HC-One Limited

Catherine House General Nursing Home

Inspection report

Cork Street
Frome
Somerset
BA11 1BL
Tel: 01373 451455
Website: www.hc-one.co.uk

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Good**
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

Catherine House General Nursing Home provides accommodation for up to 67 people who need nursing care. The home mainly provides care for older people who are living with dementia. The home is a large, purpose built property. Accommodation is arranged over four floors, although only two floors are currently in use. There is a passenger lift to assist people to get to the upper floors. There were 44 people living at the home at the time of our inspection.

This was an unannounced inspection, carried out over two days on 8 and 12 December 2014. During our inspection we spoke with seven people who lived in the home, 13 visitors, two registered nurses, six care staff, one activity coordinator, two members of catering staff, one GP, the deputy operations manager and the acting manager. There was no registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to

Summary of findings

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 and associated Regulations about how the service is run.

We carried out an inspection of Catherine House General Nursing Home in July 2014. Following this inspection we took enforcement action to ensure the provider took urgent action to make improvements to cleanliness and infection control. We also asked the provider to make improvements to the care people received and to their care records, improvements in how staff obtained consent from people or their legal representatives and staff training support and supervision. Improvements were needed in how the service responded to people's views concerns or complaints and how the service reported significant events to us.

Following the inspection in July 2014 the provider sent us an action plan to tell us the improvements they were going to make, which they would complete by 28 November 2014. We inspected the home on 17 September 2014 to follow up on the urgent improvements relating to cleanliness and infection control and found significant improvements had been made. During this latest inspection we looked to see if all of the other improvements had been made.

The service had improved in many areas since our last inspection. However, people still had mixed views about the service. While some people were happy, others were not. In addition, our own observations and the records we looked at did not always match the positive descriptions some people had given us.

Improvements were being overseen by an acting manager and the deputy operations director. One staff member said "We had absolutely no leadership before. Things are slowly changing and getting better."

People felt safe with all the staff who supported them. There were clear risk assessments which meant care was provided in a way that minimised risks. The provider checked staff were suitable to care for vulnerable before they commenced employment.

We found that people's care needs were assessed and care plans had been significantly improved. Consent was now sought from people or their legal representatives in accordance with the law. However, people's care was still not delivered consistently. There was a lack of consistent leadership on both floors where care was delivered. People did not always receive the support they needed to eat and drink. Mealtimes needed better organisation.

Although people told us they felt their privacy and dignity was respected and made positive comments about staff, we saw that care was sometimes based around completing tasks and did not take account of people's preferences. People's privacy was not always respected. We were concerned that some very frail people living at the home felt isolated as there was a lack of interaction with staff and were not enough meaningful activities for people to meet their individual needs.

Staff training, support and supervision had been significantly improved. The provider had introduced a daily meeting to improve communication and sharing of information between staff. One staff member told us "We have supervisions now and appraisals. We have had a lot more training. It's all a lot more organised now."

The process for monitoring the quality of the service had improved. People, and those close to them such as relatives, were now being involved in decisions about the running of the home as well as the care. Where people raised concerns or complaints, these were now taken seriously and responded to. All significant events were now reported to us in accordance with the law.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. The provider had systems in place to make sure people were protected from abuse and avoidable harm. People felt safe living at the home and with the staff who supported them.

Staff were aware of how to recognise and report signs of abuse. They were confident that action would be taken to make sure people were safe if they reported any concerns.

People were supported with their medicines in a safe way by staff who had appropriate training.

Is the service effective?

Requires Improvement

Some aspects of this service were not effective. People and those close to them were involved in their care but people were not always cared for in accordance with their preferences and choices. Staff support for people with meals and drinks varied.

People saw health and social care professionals when they needed to. However they did not always receive prompt care and treatment.

Staff received supervision, appraisals and on-going training to make sure they had the skills and knowledge to provide effective care to people.

Is the service caring?

Requires Improvement

Some aspects of this service were not caring. Staff were kind and compassionate but their care practice was inconsistent.

Care was sometimes based around completing tasks and did not take account of people's preferences. People's privacy was not always respected.

When people were confused or distressed, the staff managed it well.

People were supported to keep in touch with their friends and relations. They were involved in decisions about the running of the home as well as the care being provided.

Is the service responsive?

Requires Improvement

Some aspects of this service were not responsive. People did not always receive care and support which was responsive to their changing needs.

There was a lack of interaction between some people and staff and not enough meaningful activities to meet each person's individual needs.

People and those close to them were involved in planning and reviewing care. People shared their views on the care provided and on the home more generally. People's views and experiences were now used to improve the service.

Summary of findings

Is the service well-led?

The service was not consistently well led. The service had improved since our last inspection, but was not providing consistently high quality care.

There were clearer lines of accountability and responsibility within the management team. However, there was a lack of consistent leadership on both floors where care was delivered.

There were quality assurance systems in place to make sure that the necessary improvements continued to be made.

Requires Improvement

Catherine House General 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.

We visited the home on 8 and 12 December 2014. Both visits were unannounced. On the first day the inspection team consisted of an inspector and an expert by experience. This is a person who has personal experience of using or caring for someone who uses this type of service. We focussed on speaking with people who lived at the home and their visitors, speaking with staff and observing how people were cared for. Two inspectors and the same expert by experience visited on the second day. The inspectors examined care records, staff records and records related to the running of the service.

During our inspection we spoke with seven people who lived in the home, 13 visitors, two registered nurses, six care staff, one activity coordinator, two members of catering staff, the acting manager, the deputy operations manager and one GP. We observed care and support in communal areas, spoke with some people in private and looked at the care records for eight people. We also looked at records that related to how the home was managed.

We used the Short Observational Framework for Inspection (SOFI) on the second day of our inspection. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Before our inspection we reviewed the information we held about the home. We reviewed the provider's action plan sent to us following the last inspection and notifications of incidents that the provider had sent us. We did not ask the provider to complete a Provider Information Return (PIR) prior to this inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Good

Is the service safe?

Our findings

People felt the home was a safe place for them to live. Each of the 13 visitors we spoke with said they thought the home was safe for their relative.

Staff had received training in safeguarding adults; the staff training records confirmed all staff had received this training. Staff had a good understanding of what may constitute abuse and how to report it, both within the home and to other agencies. The home had a policy which staff had read and there was information for staff about safeguarding and whistleblowing displayed in the home. Staff were confident that any allegations they reported would be fully investigated and action would be taken to make sure people were safe. Staff had recently reported one such incident. This had been referred to the local authority safeguarding team. One member of staff said "Yes, I do feel people are safe here."

The risk of abuse to people was minimised because the provider checked staff were suitable before they commenced employment. Staff personnel files showed that new staff were thoroughly checked to make sure they were suitable to work with vulnerable adults and had the appropriate skills to support people safely. One new member of staff told us "all of these checks had been carried out on me" before they could start work in the home.

People were able to take risks as part of their day to day lives. For example if people were independently mobile they could wander safely in the home. There were risk assessments relating to the running of the service and people's individual care. The risk assessments identified risks and gave information about how these were minimised to ensure people remained safe. Two people's assessments rated them as high risk of malnutrition; their care plans said each person should be weighed weekly. Records confirmed both people had been weighed each week; one person had gained weight.

People were supported by staffing numbers which ensured their safety. Staffing numbers were determined using a dependency tool; people's dependency levels had been reassessed by the acting manager since our last inspection.

People used both communal areas of the home and their own rooms. When people used their own rooms and they were unable to use a call bell to summon staff, their care records stated that staff should check on them hourly. Staff had signed to confirm these checks had taken place. When people used their call bells these were answered promptly. One member of staff said "Staffing has really improved and we are minimising the use of agency; it's much better than it was."

Nurses and senior carers gave medicines to people. They were trained and had their competency assessed before they were able to do so. Medicine administration records showed that medicines were signed for when received from the pharmacy and when they were administered or refused. This gave a clear audit trail and enabled the staff to know what medicines were on the premises. There were adequate storage facilities for medicines including those that required refrigeration or additional security. A staff member from the pharmacy had carried out a medicines audit on 18 November 2014. They concluded medicines administration was "excellent, with vast improvements."

We saw medicines being given to people on both days of our inspection. Staff giving medicines explained the medicines administration procedures to us and demonstrated a good knowledge of how to maintain safety when storing and disposing of medicines. The environment was very busy when staff were giving medicines to people. However, there was a risk staff could make errors if they were disturbed whilst giving people medicines because one staff member giving medicines said "it was hard to concentrate sometimes" and occasionally other staff or visitors may interrupt them. They said "staff would have to find someone else if they tried to interrupt" but "wasn't sure" what to do when a visitor did this.

We asked how people, visitors and other staff knew they were not to be disturbed whilst giving medicines, such as using a 'do not disturb' tabard. One staff member said they had "never heard of one of those and they didn't have them here" although we later we saw one of these tabards where medicines were stored. The staff member said they had "never seen staff wearing one" and "had not been told to wear one."

Requires Improvement

Is the service effective?

Our findings

Care records showed people saw professionals such as GPs, opticians, dentists and occupational therapists. Advice was sought from these professionals when people needed their input, although this was inconsistent. One person required support due to behaviours that were difficult for staff to manage. A psychiatric nurse had been contacted and was involved in their care; they had helped to write clear guidelines which explained how staff should support this person. In another person's record, staff had documented they were concerned about a change in behaviour. Staff had contacted the GP for advice on 5 December 2014 and had been told to complete a urine test. This was not carried out for a further five days. When it was completed it showed this person had an infection. The GP reviewed these results on the second day of our inspection. This meant that it took seven days for this person to be prescribed the antibiotics they needed which placed the person's health needs at risk

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There had been changes in the staff team since our last inspection, although a core of long standing, experienced staff remained. There were vacancies in the staff team which were covered by permanent staff working additional hours or by agency staff. Where possible, the same members of agency staff were used to provide consistency of staffing. Permanent staff spoken with had a good knowledge of people's needs and confirmed they felt they had the necessary knowledge to enable them to care for people. One relative said "The carer's are OK and have the skills." A GP said they felt staff knew people well.

People's nutritional needs were identified and monitored as part of the care planning process. Records of what people ate or drank were kept if they were at risk of malnutrition. However, there was a risk that records may not accurately reflect what people had eaten or drank. Most records had been completed; some had not. One staff member told us "We do sometimes have issues with care staff not completing the charts." They reminded staff to complete these records after speaking with us.

People told us that they enjoyed the meals, drinks and snacks provided. Although staff were kind and tried to provide the support people needed, mealtimes were an issue. One the first day of our inspection lunchtime was disorganised. The food served was different to the menu. A staff member who was serving food thought the chick pea casserole (one of the main meal options) were mixed vegetables and served this to everyone. The vanilla ice cream ran out and some people had to have another flavour. One staff member said about one person "She will just have to have strawberry as that is all that is left." One visitor said to a member of staff that their relative had not liked their meal. The staff member appeared dismissive and said "well, all the others enjoyed it." Another visitor said "staffing was hopeless at lunchtime."

On the second day of our inspection lunchtime was much more organised. The meals were as described on the menu. There were more staff to help people and some additional staff had stayed on after their planned training session had finished to help people with their meals. Both the acting manager and the deputy operations manager said they knew they needed to improve the mealtime experience for people further.

People were provided with drinks and snacks during the day. Staff support for people varied. Most people were served their drinks in plastic beakers. One person's plan said they could use a "normal glass or cup" but they were given a plastic beaker. Some staff sat with people, spoke with them and helped them in line with their care plan. Other staff stood over people, did not speak with them and left people, often with no explanation, whilst helping them. Three people who needed help and encouragement to drink were offered no support for over an hour after their drinks were served. Their drinks had gone cold by this time and their snacks remained uneaten. Support and encouragement was later offered by a visitor rather than a member of staff. Staff seemed unaware these people had not had their drinks or snacks.

When we inspected the service in July 2014, we asked the provider to improve staff training, support and supervision. The provider sent us an action plan, as requested, telling us they would make the required improvements by 28 November 2014. During this inspection, we checked to see if these had been made and found that they had.

Staff told us their induction was thorough when they started working at the home. One staff member told us "My induction was good. I met everyone and read about them."

Requires Improvement

Is the service effective?

Staff training and support had significantly improved since our last inspection. One staff member told us "We have supervisions now and appraisals. We have had a lot more training. It's all a lot more organised now."

Staff now received regular formal supervision and annual appraisals had been started to support staff in their professional development. There were regular staff meetings and a handover of important information when staff started each shift. Records showed that staff training had improved; where training still needed to be completed this had been planned. Staff had been provided with specific training to meet people's care needs, such as caring for people who had a dementia. Despite staff receiving this training, the mealtime experience for people living with dementia needed to be improved.

When we inspected the service in July 2014, we asked the provider to improve how staff obtained consent from people or their legal representatives. The provider sent us an action plan, as requested, telling us they would make the required improvements by 28 November 2014. During this inspection, we checked to see if these had been made and found that they had.

We discussed the Mental Capacity Act 2005 (MCA) with staff. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. Staff showed that they were knowledgeable about how to ensure the rights of people who were not able to make or to communicate their own decisions were protected. We looked at care records which showed that the principles of the Mental Capacity Act 2005 Code of Practice had been used when assessing an individual's ability to make a particular decision.

For example, some people were not able to make important decisions about their care due to living with dementia. Where people had someone to support them in relation to important decisions this was recorded in their care plan. Records showed that people's ability to make decisions had now been assessed. They showed the steps which had been taken to make sure people who knew the person and their circumstances well had been consulted to ensure decisions were made in their best interests, such as the care people were to receive when reaching the end of their lives.

The acting manager was knowledgeable about the Deprivation of Liberty Safeguards (DoLS). DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. The acting manager was in the process of completing and submitting DoLS applications for people who met the criteria following a recent court ruling. This ruling widened the criteria for where someone maybe considered to be deprived of their liberty. For example, external doors in the home were kept locked as some people would be at risk of harm if they left the home unaccompanied.

We recommend that the provider explores the relevant guidance on how to provide a good mealtime experience for people living with dementia.

Requires Improvement

Is the service caring?

Our findings

People had mixed views about the care provided at the home. We asked seven people if they were happy living at the home and they were able to confirm that they were. One person said they were "Very happy here. The staff are all very good to me." One visitor said "I am happy with the care"; a GP felt staff were kind and the nurses were very good. Another visitor, however, said when asked about the care "I can't see it getting better" and another told us "the care was sometimes not acceptable."

When we inspected the service in July 2014, we asked the provider to improve the care people received as people were not always receiving care which met their individual needs or preferences. We also observed variable staff care practice. The provider sent us an action plan, as requested, telling us they would make the required improvements by 28 November 2014. During this inspection, we checked to see if these had been made and found the care provided to people varied.

Staff were caring but their care practice was inconsistent. Some staff responded to people promptly when they needed care or support. They spoke to people in a respectful and caring way such as "You look nice today, I really like your jumper", "Shall I get you an extra top, you look cold" and "You are looking really well today." We saw many examples where staff focussed on the task rather than the person. We observed staff telling people they were "going to help them have a wash", rather than offering them any choice. One person asked a member of staff to help them back to their room from one of the lounges. The staff member said "ok, in a sec" but this person then remained in the lounge for over 30 minutes. They were then taken to the dining area rather than their room as it was lunchtime, but this was not explained to them.

Whilst staffing numbers appeared adequate, how staff spent their time and how they were deployed did not benefit people. On both days we observed people in communal areas who had no interaction with staff for long periods of time. People who were able to communicate verbally and request attention or assistance were usually responded to. One person who was very chatty was spoken to and shared a joke with every member of staff who passed through the lounge they sat in. Four other people who sat in the same lounge did not receive any attention at all from these staff members.

Staff views on the quality of care they provided varied. Some staff felt care had improved. Others felt it had not; these staff felt staffing levels were too low to provide consistently good care. One staff member said "You now feel you are achieving something. People seem happier." Another staff member told us "If we had more staff we could give quality care to residents. I never have time to spend with people. I'm too busy doing all the tasks."

Staff supported people who were confused or distressed in a sensitive way. One person had become agitated on the second day of our inspection. Staff spent time with this person and accompanied them to a quiet area. They sat and spoke with them and engaged them in conversation. This person was calmer when we saw them later in the day.

People were supported to keep in touch with their friends and relations. There were many visitors on both days of our inspection. Staff greeted each visitor and knew them by name. Visitors told us they were able to visit their relatives whenever they wanted. Some visitors came every day. They often stayed for long periods and helped their relative with meals and drinks during their visit.

All rooms at the home were used for single occupancy so people were able to spend time in private. Bedrooms had been personalised with people's belongings, such as photographs and ornaments to help people to feel at home. People's privacy was not always respected. Some staff knocked on people's doors before entering their room and waited for a response if they knew people were able to respond. However, one member of staff entered a person's room which was occupied. The staff member didn't knock, but opened the door and then said "knock, knock." On another occasion one staff member entered a person's room whilst they were speaking to one of the inspection team. This member of staff did not knock on the door before entering the room.

We recommend that the provider explores the relevant guidance on how to provide personalised care for people living with dementia.

Requires Improvement

Is the service responsive?

Our findings

We discussed daily routines with staff, in particular how people would choose to remain in bed. Many people remained in bed for long periods throughout both days of our inspection. One member of staff said "We rotate people, so if one person is up and in the lounge today, they will stay in bed tomorrow." Staff said they decided; they said they knew people got tired if they got up every day. We asked how staff knew whether to get someone up or not. One staff member said "I know because I was here yesterday, so I know which people I got up yesterday and therefore which ones need to stay in bed today". Staff spoken with clearly felt it was personalised care, although there had been four formal complaints since the last inspection from family members about their relatives remaining in bed during the day.

There were a variety of planned activities each day. Two staff members organised and led activity sessions. On the first day of our inspection a small group of people were involved in making Christmas hats. This was well organised and the staff member who led this session interacted well with people who attended and involved them all. They were positive and encouraging. Most activities continued to be held in communal areas on the first or second floors. There remained very little planned one to one time for people who did not wish to or were unable to participate in communal activities. Some relatives remained concerned about the lack of stimulation for people, particularly those who remained in their own rooms.

During our inspection people being nursed in their bedrooms had limited social stimulation or interaction. Some people who were in bed had their TV on, although when they clearly weren't watching TV, they were unable to turn it off. One person's care plan said they should have been "included and encouraged to take part in meaningful activities during the day". On the second day of the inspection, this person stayed in their room all day. Staff offered them drinks but there was no evidence of them being encouraged to engage in any activities.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

When we inspected the service in July 2014, we asked the provider to improve people's care records. The provider sent us an action plan, as requested, telling us they would make the required improvements by 28 November 2014. During this inspection, we checked to see if these had been made and found they had.

Care records confirmed each person's needs had been assessed before they were offered accommodation at the home. Care plans had been significantly improved since our last inspection. People who lived in the home, their families and staff had been involved in improving the care plans. They now accurately described the care and support people needed. They included information about the person's life, likes and dislikes. This meant the staff had information about the person, not just their care needs.

One person's care plan stated they preferred one specific radio station; this was playing in their room. A list of phrases were used to communicate with one person whose first language was not English. Staff used these phrases to remind this person it was lunchtime. Another person used some written communication. Staff had written some set phrases which this person was able to read. We saw these in use and that the person understood them and responded to them.

When we inspected the service in July 2014, we asked the provider to improve how the service responded to people's views, concerns or complaints. The provider sent us an action plan, as requested, telling us they would make the required improvements by 28 November 2014. During this inspection, we checked to see if these had been made and found that they had.

People, and those close to them such as relatives, were now being involved in decisions about the running of the home as well as their own care. Relative's meetings had been held at different times to encourage more people to attend. Attendance at the last three meetings ranged from 7 to 15 relatives. A range of topics had been discussed but the improvements required at the home and the progress made had been the main topic. Relative's views had been listened to and acted upon. For example, relatives thought it would be useful for a relative to help interview the new manager. One had volunteered and taken part. One relative said they "regularly attended relatives meetings. They were much more organised now and more committed to providing change for the future."

Most people would not be able to use the complaints procedure; they would rely on staff or relatives to raise

Requires Improvement

Is the service responsive?

concerns on their behalf. We read the records of the complaints made since our last inspection. These had been taken seriously and investigated by the acting manager. Where these had been upheld an apology had been offered. Appropriate action had been taken, such as reimbursing people for lost or damaged clothing. Complaints had reduced; there had been no complaints since September 2014.

Requires Improvement

Is the service well-led?

Our findings

The last registered manager ceased working at the home on 11 July 2014. A new permanent manager had been recruited and would start work when all their employment checks had been completed. The home was being managed by an acting manager who was experienced in improving poorly performing services. They had led or overseen the implementation of the improvement plan sent to us following the last inspection. They had been supported by some of the provider's other senior staff, the deputy operations manager in particular.

We discussed the improvements at the home with the acting manager and the operations manager on both days of our inspection. Both were honest and open about how much had been achieved in a relatively short time. However, both said the quality of the service was not as good as they wished it to be.

The acting manager was supported by a team of registered nurses and senior care staff. The acting manager had reiterated roles and responsibilities within the nursing and senior teams because some staff appeared unclear about their responsibilities and accountability. However, there still appeared to be a lack of consistent leadership on both floors where care was delivered. At times staff were unclear about what had or had not been done. Staff were also not aware of where their colleagues were or what they were doing. At times there were no staff present in communal areas to care for people. One relative commented one nurse "runs a much tighter ship" than the others.

People respected the acting manager and felt they had a positive impact. A visitor said the acting manager "had made a huge difference, inspires confidence." One member of staff told us "Leadership is good here now, we get given encouragement and it's good when management say thank you." Another member of staff said "We had absolutely no leadership before. Things are slowly changing and getting better." There was anxiety about the acting manager leaving the home once the new manager was in post. One GP confirmed they were told about the last inspection by the acting manager. They had seen improvements in the service and hoped these would continue under the new manager.

Discussions with staff showed some had found the changes very difficult and they had not completely "bought in" to the new methods and approaches. Some staff said they felt undervalued; one described it as "being put on." However, all staff were aware of the need to improve, the reasons why and how this was to be achieved. One member of staff summed it up by saying "It has come a long way but there are still problems."

Satisfaction questionnaires had recently been given to people to complete. These were being collated so the results were not available when we inspected. Relatives said they felt they were now listened to and their views were acted on. One relative described it as being "very open and transparent."

The quality assurance processes had been improved. The heads of departments in the home met each day to discuss people's care needs as well as any other relevant issues. The acting manager completed daily checks. The deputy operations manager completed various checks and audits. The action plan sent to us following the last inspection had been regularly updated. The latest update was an accurate and honest appraisal, consistent with our inspection findings.

When we inspected the service in July 2014, we asked the provider to improve how the service reported significant events to us. The provider sent us an action plan, as requested, telling us they would make the required improvements by 20 October 2014. During this inspection, we checked to see if these had been made and found that they had. For example, when DoLS applications had been made we had been notified in accordance with the law.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered person did not take proper steps to ensure each service user received care which met their individual needs.** **Regulation 9(b)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.**