

Active Pathways Limited Brookhaven

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?

Requires improvement



Is the service responsive?

Requires improvement



Is the service well-led?

Requires improvement



Overall summary

We carried out an inspection of Brookhaven on 22 and 23 June 2015. The first day of the inspection was unannounced.

Brookhaven provides accommodation and nursing care for up to 22 people with mental health needs. The aim of the service is to provide people with care and support through a recovery and rehabilitation programme. The service is based in a residential setting within walking distance of local amenities. Accommodation is provided on two floors in single bedrooms. At the time of our inspection there were 17 people living in the home.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 last inspected this service on 4 December 2014 and found it to be meeting the regulations in force at the time. This inspection focussed on the management of medication in the home.

Summary of findings

During this inspection we found the provider needed to improve the cleanliness of the building, ensure all risks to people's health and safety were assessed, ensure people received safe care and treatment in respect of their healthcare needs and ensure people were treated with dignity and respect. You can see what action we told the provider to take at the back of the full version of this report.

We also made recommendations about the implementation of the Mental Capacity Act 2005 and making care plans more meaningful to people using the service.

People living in the home made positive comments about the home and told us they felt safe and looked after.

On arrival, we found some parts of the home had a poor level of cleanliness. Prompt action was taken to clean these areas. However, we also noted one person's bedroom only contained a bed and had no heating or soft furnishings. Whilst there were mitigating factors, this situation had not been risk assessed in order to manage the risks to the person.

Staff knew about safeguarding people from harm and we saw they had received appropriate training on these issues.

We found the arrangements for managing medicines were safe and all records seen were complete and up to date.

We found staff recruitment to be thorough and all relevant checks had been completed before a member of staff started to work in the home. Staff had completed relevant training for their role and they were well supported by the management team.

Whilst people had access to healthcare services, we found there had been a delay in obtaining a medical diagnosis for one person and specialist advice and support had not been sought for another person.

People told us the staff were kind and supportive. However, we noted some practices which did not promote the dignity of people living in the home. For example, there were locks on all external doors and some internal doors and many of the staff had a bunch of keys on a strap attached to their clothing. Although some people had a fob to get out the front door other people had to ask staff every time they wished to go out for fresh air or smoke a cigarette.

The unit manager had made two applications to the local authority for Deprivation of Liberty Safeguards (DoLS). However, we found there was no information in one of the people's care plan about the DoLS application.

We noted from looking at people's personal files each person had an individual care plan. However, apart from one person, people were not aware of their care and recovery plan.

People were able to express their views about the service at weekly "Have your say" meetings and they had also been given the opportunity to complete a satisfaction questionnaire.

We saw there were systems in place to monitor the quality of the service, including audits. The registered manager had also devised a detailed operational development plan, which included an action plan to improve the service.

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 consistently safe.

Although people told us they felt safe in the home, we found some areas of the premises were unclean on our arrival and some aspects of risk had not been assessed and addressed.

Staff knew how to report any concerns regarding possible abuse and were aware of the vulnerable adults safeguarding procedures.

The way staff were recruited was safe as thorough pre-employment checks were carried out before they started work. There were a sufficient number of staff on duty to meet people's needs.

There were systems in place to manage medication safely.

Requires improvement



Is the service effective?

The service was not consistently effective.

Whilst people's healthcare needs were addressed within their care plan, we noted there had been a delay in obtaining a medical diagnosis for one person and a delay in seeking specialist advice for another person.

We noted documentation and care planning was inconsistent in respect of the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff received appropriate training and were supported by the management team.

Requires improvement



Is the service caring?

The service was not consistently caring.

Whilst people were satisfied with the care provided, we found there were areas of practice which did not promote people's rights to dignity, respect and independence. We also noted the information handbook designed for people contained inaccurate information.

People told us the staff were kind and supportive. We observed positive interactions throughout our visit.

Requires improvement



Is the service responsive?

The service was not consistently responsive.

Whilst people were satisfied with the care and support provided, they were unfamiliar with their care and recovery plans.

People told us there were few activities, however, we were assured arrangements were in place to improve this aspect of the service.

Requires improvement



Summary of findings

People were aware of how to make a complaint should they need to.

Is the service well-led?

Whilst people and members of staff told us they were satisfied with the way the home was run, our findings demonstrated some restrictive practices. These issues were being addressed by the registered manager; however more progress needed to be made.

There were systems in place to monitor the quality of the service, which included regular audits and feedback from people living in the home. Appropriate action plans had been devised to address any shortfalls and areas of development.

Requires improvement



Brookhaven

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 22 and 23 June 2015 and the first day was unannounced.

The inspection team consisted of two adult social care inspectors 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 the inspection we gathered information from a number of sources. We looked at the information received

about the service from notifications sent to the Care Quality Commission by the registered manager. We also contacted a social worker from the local authority safeguarding team.

During the inspection, we used a number of different methods to help us understand the experiences of people who lived in the home. We spoke with 10 people who used the service. We spoke with the registered manager, unit manager and seven members of staff including ancillary staff. We also discussed our findings with the owner. We spent time observing care and carried out general observations of the care and support people were given. This helped us evaluate the quality of interactions that took place between people living in the home and the staff who supported them.

In addition, we looked at various records that related to peoples' care, staff and the overall management of the service. This included six people's care plans, five staff files, staff training records, meeting minutes, the complaints record, 17 medication administration records, cleaning records, accident and incident forms, quality assurance tools and a sample of policies and procedures.

Is the service safe?

Our findings

People told us they felt safe in the home. One person told us “It’s a lovely place; the staff are very nice with all of us.”

On arrival at the home we were taken on a tour of the premises by the unit manager. With the exception of one bedroom we did not access people’s personal space without permission. We noted a shower room on the first floor was heavily contaminated with dust and dirt from an ongoing refurbishment of a nearby bathroom. We were told this facility was in use by people living in this part of the building. The unit manager explained an ensuite shower room in a vacant bedroom had also been made available during the refurbishment. We noted the empty bedroom had cobwebs hanging from the ceiling and all surfaces were dusty. The wall area round the toilet in the shower room was heavily stained. A metal utility rack for soap and shampoo in the shower was rusty and dirty. We expressed concern about this situation and the areas were promptly cleaned. The registered manager assured us all bedrooms were refurbished when they were vacated, however, we would expect these issues to be addressed without our intervention in order to maintain people’s dignity and minimise the risk of infection.

We saw the hob and oven in the skills kitchen were dirty and greasy. These were in regular use by people practising their skills or choosing to self-cater. We also noted there was food debris on the window ledge in the conservatory and outside the conservatory on the path. This area was cleaned during our visit, along with the smoking area which was covered in cigarette ends.

Whilst there were infection control policies and procedures in place, we noted the cleaning records lacked detail about how areas should be cleaned and with what substances. According to the records seen, the vacant bedroom, which had to be passed through by people using the shower room was last cleaned approximately one week ago.

The provider had failed to keep all areas of the premises clean. This is a breach of Regulation 15 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We looked at how the service managed risk. We found individual risks had been assessed and recorded in people’s care plans and management strategies had been drawn up to provide staff with guidance on how to manage risks in a consistent manner. The risk assessments included

nutrition, behaviour which challenged the service and falls. We also noted the health and safety committee had carried out a general risk assessment of the service and any identified risks were added to a risk register. However, we observed on our tour of the premises that one person’s bedroom was completely bare apart from a bed. This meant the person had no heating, storage, wash basin or window covering. The unit manager explained there were mitigating factors for this situation and we saw from the person’s care plan staff were considering ways of how to redecorate the room. However, we saw no risk assessment in the person’s file to assess, identify and address the risks associated with these circumstances. The person told us they were unhappy with their room. Although we spoke with staff and looked in detail at the person’s file we were not able to determine when the room last had heating. We were concerned about this situation and raised a safeguarding alert with the local authority.

The provider had failed to assess the risks to a person’s health and safety. This is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Following an accident or incident, a form was completed. The details were added to a database and systems were in place for analysing any trends or patterns. Many of these incidents were categorised as “other” and had not been fully analysed. This meant appropriate action could not always be identified to minimise the risk of re-occurrence. We discussed this issue with the registered manager during the visit and were given assurances this matter would be addressed.

We looked at how the service protected people from abuse and the risk of abuse. We discussed the safeguarding procedures with three members of staff. Safeguarding procedures are designed to direct staff on the action they should take in the event of any allegation or suspicion of abuse. Staff spoken with understood their role in safeguarding people from harm. They were all able to describe the different types of abuse and actions they would take if they became aware of any incidents. All staff spoken with said they would not hesitate to report any concerns. They said they had read the safeguarding and whistle blowing policies and would use them, if they felt there was a need.

The registered manager explained all staff received safeguarding training on an annual basis and records seen

Is the service safe?

confirmed this. New staff completed on line training within the first month of their employment. However, we found two members of new staff had not completed the training. The registered manager told us they were aware of this situation and arrangements were being made to ensure the staff completed their training in a timely manner.

We looked at how the service managed staffing and recruitment. The home had a rota which indicated which staff were on duty during the day and night. We noted this was updated and changed in response to staff absence. Whilst staffing levels were flexible depending on the needs of the people using the service, we found there had been no analysis or systematic approach to determining the number of staff required to ensure all people received equal time for their recovery programme.

We looked at recruitment records of five members of staff and spoke with one member of staff about their recruitment experiences. Checks had been completed before staff commenced work in the home and these were clearly recorded. The checks included taking up written references and a Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with vulnerable adults, to help employers make safer recruitment decisions.

The recruitment process included applicants completing a written application form with a full employment history and a face to face interview to make sure people were suitable to work with vulnerable people. Staff completed a probationary period during which their work performance was reviewed at intervals. We noted the provider had a recruitment and selection policy and procedure which reflected current regulatory requirements.

We looked at how medication was managed in the home. People spoken with told us they were not aware of what medication they were taking. Medication was administered by qualified nurses. The nurses had access to a set of policies and procedures which were readily available in the clinic room.

The provider operated a monitored dosage system of medication. This is a storage device designed to simplify the administration of medication by placing the medication in separate compartments according to the time of day. As part of the inspection we checked the procedures and records for the storage, receipt, administration and disposal of medicines. We noted the medication records were well presented and organised. All records seen were complete and up to date.

Is the service effective?

Our findings

People were satisfied with the care they received and told us that it met their needs. One person said, “The staff are nice and kind”.

We looked at how people were supported to maintain good health. Records we looked at showed us people were registered with a GP and received care and support from other professionals. We saw people’s healthcare needs had been assessed and included in people’s care plans. However, whilst district nurses and the GP were involved in one person’s care, we noted there had been a delay in obtaining a medical diagnosis and there was no evidence of ongoing monitoring of their condition. We also noted advice and assistance from specialist services had not been sought, in line with one person’s mental health needs. This meant there was an increased risk to the person’s health and well-being.

The provider had not ensured people received safe care and treatment. This is a breach of Regulation 12 (1) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the manager. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people’s best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

Staff spoken with told us they had received training on the MCA 2005 and we found they had a working knowledge of the principles associated with the Act. We also noted there were policies and procedures available and the registered manager had prepared a detailed briefing paper for staff to help them understand the main concepts of the Act. At the time of the inspection, the unit manager had made two urgent applications to the local authority for a DoLS. However, on checking one person’s personal records we found the person’s care plan did not contain information about the DoLS application. The provider’s procedure advised that a checklist should be completed prior to

applying for a DoLS application, but this had not been carried out for the person. We noted a mental capacity assessment had taken place but this was generic and not specific to a particular decision. Further to this one member of staff spoken with was not aware of one of the DoLS applications. This meant staff may not have been aware of how to support the person in the least restrictive manner.

We found all exit doors and some internal doors were locked. Whilst some people were given fobs to open the front door, other people had to knock on a thick glass wall to let office staff know they wished to go out so the staff could open the door. Out of office hours people had to find a staff member to open the door. The back door to the smoking area was also locked at all times. Whilst we saw in two people’s files their signed agreement to the use of locks, this agreement was not apparent on all files looked at. This is important because people are entitled to be cared for in the least restrictive way possible.

We examined six personal files and noted a mental capacity checklist had been completed for one person. However, this documentation was not on other people’s files inspected during the visit. The unit manager explained this paperwork had been completed and was probably on archived files. This meant staff may not have been aware of the checklist and the findings.

We looked at how the provider trained and supported their staff. All staff completed induction training when they commenced work in the home. This included a corporate induction on the organisation’s visions and values and mandatory training. The provider’s mandatory training included, safeguarding, fire safety, infection control, food hygiene, health and safety, information governance, managing mental health and non-violent intervention. We spoke with one new member of staff who told us their induction training had been beneficial and useful. Staff newly recruited to the home were initially supernumerary and shadowed more experienced staff to enable them to learn and develop their role. Existing staff were provided with refresher training on a regular basis. We saw staff training certificates, the staff training matrix and the overall staff training plan during the inspection. The registered manager explained plans were in place to implement the new care certificate for all new members of staff.

Staff spoken with told us they were provided with regular one to one supervision and they were supported by the

Is the service effective?

registered manager. Supervision provided staff with the opportunity to discuss their responsibilities and to develop their role. We saw records of staff supervision during the inspection and discussed the topics covered with the registered manager. Staff were also invited to attend regular meetings. Staff told us they could add to the agenda items to the meetings and discuss any issues relating to people's care and the operation of the home. Staff confirmed handover meetings were held at the start and end of every shift during which information was passed on between staff. This ensured staff were kept well informed about the care of the people who lived in the home.

We looked at how people were supported with eating and drinking. People spoken with made complimentary comments about the food provided. One person told us, "It's really nice, we always get a choice."

People were offered a choice of menu at each meal time and could request an alternative to the two main meal choices. The menu was displayed on the notice board and on laminated cards on each table in the dining room. The registered manager explained a questionnaire had been

distributed to people asking for their views on the food provided. The results had been collated and the menu had been devised based on the results. The registered manager carried out regular spot checks on the quality and quantity of the food and fed back her observations to the head chef. People could help themselves to hot and cold drinks, snacks and fruit throughout the day from trays set out in the dining room.

Nutritional risks were assessed within people's care plans. The chef spoken with told us they were aware of people's preferences and special diets were catered for as necessary.

As part of their recovery programme people could opt to have their own personal budget for food. This enabled them to shop for their own food and prepare their meals in the skills kitchen.

We recommend the service consider the relevant guidance and principles contained in the code of practice for the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

Is the service caring?

Our findings

People spoken with were satisfied with the care and support provided and were complimentary about the staff. One person said “It’s wonderful, everyone’s needs are catered for and the staff are really pleasant.” We observed staff interactions throughout our visit and noted staff were courteous and responded positively when people needed assistance. People told us staff also had time to sit and talk to them when necessary.

On the provider’s website Brookhaven is described as an “Open rehabilitation service.” We found this was not the case. One person told us, “Everywhere is locked and feels like a prison.” We noted many of the staff had bunches of keys on straps attached to their clothing, this suggested the home was a locked facility and differentiated them from the people using the service. This practice did not promote people’s dignity and independence.

We noted stable doors were fitted to the clinic room and the kitchen. People routinely went to the clinic for their medication and told us they formed a queue. We spoke to a nurse on duty who told us, “I know who to expect and who to call for.” We observed on one occasion that a person who was sitting in the foyer outside the clinic was called to get their medication; we noted there was no attempt to take the medication to them despite the person being very elderly. We further noted people collected their meals from the stable door to the kitchen. These practices demonstrated a lack of sensitivity and respect.

We observed people had to ask staff to unlock the back door each time they wished to access the smoking area. The smoking area comprised of a picnic table and parasol. There was no shelter to and from the area which meant people would get wet on days when it was raining. This situation did not promote the dignity of people using the service.

The provider had not ensured people using the service were treated with dignity and respect. This is a breach of Regulation 10 (1) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People’s bedroom doors were fitted with locks and people were given a key. People spoken with confirmed staff knocked on bedroom doors and waited for a response before entering. This meant they could maintain their privacy within their own room.

People were provided with information about the service in the form of an information handbook. We looked at the handbook and noted from our discussion with the registered manager that some information was misleading and inaccurate. For instance people were referred to as patients, the registration details for the service were incorrect and it stated wherever possible visits were to be prearranged through the nurse in charge. The registered manager assured us people could receive visitors and it was not normal practice to pre-arrange such visits. This was confirmed in our discussions with people living in the home. We further noted there was no mention in the handbook about the locks on all exits and some internal doors. This meant people may not be aware of how the service operated. The registered manager told us the handbook was due to be reviewed and updated at the first opportunity.

We noted there was information in the handbook about advocacy services and there was information leaflets freely available on a notice board in the hall way. This service could be used when people wanted support and advice from someone other than staff, friends or family members. The registered manager explained the service was visited on a frequent basis by an IMCA, (Independent Mental Capacity Advocate) from the local advocacy service and they spent time talking to people living in the home.

People could express their views at the weekly “Have your say” meetings which were held for people living in the home and the staff. We looked at recent meetings and noted a variety of topics had been discussed. Any suggestions for improvement were reviewed at the next meeting. This meant people were aware of any action which had been taken.

On looking at care records we noted some people had signed their care plans, however, apart from one person none of the people spoken with were aware of their care and recovery plan. It is important the care planning processes are meaningful to people to ensure they can actively participate and contribute their views.

Is the service responsive?

Our findings

People spoken with expressed satisfaction with their current service. One person told us, “It’s very good here.”

We looked at six people’s care files and found each person had an individual care plan. They included risk assessments on specific areas of need. We noted the care plans were written in the first person, however, people spoken with were not familiar with their plans. This meant there was a risk the information did not fully reflect their views and preferences.

People’s recovery programme was underpinned by the use of the “Mental Health Recovery Star.” This is a tool that measures change and supports recovery by providing a map of people’s progress. It focuses on ten areas of life which are seen as critical to recovery. These include managing mental health, self-care, social networks, responsibilities, trust and hope and identity and self-esteem. People used the star as a way of plotting their progress and planning actions. We saw completed recovery stars in people’s files. However, we noted people’s aspirations and what recovery meant for them was not covered in their care plans. It is important the care plans accurately reflect people’s views and personal objectives.

One person told us they had been informed of a change in circumstances which would occur later in the year. However, when we looked at the person’s care plan we noted there was no information or guidance for staff about this situation. This meant there was a risk staff would be unaware of how best to support this person. We noted the occupational therapist had produced a therapy activity plan; however, it was unclear what progress the person was making to build their skills.

We saw evidence the care plans had been reviewed. People were invited to attend their “Recovery Approach” meetings if they wished to. However, we noted many people preferred not attend.

We noted an assessment of people’s needs had been carried out before people were admitted to the home. We looked at a completed assessment and found it covered all aspects of the person’s needs. Information was also gathered from health and social care professional staff. People new to the home were invited to visit so they could

meet other people and the staff. This process helped to ensure the person’s needs could be met within the home. We noted a person was visiting the home during our inspection with a view to moving in.

People told us there were few opportunities to participate in activities. One person told us they enjoyed going out; however, when we checked the person’s records the last recorded trip occurred in March 2015. We also noted two people reported feeling bored in a report of the service carried out by a senior manager in April 2015. The registered manager and unit manager explained arrangements were in place to develop the activities in the home. A forthcoming trip had been arranged to the Lake District as well as a walking trip. The lounge on the first floor was being converted into an activities room. During our visit we observed people participating in a music quiz and an arts and crafts session. One person also made some cakes in the skills kitchen with the occupational therapist. The person told us baking was one of their favourite activities.

People had access to therapeutic earnings by working in the grounds or kitchen. The job opportunities were advertised and job descriptions had been compiled for the roles. Induction training was also offered.

We looked at how the service managed complaints. People told us they would feel confident talking to a member of staff or the registered manager if they had a concern or wished to raise a complaint. Staff spoken with said they knew what action to take should someone in their care want to make a complaint and were sure the registered manager would deal with any given situation in an appropriate manner. We noted the complaints procedure was incorporated in the information handbook and included the timeframe for a response and appropriate contact details.

We found the service had systems in place for dealing with complaints. Records seen indicated the matters had been investigated; however, there was no information available to indicate the complaints had been resolved or if any service improvements had taken place.

We recommend that the service seek advice and guidance from a reputable source, to ensure care plans are more meaningful to people living in the home.

Is the service well-led?

Our findings

People were satisfied with the way the service was run. One person told us, “Everything is alright.” All staff spoken with told us the home was well managed and organized. One staff member said, “I love working here, all the staff get on well and there is a good teamwork.” Another member of staff commented, “I have no issues or concerns, we support people the best we can.”

The service was led by a manager who is registered with the Care Quality Commission. The registered manager told us she was committed to the on-going improvement of the home. At the time of the inspection, the registered manager described her achievements as the development of a management structure, the introduction of reflective practice and starting the refurbishment programme. She was also able to describe her key challenges. These included, recruiting more nurses and developing the identity of the service. The registered manager explained some people had lived in the home for many years and their needs were different from people needing short term rehabilitation. She recognised it was important all people’s needs were met.

We noted throughout our visit there were some restrictive practices which impacted on the lives of people living in the home, for instance the locks on external and some internal doors, staff wearing keys on a strap, the way medication was administered, people having to ask to go outside to smoke and the description of rooms for example “the clinic.” We noted a report completed in April 2015 by a senior manager in the organisation highlighted a need to move away from hospital terminology. The registered manager had devised a crisis plan to deal with immediate issues and from this had produced an operational development plan to cover all aspects of the service. This

included a detailed action plan which was being used to shape future developments. The owner also told us he was committed to the future development and improvement of the service. We recognised the service was going through a transition, however, more improvements needed to be made.

People using the service had recently been given the opportunity to complete a satisfaction questionnaire. The results from the survey were due to be collated. We saw the completed forms during the inspection and noted the responses were generally positive. However, four respondents reported a lack of involvement in their care plan and two respondents were not aware of any improvements in the service.

Staff spoken with described their roles and responsibilities and gave examples of the systems in place to support them in fulfilling their duties, for instance handover meetings. Staff were also allocated tasks on an activity planner throughout the day. This meant they were aware of who they were supporting and what tasks they needed to undertake. Staff spoken with were aware of the lines of responsibility and told us communication with the registered manager was good. They said they felt supported to carry out their roles in caring for people and were confident to raise any concerns or discuss people’s care.

The registered manager and management team used various ways to monitor the quality of the service. This included audits of the medication systems, physical health, incidents and accidents, staff training and staff supervisions. These were to ensure different aspects of the service were meeting the required standards. We noted the audits included action plans where any shortfalls had been identified.

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

Accommodation for persons who require nursing or personal care
Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment
The provider had failed to keep all areas of the premises clean. Regulation 15 (1) (a)

Regulated activity

Accommodation for persons who require nursing or personal care
Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
The provider had failed to assess the risks to a person's health and safety. Regulation 12 (2) (a).

Regulated activity

Accommodation for persons who require nursing or personal care
Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
The provider had not ensured people received safe care and treatment. Regulation 12 (1).

Regulated activity

Accommodation for persons who require nursing or personal care
Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect
The provider had not ensured people using the service were treated with dignity and respect. Regulation 10 (1).