saw staff reposition people when they became uncomfortable and saw staff respond to people's requests to go to toilet in a timely manner. Staff spoke to people before transferring them from their chair to a wheel chair and whilst they assist people to eat their food.

People who chose to stay in their rooms were checked intermittently throughout our visit. However, most staff were in the lounge where the majority of the people spent their day. We observed that call bells were answered within three minutes throughout our visit. Staff politely asked people how they could be of help as they switched off the buzzer and listened to their requests and acted upon them. People we spoke to said staff usually responded promptly to their calls. People in their rooms were left with call bells within reach and had drinks in their rooms to promote hydration.

Requires Improvement

Is the service responsive?

Our findings

We found inconsistencies in documentation such as some oral assessments being left blank, an incomplete bedrail consent form and an incomplete DNAR form. We reviewed four care plans and found that people had initial assessments before they arrived. Care plans were then constructed on arrival in conjunction with the person and their relatives where appropriate. We found that an A4 laminated page at the beginning of each care record was individualised as it clearly outlined people's tastes and preferences for food, wake up and bed times. However, the actual care plans and support plans in place were not always specific and did not always outline how people preferred to have their care delivered. In particular, medicine administration care plans and personal care plans were not very specific or person centred. For example one care plan read "requires privacy and dignity to be maintained" but did not specify how they were assisted with personal care or their personal preferences. Mouthcare care plans were not always completed. Although the daily mouth care log was completed this was not specific. It just ticked that mouth care had been given but did not detail the type duration or what tools and products were used to deliver the mouth care.

This is a breach of Regulation 20 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were encouraged and supported to develop and maintain relationships with people that matter to them and avoid social isolation. One person's plan around family and relationships stated that although the person had no family nearby "his friend visits every Saturday for about four hours." We saw several visitors on the day of our visit. Some said they took their family member out. Others said they visited regularly. Staff told us that Saturdays were their busiest days as they have lots of visitors about and have decided not to have activities on a Saturday. For those without family close by we saw that they encouraged friends to come.

On the day of our visit people were actively involved in bingo then a sing-along activity where the manager joined in. We saw the weekly activities schedule which included a mix of board games, one to one coffee chats, bingo, cooking and sensory games. We were told by staff and people that the hairdresser visited and feet massage was also available every Thursday. We saw activities were documented in people's care files we reviewed. One person said, "Do enjoy it when we have shandy afternoons." Another person said, "Getting my hair done is the highlight for the week."

We observed that for two people with birthdays that occurred during our visit, staff had made sure that each person had an individual experience. One person had their celebration during lunch and the other had their celebration at dinner time in order to make it unique for each person. Each person had a birthday cake made at the home and had friends and family around them during their time of celebration.

The staff we spoke with all knew the people who lived at the home well including their life story prior to living at the home and they felt because of this they gave personalised care. We were told and saw documentary evidence that the activity co-ordinators met and discussed with new people their social interests so that their preferences could be either incorporated as group activities or as one to one sessions. However, all six care staff said they did not have enough time to spend with people and it was often difficult for those who were left in their rooms. This also applied to the activities as they appeared to be centred in the main lounge area. One member of staff felt the end of life care could be greatly improved to ensure more staff were available to spend time with people as needed. However our observation on the day of the visit and the staff ratio we saw did not support this with the exception of the shared view that people in their rooms appeared to have little stimulation.

People were listened to on a daily basis, during one to one with the activity co-ordinator and during annual care reviews where next of kin were invited to take part in reviews. We saw evidence that suggestions to food preferences and activities had been honoured. For example one person had been requesting to go out for a meal at a local food chain store. Staff told us and we verified this with the care records and found this had been organised by the home.

Staff we spoke with on the day of the inspection knew how to support people to make a complaint or who to direct them to do so. A complaints log was kept at the home which we viewed on the day of the inspection. The log showed that complaints received were acknowledged and investigated. A final response was recorded in the log and

Requires Improvement

Is the service responsive?

any learning was shared with staff. Information was available within welcome packs about how to make a complaint. One member of staff said, “The residents are able to express what they want to us and we will listen.”

Requires Improvement

Is the service well-led?

Our findings

The home had systems in place to ensure that the service monitored the quality of care delivered. All the policies were reviewed had been reviewed recently and had a review date. However, we identified shortfalls. We saw evidence that audits on infection control, medicines and record keeping were completed regularly and actions acted upon in a timely manner. However, these had failed to pick up the problems of medicines being found lying around within the service. There was an analysis complaints made so far. These were used to concentrate on themes emerging such as falls for one particular person. Appropriate actions had been taken. For example floor mats had been put in the person's room and bedrails after appropriate risk assessments and best interests decisions.

Although staff were aware that there was an incidents book and we reviewed incidents that had occurred between September and November 2014. We identified that staff lacked knowledge about reporting some incidents they described to us. For example three staff we spoke to on the day of the visit all said they had picked up tablets on the floor or on furniture in peoples rooms. None of these had been recorded as incidents. Therefore no learning had been identified in order to stop this from happening. The quality assurance in place had failed to identify both the gaps in in knowledge of staff relating to Mental Capacity and reporting of medicine related incidents.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us that they were happy with the staff and that they had built positive relationships with staff. All of the ten staff interviewed enjoyed working at the home. Comments included, "I love working here. It is like an extended family" and "I enjoy it here. We leave our own trouble at the door and give 100%."

All staff said the new manager was approachable and that there were doing a good job. One person said it had been unsettling to have different managers over the years but at the moment they "felt supported." Some members of staff felt that some leaders were not very approachable and would raise their voice at them at times. We feedback this to the manager said they would address this.

The staff felt that people had a voice and were able to express their views. We looked at the residents' survey which had recently been completed. One person who used the service said, "I would prefer different food but it is ok." Another said, "I like all the carers in the home." We reviewed two resident meeting minutes held in June and September 2014. Both meetings were well attended by people and their relatives and we saw evidence that people's views and concerns were listened to including meals and cleanliness of the home. The cook had attended in order to answer any queries about food. People were happy with the services of the newly employed hairdresser and were kept up to date with recruitment and the roles of the team leaders and nurses.

There was a registered manager who had been in post since April 2014 but had been fully registered in November 2014. We had been receiving all the relevant notification relating to deaths and any safeguarding concerns. The manager was supported by a regional manager who came and monitored performance. The manager was visible throughout the inspection and knew people by name and joined in the activities. We observed that team leaders were more visible and in direct contact with people than the nurses who came out periodically during medicine rounds and meal times

All staff we spoke to were clear on their individual roles and responsibilities as well as accountability for care delivered. The home had recently undergone a staff restructure which involved some staff changing their role to a lower or higher position. We saw evidence that this change went for consultation and that staff, people and relatives were kept informed of the details of these changes. The manager was aware of the attitude, culture and values of staff who were still adjusting to the staff restructure. On the day of the visit care staff still felt that nurses did not help much on the floor. However, there were still team leaders on the floor and carers supporting people.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records he registered person must ensure that service users are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person did not protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment. Risks were not always identified, assessed and managed. Where necessary, changes to the treatment or care provided were not always made in order to reflect information, relating to the analysis of incidents that resulted in, or had the potential to result in, harm to a service user. Regulation 10 (1)(a)(b)2(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines

This section is primarily information for the provider

Action we have told the provider to take

The registered person did not always protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the Handling and safe administration of medicines.