HC-One Limited

# Aspen Court Nursing Home

**Inspection report**

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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? | Requires improvement |
| Is the service responsive? | Requires improvement |
| Is the service well-led? | Requires improvement |

## Overall summary

The inspection took place on 14, 15 and 17 April 2015 and was unannounced. At the last inspection on the 15 April 2014 we found the provider was not meeting the regulations in relation to care and welfare such as the management of medicines and consent. Following the inspection the provider sent us an action plan telling us how they were going to address the shortfalls.

During this inspection we found that the provider had not made all necessary improvements with regard to the management of risk.

The provider had made strides to comply with legal requirements contained in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards but required improvements to obtain people's consent.

Aspen Court Nursing Home provides personal and nursing care for up to 72 older people, many of whom also have dementia.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

# Summary of findings

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 found the service was not safe with the majority of concerns found on the nursing unit. Records demonstrated that the provider did not deploy sufficient staff at the service to meet people's needs. We reviewed the payroll for 2015 to date and noted there were routinely less staff on shift than required under the provider's procedures. The rota was irregular with staff working excessively long hours and shift patterns.

Medicines were not administered, stored or disposed of safely. Furthermore records were not completed accurately. We noted that morning medicine rounds finished late and people were at risk at receiving medicines at the wrong time and without a sufficient gap between doses.

The control and prevention of infections was not always well managed, for example, we observed bathrooms on the nursing unit were unclean but the residential units were clean and staff had completed barrier nursing training.

Staff had a good understanding of how to safeguard people from abuse, however, they were not supported to whistleblow or raise concerns to external agencies.

People were not protected from risks to their health and wellbeing because the provider did not have an effective system to identify and mitigate risks to people's safety.

Accidents and incidents were well managed and we reviewed action plans that were used to reduce the likelihood of the event occurring again.

The provider supported people who whose behaviour may have challenged others. Staff demonstrated an awareness of how to defuse such situations.

The provider had a robust recruitment system which meant the staff were suitable to work with the people using the service.

Staff had a good understanding of the principles of the Mental Capacity Act 2005. The provider had worked hard to submit Deprivation of Liberty Safeguards applications to the local authority when people's liberty was restricted to protect their safety. However, staff were not always supported to carry out care tasks in line with someone's best interests because representatives were not always consulted and care plans did not always contain sufficient guidance.

People were at risk of poor nutritional intake because the provider did not always monitor that people were eating and drinking enough or receiving supplements as required.

The provider had good links with healthcare professionals and referrals were made in a timely manner. Care staff received specialist training to meet people's needs. However, clinical staff required further training in areas such as catheter care to meet people's needs effectively.

Some staff had developed caring relations with people and we observed positive interactions between staff and people using the service. However, at times we observed staff talking to each other rather than focussing on supporting the people for whom they cared. People were not always supported to make choices about day-to-day care tasks such as what food to eat.

The provider developed care plans based on clear and detailed assessments of people's needs and preferences. These plans were updated following incidents to ensure staff responded to their changing needs. However, routine reviews of care plans did not always take place and time constraints meant staff were not able to respond to people's emotional needs by spending extra time with people who were receiving end of life care.

People were able to take part in day-to-day activities at the services and celebrate festivals. However, a lack of human resources meant outdoor activities were limited.

Complaints were dealt with effectively when raised by relatives or healthcare professionals. However, formal methods to elicit the views of people using the service were not utilised effectively to form a basis of service delivery.

The provider did not always promote a positive culture because staff were not always supported to express their views about service improvement. We found there were discrepancies in quality of care between the units which had not been identified demonstrating the service was

# Summary of findings

not set up to consistently promote good quality care. The registered manager did, however, make daily walks around the service and seemed to know the people using the service well.

We found six breaches of the regulations relating to consent, staffing, medicine management, safe care and treatment, infection control and good governance. You can see what action we told the provider to take at the back of the full version of the report. We have made a recommendation about supporting people to partake in hobbies in the community.

# 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**

The service was not safe. Staffing levels were inadequate and medicines were not administered or stored safely.

Risks to people's safety and the control of infections were not managed safely.

Incidents and accidents and behaviour which may challenge others were well managed and action plans drawn up to support the person concerned.

**Is the service effective?**

**Requires improvement**

The service was not always effective. The provider could not always be assured that people were having enough to eat and drink because records were not completed accurately.

Staff on the nursing unit were not always supported to receive the specialist training to meet care needs. However, a comprehensive training system was in place for care staff.

Consent to day-to-day care tasks was not always obtained where appropriate. However, the provider had undertaken a large piece of work to assess people's mental capacity and submit Deprivation of Liberty Safeguards applications where appropriate.

**Is the service caring?**

**Requires improvement**

The service was not always caring. People's dignity was not always maintained and we observed staff talking with each other at times rather than focussing on the people they support.

We did observe some compassionate interactions between staff and people using the service and at times care had been taken to communicate effectively with people who could not be readily understood. Staff took care to respect people's privacy.

**Is the service responsive?**

**Requires improvement**

The service was not always responsive. People's care files were not always reviewed on a regular basis and were not always based on the views of people using the service or their representatives. People were not supported to take part in hobbies outside of the service.

The level of care or support was reviewed following accidents as appropriate and there were a number of activities people could be involved in at the service.

# Summary of findings

**Is the service well-led?**

The service was not always well led. The management structure was not robust and communication amongst staff required improvement. Quality monitoring systems were in place and at times impacted positively on service delivery. However these systems were not effective enough as they did not always pick up on problem areas or lead to service improvement

Incidents and accidents were well recorded.

**Requires improvement**

# Aspen Court Nursing Home

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 14, 15 and 17 April 2015 and was unannounced. The inspection was conducted by two inspectors, a nurse 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, specifically dementia care.

Before the inspection we reviewed the information we held about the service and statutory notifications received.

During the inspection we used a number of different methods to help us understand the experiences of people supported by the service.

We talked with 10 people using the service and seven relatives. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with a visiting healthcare professional and the local authority safeguarding team to obtain their views about the service.

We spoke with the registered manager, the deputy manager, the administrator, five care workers, three nurses and six auxiliary staff members.

We looked at 10 people's care records in detail, six staff files, as well as records relating to the management of the service.

Following the inspection we spoke with one other healthcare professional.

Inadequate

# Is the service safe?

## Our findings

The provider did not deploy sufficient staff with the rights skills and experience throughout the service to meet people's needs. Relatives reported inadequate staffing levels stating, "Generally 80 per cent of the staff are great. They do their best with the resources they have, but staff numbers are stretched." The manager told us staffing levels were based on a standard ratio of 5:1 on residential units and 5:2 on the nursing floor rather than based on the level of people's needs. However, payroll records showed there was routinely not even enough staff to meet the provider's staff ratio.

Healthcare professionals stated staff were "over-stretched" and permanent staff had to work extra shifts which caused problems with the rota. This impacted on follow-up care received by people and often duplicated work. Some staff were working exceptionally long days without a break and in 2015 one clinical staff member had worked more than 60 hours per week on three occasions and on three occasions clinical staff had been scheduled to be on duty for 24 hours.

Staff we spoke with reported additional clinical support was required because the current levels were "dangerous" and "unsafe". They stated they were prioritising between different care tasks and not all were being completed. We observed that staff were rushed and carrying out multiple tasks concurrently. For example, conducting the medicines round and calling the GP. We observed one person not getting the assistance they required during lunch for 10 minutes because staff were busy assisting other people who were eating in their rooms. This meant people may not have received the level of care of support they required to maintain their safety or wellbeing.

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

Medicines were not managed safely. There was unsafe administration of medicines on the second floor. We found the morning medicines round finished at 11:45 on the first day of our inspection. We discussed this issue with a member of the clinical team. They stated the 08.00 medicines round finished between 10.00 and 11.00 routinely. Five people needed their medicines crushed, and others had difficulty swallowing so needed time and encouragement with their medicines. Staff thought they did not have enough time to administer medicines at the correct time and complete all other duties.

Records were completed inaccurately. For example, the medicines due at 08.00 were signed for on the medicine administration records (MAR) as though they had been given on time on the first day of our inspection. Therefore some of these people may have been placed at risk of harm by receiving their next dose due at 12.00 without an adequate time interval in-between doses. This was critical as someone had medicine for Parkinson's disease and one person was prescribed insulin. People were also at risk of being left in pain as their analgesia was administered late.

Controlled drugs were not managed safely because they were not always stored in a locked cupboard as required by law. We asked for these to be moved into the CD cupboard on the day and this was done. Not all medicines had been administered as prescribed. For example, an antibiotic suspension could not have been administered as prescribed in February 2015, as almost half of the amount dispensed was found in the disposal bin, although all doses had been signed for on the MAR.

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

People were kept safe by staff who could recognise signs of potential abuse and knew what to do when safeguarding concerns were identified. People told us, "I do really feel safe" and "Dad likes to come back here". Staff were clear they would report suspected abuse to the registered manager immediately and 98.5% of staff had completed relevant training and were supported by a policy document that listed different types of abuse. There were accurate records of safeguarding cases with correlating action plans to improve the safety for individuals.

However, people were not protected from the risk of systemic poor practice because staff were not supported to escalate concerns beyond the provider. The whistleblowing procedure did not include contact details for the local authority safeguarding team or the Care Quality Commission to guide staff. One member of staff who knew they should escalate concerns if they were not dealt with satisfactorily within the service told us they could not find the numbers to call. Two members of staff told us they had raised concerns about inadequate staffing levels with

Inadequate

# Is the service safe?

"head office" but they felt these had not been dealt with satisfactorily and they had not raised this with anyone outside of the service. No record of these concerns were produced during the inspection so the service could not evidence they had acted on these concerns.

People were not protected from risks to their health and wellbeing. We saw risk assessments relating to nutrition, continence, falls, moving and handling, Waterlow and dehydration in people's care files. However, we found several areas of concern. For example, care plans did not always reflect the risk assessments, one care plan detailed that the dietitian was to be contacted if the person's weight reduced, however, the risk assessment stated the person was already on supplements. One person was blind and had a hearing impairment but this was not considered in their moving and handling care plan. We found that risk levels were inaccurate. The level of risk to someone was calculated inaccurately and meant there were times when people were recorded as low risk in their environment whereas they were actually at medium risk. Records were dated incorrectly. One risk assessment predated someone's admission to the service and risk assessments did not provide sufficient detail for staff. For example, one instructed staff to 'monitor for signs of hypo/hyper glycaemia and to be managed promptly' it did not record what to specifically look out for or what action must be taken to minimise the risk to that individual

The control and prevention of infections was not well managed across the service. On the nursing floor, we observed three en suite bathrooms that had unclean sinks and floors. One bathroom that was set for refurbishment and meant to be locked was in use. There was a four inch brown stain on the bath hoist and black grit in the bath. In another bathroom we found the chair that was used to transport people to the bathroom had a large brown stain underneath.

Staff were seen walking around wearing gloves but no aprons were observed being used during the morning when personal care was being provided. Gloves were disposed of in pedal bins in people's rooms that did not have a bin liner in them. None of these issues were identified in an infection control audit tat had taken place shortly before our inspection. Policies and procedures were in place to guide staff, however, staff we spoke with did not know where they were kept and could not refer to them. We did note that senior staff had barrier nursing training.

The issues above relate to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks during a potential emergency were managed adequately because staff understood how to support people in the event of a fire or medical emergency. The fire risk assessment was discussed at a team meeting. Personal Evacuation Plans provided some guidance to staff about what support individuals needed to evacuate the building during an emergency, although information about people's behaviour or communication needs were not included. Routine fire drills took place.

The service took action to improve safety for people who had been involved in an accident or incident The service monitored such occasions and created detailed action plans to reduce the likelihood of it happening again, for example in the case of a fall. We noted that following an incident referrals were made to the relevant healthcare professional and the family were informed in a timely manner. A falls committee had been assembled to produce an action plan for people. However, we did observe people wearing unsupportive footwear which may have put them at risk of falling.

The provider supported people whose behaviour may have challenged others. Relatives were satisfied with the approach of the service stating, "They seem to know how to cope with [them]. They work really hard here to look after [them]." Staff had a good understanding of individuals' "flash points" and we observed staff defusing situations using distraction techniques. They demonstrated an awareness of health conditions that may have an impact on people's behaviour such as dementia and infections. There was evidence they investigated the root cause of behaviour changes to best support the people they cared for.

A thorough recruitment system meant people were supported by staff who were suitable for work in the caring profession. We reviewed six staff files that contained criminal record checks, application forms, interview records, proof of right their to work in the UK, and two references. Where nursing staff were employed, the service checked they were registered to practice as qualified nurses.

Requires improvement

# Is the service effective?

## Our findings

The Mental Capacity Act 2005 (MCA) provides the legal framework to protect and support people who do not have the capacity to make specific decisions. The provider carried out mental capacity assessments when required under the MCA. Care staff had completed training and had a basic understanding of the principles of the Act. For example, they knew some people could consent to or refuse certain care tasks but not others. However, in practice, we observed that people's consent was not always obtained where possible. For example, during lunch time people were not supported to consent to wearing aprons.

The Deprivation of Liberty Safeguards (DoLS) ensure that any restriction on a person's liberty is in their best interests. The provider had formed a small committee to oversee this work and they had worked hard to meet the legal requirements. They had submitted DoLS applications for people who could not consent to restrictions on their liberty, such as not leaving the service without a member of staff accompanying them. The local authority had approved the vast majority of applications. We noted that a best interests assessor attended the service on the first day of our inspection and we found all relevant paper work was held in people's care files. Care staff had a basic understanding of the legal framework.

However, care plans did not always provide guidance about how to act in peoples' best interests. For example they included phrases such as, "because of lack of capacity staff should act in her best interests." However, there was no guidance about what action that might have been to ensure that people's rights were protected and their needs met.

Records demonstrated that, in practice, people's consent to care was not always obtained. The provider had not consistently obtained views from a person's representative before care tasks were carried out. For example, three care plans reviewed did not evidence involvement from a representative and in one instance an Independent Mental Capacity Advocate had not been involved in a decision about how to spend a person's money.

At our last inspection the provider had not obtained consent to bed rails from representatives. We noted that one bed rail form had not been signed by a representative to evidence their involvement in the decision making process.

The issues above relate to a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk of poor nutritional intake because the provider did not always monitor that people were eating and drinking enough. For example, we noted that the dietitian had directed people to be given a snack but, other than on one occasion, this had not been recorded as offered. For one person who had lost weight the dietitian had instructed that a whole pint of milk was to be given daily and they were to be weighed weekly. The fluid chart was being completed, however, over the last 2 days there was no record of milk being given and there was no evidence that the person's weight was monitored weekly.

Feedback about the quality of food was inconsistent and two people felt the food didn't meet their cultural needs. However, relatives felt there were plenty of snacks and drinks available. We observed tea, water and squash being offered throughout the inspection and two people who did not eat a main meal were offered a fortified drink by staff. A new chef had been appointed who had a good understanding of people's preferences.

The provider did not fully support people to maintain good health. Follow up observations for people who were experiencing ill-health were not always completed putting them at risk of not receiving necessary treatment. Records did not always contain detailed guidance for staff about how to manage people's medical conditions. For example, one person had a diagnosis of depression but there was no information in the care plan about how to support them.

Positively, people had good access to healthcare services for ongoing support. Good working partnerships had been developed with the local GP, dietitians and speech and language therapists. A palliative care nurse visited during the inspection who felt healthcare professionals were involved adequately in people's care and treatment.

The provider did not always ensure staff were trained to meet peoples' needs. For example, there was an over-reliance on the GP to change catheter bags because

Requires improvement

# Is the service effective?

staff nurses were not trained to do so. Senior staff expressed concern that more newly qualified members of the clinical team were not inducted and supported adequately to fulfil their roles.

Conversely, care staff understood people's specific care needs and the provider had established links with an external organisation to ensure they received specialist training in areas such as dementia awareness. An e-learning ambassador had been appointed to guide staff through training modules and most of the staff had completed this mandatory training. Care staff discussed their professional development in one to one supervision meetings and annual appraisals that were designed to support staff to carry out their roles effectively in line with the provider's policies and procedures.

Requires improvement

# Is the service caring?

## Our findings

We found some staff had developed caring relationships with people using the service. People told us, "Some of the staff are very nice. They look after me ok. There is no-one nasty to me and at night it's OK." A relative spoke warmly about the relationship between their family member and their keyworker, "[My relative] calls her 'the boss'…she brightens up [their] day." Staff were able to describe people's backgrounds and were guided by care plans that contained 'easy glance sheets' with essential information about people such as their nicknames.

We spent some time in communal areas and observed the care provided to people and their interactions with staff. We saw that at times staff were respectful and spoke with people kindly. We saw staff trying to help people when they were distressed and hold their hand or dance with them. Staff implemented 'butterfly moments' whereby they made sure to promote a different person's wellbeing each day. However, at times staff were not attentive to people. For example, staff often sat next to each other in the lounge and we heard them discussing a "night out" with each other during the lunch service rather than creating a warm atmosphere for people using the service. Another member of staff who was accompanying three people in the garden was texting on their personal mobile telephone and not interacting with people in the garden.

The provider often involved people in their care options but was inconsistent in their approach. There was evidence that at times care had been taken to communicate effectively with people to elicit their views. For example, a person who spoke Spanish was supported by a member of staff who was fluent in Spanish. The provider ensured they were always scheduled to work on the same floor as this person. One person told us how the staff knew about their bathing preferences and supported them well.

However, this approach was not consistent; we observed that consent was not always obtained before tasks were carried out. Staff did not always include people in conversations about what they wanted to do nor did they always explain all activities prior to them taking place. For example, people were not asked if they would like to wear an apron during lunch time nor were they informed of what was happening to them when they were put on.

People's views about their end of life care were not always sought. For example, there was not a care planning document in a person's care file. Another was not completed and areas such as their preference to be cremated or buried, were left blank. On two occasions we saw people were not supported to change their tops which had large stains on them from an earlier meal meaning their dignity was not maintained.

People's privacy was preserved. Staff understood how to promote privacy such as knocking on doors before entering. One person's wish not to divulge personal information about themselves was respected.

Requires improvement

# Is the service responsive?

## Our findings

People were supported by staff who had a good understanding of how to provide care that was personalised for an individual's needs. Care plans contained guidance about people's needs, choices and preferences. The provider operated a keyworker system that enabled staff to develop a deeper understanding of a person's needs. Staff spoke knowledgeably about people's care and were aware of their diverse needs. For example, we noted that it had been arranged for one person to have their meal in their room because they had expressed a wish to have a "quieter meal time".

However, staff felt they were not able to respond effectively to people's needs as they did not have enough time to provide emotional support to those they knew required it. For example, for those who were receiving end of life care or who were unwell.

We reviewed assessments of need that had been carried out prior to admission at the service. These were detailed and clear and included people's preferences, such as types of toiletries and bathing options. The assessments formed the basis of the care plans. As soon as someone arrived at the home, a seven day care plan was drafted to be followed whilst a more in-depth version was created.

Care was not always responsive to people's changing needs. While people who had capacity to make decisions about their care were involved in their care planning and had signed their care plan, those without capacity were not involved as much as possible. Care plans and assessments were not always signed by a representative to evidence involvement. One care plan was scheduled to be reviewed per day; however, this was not always possible given limited time available for staff to dedicate to this task. Staff handovers between shifts were held but food and fluid intake was not included so there was a risk staff would not be aware of who needed to be encouraged to maintain adequate intake.

Following incidents needs were reassessed and care plans were updated to reflect any change of need. For example, one had been updated so staff knew how to support someone to move around the service following a fall.

Although people were supported to take part in indoor activities resources were not sufficient to help people maintain their interests and integration with the wider community. The activities coordinator had left recently and a member of care staff was undertaking a dual function to cover the position until the provider could recruit someone into the role. There had been a Christmas party at a hotel and a person who had requested a trip to buy a new outfit for the event had been supported to go shopping. A member of staff explained that when another person had heard that someone had been able to go out they were "upset as [they] wanted to go out". This person had asked every day until they were supported to go to a pie and mash restaurant which they had enjoyed. Staff explained that there were not enough staff to organise many trips and we noted that only the one trip to the pie and mash restaurant had occurred in 2015 to date. One staff member said, "Most just get a trip to the garden in all honesty".

During our visit we observed people having their hair styled and making cards. There was also a bar called the Ark on site and we were told that one person liked to spend time there during the evening. We saw that activities for special days such as St George's day and birthdays had been planned.

The provider had made some inroads into listening to concerns of relatives. The Relatives we spoke with felt they could make a complaint to the manager if they needed. One said, "I speak to anyone in charge if I'm worried." There was a clear complaints procedure and complaints monitoring system utilised by the provider. For example we saw complaints that were followed up and dealt with to the satisfaction of the family member or healthcare professional. Associated action plans were drafted to implement any required improvements. Family members had sent the staff complimentary cards that were displayed in a communal area.

However, formal systems to gather people's views to help develop the service were not effective. We noted that resident meetings where people had the opportunity to discuss their experiences had not taken place for four months prior to our visit.

**We recommend that the provider seek advice and guidance from a reputable source about supporting people to maintain their interests in activities in the community.**

Requires improvement

# Is the service well-led?

## Our findings

Feedback from staff and relatives about the culture of the service was inconsistent. Care staff expressed they felt supported by the provider and were able to raise queries or concerns to the registered manager directly on a day-to-day basis and at supervisions. Some relatives were satisfied with the response of the registered manager about any issues raised. However, some relatives were hesitant to discuss the culture at the service and not all staff felt their concerns were taken seriously by the provider and acted upon. For example, concerns raised in relation to staffing levels were not deemed to have been dealt with satisfactorily by those who raised them.

Teams were not always supported to feedback their views. There were no records that unit or full team meetings were held on a regular basis for staff where they could discuss their experiences and input into the delivery of the service as a whole. A healthcare professional stated that communication between staff needed improvement. We noted there was evidence that meetings were held if something unusual had occurred such as when the lift was to be repaired and committees were formed where a long term piece of work needed to be completed such as submitting Deprivation of Liberty Safeguards applications. Handovers between staff happened every day.

We noted the registered manager made daily walks around the service and knew people and their relatives by name suggesting she knew people well. However, the service did not always demonstrate good leadership. Relatives of people living at the service stated “the management is not up to standard. There is no organisation”. The management structure included the position of deputy manager, however, we noted the person who was employed to fulfil this role was being taken out of position and routinely working on the nursing floor. This breakdown in the structure meant other members of staff were taking on additional responsibilities and there was a lack of comprehensive oversight of the service as a whole.

We found that the registered manager had implemented the provider’s new management system and had completed a number of quality audits including, medicine stock audits, internal inspections, daily audits, care plan audits, care bell audits and infection control audits.

However, these audits either did not identify all the issues we found, such as concerns with risk assessments. Where areas had been identified for improvements these had not all been rectified. For example, concerns with medicines had been found in both a previous internal inspection and an external inspection by the Clinical Commissioning Group however these had not been rectified and we found similar issues at our inspection.

We found that there were discrepancies in the quality of care between the three units at the service which may have been identified and rectified by a more robust quality monitoring system being implemented by a cohesive management team.

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

Accidents and incidents were well documented by staff. Details recorded information such as the person involved and location and all those involved in a person’s follow up care. This information was electronically recorded, and used to identify trends.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA (RA) Regulations 2014 Need for consent<br><br>Care and treatment of service users was not always provided with the consent of the relevant person. Regulation 11(1) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>Systems were not established or operated effectively to assess, monitor and improve the quality and safety of the services provided nor did they assess and mitigate the risks relating the safety and welfare of service users. Regulation 17(1)(a) and (b) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>The provider did not prevent the risk of the spread of infections. Regulation 12(2)(h) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>The provider did not assess all risks to the safety of service users and did not do all that was reasonably practicable to mitigate all risks. Regulation 12(2)(a) and (b) |

This section is primarily information for the provider

# Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>**Sufficient numbers of suitably experiences persons were not deployed. Regulation 18(1)** |

| Regulated activity | Regulation |
| --- | --- |
| | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>**Medicines were not managed safely. Regulation 12(2)(g)** |