Care Quality Commission

Royal Bay Care Homes Ltd

Royal Bay Residential 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?	**Good**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 24 April 2017 and was unannounced.

Royal Bay Residential Home provides care and accommodation for up to 42 older people and there were 35 people living at the home when we inspected who were all aged over 65 years. The home is situated close to Bognor Regis town centre and beach.

All bedrooms were single and each had an en suite toilet with a wash basin. Some of the bedrooms were large enough so they could be used as double if a couple requested this. There is a passenger lift so people can access the bedrooms on the first and second floors.

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.

At the previous inspection of 16 December 2014 we identified that not all care staff knew how to appropriately support people who displayed behaviours which may be challenging to others. We made a requirement for this to be addressed and the provider sent us an action plan outlining how staff were to be trained in this. At this inspection we found staff were trained in supporting people who had behaviour needs and responded appropriately to people who were living with dementia.

At this inspection we observed people who needed assistance with mobility needs were not always safely supported and supervised by staff. One person was lifted in an unsafe way and staff did not apply a safety brake to wheelchairs when lifting people into them. Care plans did not always have the correct details about supporting people when helping them to transfer safely.

People's privacy was not always upheld. Each bedroom door had a window with a blind over it for privacy. In several cases these were damaged and did not afford privacy. In one case the blind was partially open in the day time and a person was in a state of undress and was visible to anyone walking along the corridor. Following the inspection the provider confirmed that action was taken to remove the blinds and to cover the windows in the doors in order to given people privacy. People told us staff knocked on their bedroom door before entering but we observed two staff entered someone's room without knocking or asking for permission to enter.

Providers are required to notify the Commission of certain events such as the deaths of people at the home. The provider had not notified the Commission of eight people who had died at the home.

There was a variation in the standard and state of décor. Bedrooms were well maintained. Some communal areas were in need of attention. Carpets in halls and landings were not always secure and were held

together with tape in many areas. This increased the risks of possible tripping as flooring was not always secure. Carpets had been replaced in some hallways. Following the inspection the provider confirmed there was plan with dates to replace the damaged carpets.
There were sufficient numbers of staff to meet people's needs and staff recruitment procedures ensured adequate checks were made on staff before they started work

Medicines were safely handled and administered.

Staff training was well organised and there was a system of staff supervision and appraisal.

The CQC monitors the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Staff were trained in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). People's capacity to consent to their care and treatment was assessed and applications made to the local authority where people's liberty needed to be restricted for their own safety.

There was a choice of food and people were supported to eat and drink. The meals were of a good standard.

Arrangements were made for people to receive health care and health care professionals said the staff worked well with them to ensure people received appropriate care and treatment.

People said the staff treated them well and with respect. Staff were observed talking to people respectfully and calmly. Staff demonstrated values of compassion and of treating people in the same way they would treat a family member.

People said they were consulted about their care but this was not always evident in people's care plans. People's care needs were assessed and each person had a care plan which included details about how staff should support people. A range of activities was provided including trips out from the home.

The complaints procedure was provided to people.

The provider had a quality assurance system for monitoring the quality, safety and welfare of people which included obtaining the views of people and professionals.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of the 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 did not always provide safe care.

Staff did not always support people to move safely and care plans did not always accurately reflect people's mobility needs.

Sufficient numbers of staff were provided to meet people's needs.

Medicines were safely managed.

Is the service effective?

Good

Staff were supported to complete relevant training and received regular supervision.

People's capacity to consent to care and treatment was assessed and staff were aware of the principles and procedures as set out in the Mental Capacity Act 2005 Code of Practice.

People were supported to have a balanced and nutritious diet. Health care needs were monitored. Staff liaised with health care services so people's health was assessed and treatment arranged where needed.

The home was generally clean and well maintained. There were some areas in need of improvement such as carpets. The provider confirmed there was a plan to replace these.

Is the service caring?

Requires Improvement

The service was not always caring.

People's privacy was not always promoted.

People were treated with kindness and patience by the staff who demonstrated values of compassion and respect for people.

People received support and care which reflected their needs and choices, although care plans lacked documentation to show people were fully consulted and involved in decisions about their

care.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and reviewed. Care plans were individualised and reflected people's preferences.

A range of activities were provided to people which included trips out in the community.

The service had a complaints procedure and people knew what to do if they wished to raise a concern.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Notifications as required by the regulations were not always made to the Commission.

The provider sought the views of people regarding the quality of the service and to check if improvements needed to be made.

There were a number of systems for checking and auditing the safety and quality of the service.

Royal Bay Residential 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. The 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.

The inspection took place on 24 April 2017 and was unannounced. The inspection was carried out by an inspector and an Expert by Experience, who had experience of services for older people. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We reviewed information we held about the service, including previous inspection reports and notifications of significant events the provider sent to us. A notification is information about important events which the provider is required to tell the Care Quality Commission about by law.

During the inspection we spoke with eight people who lived at the home and to a relative of one person. We spent time observing the care and support people received in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We looked at the care plans and associated records for six people. We reviewed other records, including the provider's internal checks and audits, staff training records, staff rotas, accidents, incidents and complaints.

We spoke with four staff, the registered manager and the deputy manager.

We also spoke with two health and social care professionals who were visiting the home at the time of the inspection.

Requires Improvement

Is the service safe?

Our findings

Whilst staff were trained in moving and handling, we observed they did not always transfer people safely. We observed staff lift one person in the lounge using unsafe methods. The person was lifted by two staff from a wheelchair to an armchair without the brakes on the wheelchair being applied. This meant there was a risk the wheelchair could have moved during the process which could cause injury to the person and/or staff. The person was lifted by staff by placing their arms under the person's arm pits and not by the use of any hoist. This increased the risks of injury to the person or to staff through this unsafe manoeuvre. This person's care plan did not include any reference to the person needing to be transferred by wheelchair or by lifting and said the person was independently mobile. Another person was observed in a wheelchair propelling themselves by one of their feet. This person's care plan did not include any details or assessments about the person using a wheelchair. Therefore the details in people's care plans related to their moving and handling needs was not always accurate or up to date to ensure staff understood how to move people safety with appropriate equipment.

The provider had not always ensured the risks to people when assisting them to move were fully assessed and mitigated for. The provider had not ensured staff safely transferred people. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe at the service. For example, when we asked one person if they felt safe they replied, "Oh yes."

Staff were trained in safeguarding people and demonstrated they knew what to do if they suspected someone had been mistreated in some way by reporting it to their line manager or to outside organisations such the Care Quality Commission if needed.

There were risk assessments regarding risks of injury to people and the action needed to keep people safe. These included the use of bed rails, the risk of falls and maintaining a safe environment. The risk of pressure areas developing on people's skin was assessed and equipment was used to relieve pressure areas such as air flow mattresses and air cushions. Care plans gave details of when people needed to be repositioned to relieve pressure on their skin from prolonged immobility. We saw charts were completed when these took place. A health care professional said monitoring charts were up to date where they were used to record interventions such as food and fluid intake and repositioning.

We looked at the service's staffing levels. People generally said there were enough staff but two people said they were not. For example, one person said, "They are about all the time. They're always busy. They come if I ring the bell." Another person told us, "There's not enough at night."
One person considered there were not enough staff and there were sometimes delays in staff responding to them. Other people said how staff responded promptly when they used their call point to ask for help. A relative told us they considered there were enough staff.

Staffing levels were based on the occupancy levels and needs of people. The registered manager told us

staffing levels could be adjusted to meet these changing needs. At the time of the inspection five care staff plus a senior care staff member were on duty from 8am to 2pm each day. From 2 to 8 pm there were four care staff plus a senior care staff member on duty. In addition to this were the hours worked by the registered manager and deputy manager both of whom worked full time. These hours were reflected in the staff duty roster which also showed these hours were exceeded on some days. Night time staffing consisted of three care staff on a 'waking' duty.

There were also staff deployed for cleaning, laundry, maintenance and activities to ensure these aspects of people's needs were met.

We observed there were enough staff to meet people's needs which included responding to people who used their call point and during the lunch meal. Staff said they considered there were enough staff to meet people's needs. Staff commented on a good team ethos where they supported each other. A health and social care professional also commented that there were enough staff in the home.

We looked at the staff recruitment procedures. Appropriate checks were carried out to ensure staff were safe to work with people. References were obtained from previous employers and checks with the Disclosure and Barring Service (DBS) were made regarding the suitability of individual staff to work with people in a care setting.

We looked at the medicines procedures which we found were safely managed. People said staff supported them to take their medicines. Staff recorded a signature on a Medicines Administration Record (MARs) each time they administered medicines to a person. The MARs charts were checked for the current medicines for all the people accommodated at the service. We checked a sample of medicine stocks on each of the three floors of the service which showed medicines had been administered as prescribed. Medicines were safely stored.

There were hand sanitisers for staff and visitors to use for good infection prevention. We saw waste was appropriately stored. There was an absence of any unpleasant odours. A relative said the home was clean and free from any offensive odours adding, "It smells of flowers and polish."

Checks were made by suitably qualified persons of equipment such as the passenger lift, hoists, fire safety equipment and alarms, electrical wiring, gas heating and electrical appliances. The risk of legionnaire's disease was checked by a suitably qualified contractor. Fire safety equipment was checked and serviced. Each person had a personal evacuation plan so staff knew what to do to support people to evacuate the premises.

Good

Is the service effective?

Our findings

At the previous inspection of 16 December 2014 we identified that not all care staff knew how to support people appropriately who displayed behaviours which may be challenging to others. This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We made a requirement for this to be addressed and the provider sent us an action plan outlining how staff were to be trained in this. At this inspection we found staff were trained in supporting people who had behaviour needs and responded appropriately to people who were living with dementia. Therefore the requirement was now met.

People told us the staff were helpful. Health care professionals said the staff were skilled in managing people's behaviour needs and had a good skill level.

The home was generally clean although we noted relieving cushion was very worn which meant it would be difficult to keep it clean and hygienic. This was brought to the registered manager's attention who confirmed it would be replaced.
There was a good system for the induction of newly appointed staff. This involved a period of shadowing more experienced staff and the completion of an induction training book over a 12 week period. The induction involved observation of the competency of newly appointed staff to provide effective care. Newly appointed staff also registered for the Care Certificate. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. It is the minimum standard that should be covered as part of induction training of new care workers. Recently appointed staff said they received an induction which involved a period of 'shadowing' more experienced staff. These staff said the induction was of a good standard and prepared them for their role.

A staff training matrix was maintained so the management team could monitor that staff had attended courses considered mandatory to their roles. These included fire safety, moving and handling, end of life care, dementia, first aid, food hygiene, diet and nutrition, fire safety and coping with aggression. A health and social care professional told us how community health care professionals worked with staff to provide training and instruction in care related to skin care and in the care of those living with dementia.

Staff also completed nationally recognised training in care such as the National Vocational Qualification (NVQ) in care and the Diploma in Health and Social Care. Twelve of the 18 staff were either trained to NVQ level 2 or 3 or were studying for the Diploma. The registered manager had completed NVQ level 4 and the Registered Manager's Award (RMA). The deputy manager had completed the level 5 Diploma in Leadership and Management. These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard.

Staff told us they were supported in their work and could ask for advice when they needed. Staff also said they received supervision on a regular basis and that they were observed by their line manager who assessed their competency. We saw records of staff supervision and appraisal which were recorded to a

good standard and showed staff competency was assessed. In view of our observations of staff lifting a person in an unsafe way, the supervision of staff needs to include this aspect of staff practice to ensure it is done safely and consistently.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The service had policies and procedures regarding the Mental Capacity Act 2005. Staff were trained in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). People's capacity was assessed where this was needed. Where appropriate applications were made for people's liberty to be restricted for their own safety. At the time of the inspection six people were subject to a DoLS authorisation and six further applications had been made. Where people lacked capacity to make decisions there were records of situations when staff needed to make a decision in behalf of someone called a 'best interest' decision. We observed staff asking people who they would like to be helped and explained to staff how they were supporting them.

People told us they liked the food and that there was a choice. For example one person commented, "I can go to the dining room and join the others or they bring it on a tray. Usually it's very hot and tasty." Another person told us how they were able to make a choice, "Yes they come round the day before and give you a choice of several items." A relative described the food as "lovely" and said visiting relatives were able to eat with the residents which encouraged sociability. This relative said how much they liked the dining room with table cloths and flowers. We observed the lunch time in the dining room. Meals were served to people at dining tables and people were able to have wine, sherry or beer if they wished. The meals were homemade and of a good standard. For example, desserts were homemade cherry lattice with homemade short crust pastry or homemade chocolate sponge. People were supported to eat where this was needed. People enjoyed the food.

People's nutritional needs were assessed using a malnutrition universal screening tool (MUST). A care plan was devised if people needed support to eat or if their food and fluid intake needed to be monitored. We saw charts were completed for food and fluid intake where this was needed. Health care professionals told us people's nutrition and hydration was managed well with monitoring charts in place. A health care professional also said referrals for specialist assessment and support were made where people were at risk of losing weight or had difficulties swallowing.

Health care professionals told us the staff worked well with them to meet people's care needs. For example, one professional said, "The staff work well with us. They are amazing. They are responsive to health care needs. Really good. Brilliant at following instructions. The deputy has impressed me." Another health care professional said staff called them for advice and took on board any instructions.

People's medical needs were assessed at the time of admission. Assessments also showed health care needs were assessed such as wounds, continence and oral health care. People's blood pressure was monitored. Records were maintained when health care professionals were contacted or attended to people at the home.

The décor of the home was generally intact and reasonably maintained. Bedrooms were well decorated. There were a number of areas of the home, however, where there was damage caused by wear and tear. There was peeling paint on some skirting boards and damage to walls and skirting from wheelchairs. There was damage to a toilet door which had a hole in it. Carpets varied in condition with some areas in need of attention. There was other minor damage to vinyl flooring in a bathroom was marked and damaged with tape used to hold it together. The registered manager was aware of these defects and confirmed they were included in the rolling maintenance programme. On one of the landings a significant length of the hall corridor carpet was worn which exposed the carpet grip. This meant the carpet was not fully secure and could become rucked which could be a trip hazard. In a number of other areas carpet edging was held intact with tape. Following the inspection the provider confirmed that there was a plan with timescales to replace the damaged hall and stair carpet.

Requires Improvement

Is the service caring?

Our findings

Whilst people said staff respected their privacy by knocking on their bedroom doors before entering, we observed two staff entered a person's bedroom without knocking or saying they were coming in. This was an isolated example as we also observed staff knocking and waiting before going into people's rooms. This is an area which needs attention.
The registered manager told us people were able to have a key to their bedroom door for privacy if they wished but this was not assessed or recorded. The registered manager said one person chose to have a key to their bedroom door but this was not of a type that would allow staff access in an emergency or allow the person to leave in an emergency. We were concerned that this person said they put an armchair across their bedroom door until bedtime to prevent people coming into their room. A suitable privacy lock could prevent this practice and make the person feel safe without compromising their safe exit in the event of an emergency. Following the inspection the registered manager confirmed this was discussed with people and that the person in question would be supplied with a suitable lock. The registered manager also confirmed this facility would be offered to other people.
At the time of the inspection we noted each bedroom door had a glass panel and there was venetian blind inside the door so people could have privacy. However, several of these did not work properly and compromised the privacy of people. For example, in two bedrooms we noted three of the venetian blind slats were folded back which allowed staff, visitors or people to see in. One blind closed at the top but not the bottom thereby allowing people to look in. We noted some of the blinds were partially raised which also did not give sufficient privacy. One person was visible from the corridor in a state of undress in their room as the blind was not closed properly. A staff member said the blinds were usually closed and added replacement blinds were needed. The registered manager said people were able to choose if they wanted their blind open so staff could check on them at night. This was not recorded in care plans and we observed the blinds did not give people sufficient privacy in the day time. The registered manager also said the blinds were usually kept closed for people's privacy and dignity but this was not our observation on the day of the inspection. We asked people what they thought of the blinds. One person said they did not need their blinds closed and said staff did not ask them if they wanted them closed at night. Another person commented, "I don't worry about them. It varies if they're open or closed." The registered manager and staff were aware that the blinds compromised people's privacy and took action following the inspection to remove the blinds and to cover door windows to ensure people had privacy.

People told us the staff treated them well. For example, one person said, "There's a good relationship between us and the staff. I find if you treat people with respect you will get it in return."
We spoke to the registered manager about people being able to have a choice of gender of the staff providing personal care. The registered manager said people were able to choose but there was no record of this being asked of people to ensure their preferences were respected. We asked one person about this and they replied, "I prefer female carers. At night there's one of each. I'm used to it now."

People said they were able to choose how they spent their time. For example, one person said , "We get up when we're ready, they don't call us." People also commented on the kindness and caring nature of the staff. For example, one person said, "They really do care for us here." A relative said staff dealt with people's

behaviour well, "They are so kind and patient to everyone. If someone keeps asking the same questions because they are confused the staff always listen and answer politely." People said the staff supported them emotionally. For example, one person said, "I get fed up sometimes but they are very kind and considerate."

We observed staff interacting with people. Staff spoke to people politely, listened to what people asked and responded appropriately. Where people needed help to eat staff did this in a way which made people feel they mattered by talking to them and making eye contact.

Staff demonstrated they had values of compassion and valuing the people they looked after. Staff told us of the importance of listening to people and being emotionally supportive. Staff said they treated people in the same way they would treat a member of their own family. We observed staff were cheerful with people and they told us they liked to have a good rapport with people. A relative and a health care professional said there was a family atmosphere at the home.

A relative said they were always made to feel welcome at the home and could visit when they wanted.

People said they were consulted about their care and we observed staff asking people how they would like to be helped. We noted that care plans included details about people's preferences, likes and dislikes. However, it was not clear that people were fully involved in decisions about their care as there was a lack of information to show the person was fully involved and consulted such as a record of their agreement. This is an area for improvement.

The service is registered with the Gold Standards Framework for accreditation for high quality care at the end of people's lives. We saw people had a care plan regarding their preferences for their end of life care. A health and social care professional told us the end of life care plans were of a good standard and that staff followed the care plans in ensuring people received the right care.

Good

Is the service responsive?

Our findings

People said they received the care they needed and that staff were responsive to their needs. For example, one person said, "I'm really happy here. We get plenty of entertainment and things to do.
We go out on a bus, it can take 2 wheelchairs and 5 or 6 walkers. I enjoy the shopping trips to Asda, Morrisons and Tesco." Another person said, "It's very good, excellent. I couldn't ask for better. They look after me very well."

Health care professionals told us the staff met people's care needs and worked with them to meet people's changing needs. A relative said the care was good adding, "The care is great. Whatever I ask is done."

Each person had a care plan and assessments of their needs. These showed people's needs were assessed before they were admitted to the home. This enabled the staff to assess if people's needs could be met and what the arrangements for meeting their needs should be. Care needs were assessed and there were care plans of how those needs were to be met. The assessments and care plans covered needs such as communication, continence, personal care, sleeping, mental health and spiritual needs. Care records showed specific needs were monitored and changes made when needs changed. Care records also showed people's social and recreational needs were assessed. For example, there was a section called 'This Is Me' which included details about people's lifestyle preferences. Each person had an activities care plan with details of how recreational needs were met. The Safe section of this report highlights the lack of accurate assessments regarding the moving and handling of people.

The service employed an activities coordinator from 9am to 4pm four days of the week. The registered manager and activities coordinator said there were plans to increase the provision of the activities coordinator to seven days a week. A weekly activities programme was displayed, which showed a range of activities on each day including weekends. People confirmed they received a copy of the activities programme. This included one to one sessions with the activities coordinator and individual people, exercises, singing, bingo and board games. The activities coordinator said there were a range of activities for people and that the activities were based on what people wanted to do. Entertainment was also provided by external musicians and artistes. We observed activities taking place in the lounge.

The complaints procedure was provided to each person in a service users' guide, which was in each person's room. People said they would approach the manager if they had a complaint and that any issues were dealt with. For example, one person said, "I spoke to the deputy manager and made a written complaint. They saw to it straight away. The manager has said, any complaints 'come to me, don't store things up."

A record of complaints was maintained which showed two complaints were investigated and there was a record of a response to the complainant in line with the provider's policy.

Requires Improvement

Is the service well-led?

Our findings

Care providers are required to notify the Commission of certain incidents which occur including when people die whilst living at the home and the circumstances of the death. For the year preceding the inspection the provider had notified us of two deaths but the registered manager confirmed there were eight deaths. The provider had not notified the Commission of all the deaths of people at the service. This was a breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009.

People said they were consulted about the running of the service such as the residents' meetings. For example, one person said, "Tomorrow afternoon is the tenants' meeting. The majority haven't got the courage to speak up. I shall go to the meeting. In the past I've brought things up, I think they discuss the problems and act accordingly." A relative also said they had good communication with the management and felt able to raise any issue they had. This relative also confirmed they were given a satisfaction survey questionnaire to complete.

Health care professionals described the service as being well managed and that staff worked well to ensure there was joint working to meet people's needs. Professionals and a relative described the management as approachable. The relative described the registered manager as friendly, polite and attentive. A professional said they had noticed improvements in the way the service was managed. A professional also described the ethos of the home as being "like a family."

People's, relatives, professionals and staff views were sought regarding the quality of the service. These showed people felt they were treated well by the staff. Professionals also gave positive comments in the surveys regarding the quality of care. Records were maintained of residents' meetings where subjects such as the food and activities were discussed. These records also showed suggestions for improvement were made to meet people's wishes.

The service had a structured management of a registered manager, a deputy manager, senior care staff and care staff. Staff said they felt supported and were able to raise any queries with their line manager. Staff confirmed they attended staff meetings where they could discuss their work and the running of the home. Staff reported they worked well as a team.

There were a number of audits and checks regarding the safety and quality of the service. These showed any incident or accidents were looked into and actions recorded of any changes which were needed to prevent a reoccurrence. Records were maintained of falls to people to determine any patterns. A number of audits were also carried out such as regarding any complaints, health and safety in the home and medicines procedures. The provider also carried out a monthly audit visit and prepared a report on the findings as well as an annual audit. Audits of the environment were also carried out and there were maintenance plans to address any defects.

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 Treatment of disease, disorder or injury	Regulation 16 Registration Regulations 2009 Notification of death of a person who uses services The provider had not notified the Commission of the death of people and the circumstances of the death. Regulation 16 (1) (a) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured care and treatment was provided in a safe way. Risks to people were not adequately assessed and appropriate action taken to mitigate those risks. Regulation 12 (1) (2) (a) (b) (c) (e)