

The Council of St Monica Trust

The Russets

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?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

We undertook the inspection of The Russets on the 15 and 16 October 2018. This inspection was unannounced, which meant that the provider did not know we would be visiting.

The Russets is registered to provide accommodation for people who require nursing or personal care for up to 105 people. Up to 73 people are accommodated in a specialist dementia unit called The Russets, whilst separate accommodation for up to 32 people with general nursing care needs is provided in the unit called Sherwood. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of our inspection 102 people were accommodated at the service.

At the last inspection the service was rated as Requires Improvement. At this inspection we found the service Requires Improvement in safe, responsive and well-led.

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 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.

The provider's quality assurance system had not identified all shortfalls found during the inspection. We found improvements were required to ensure adequate stock of medicines, check that bed rails in use were within guidelines, the accuracy of records relating to fluid intake and care plans relating to people's health needs.

Two people were at risk from dirty and contaminated equipment as we found one person's bed sides and another person's cushion was dirty and had internal staining.

People were supported by staff who received supervision an annual appraisal and training. Checks had been completed prior to staff starting work at the service. Staff enjoyed working at the service and could approach the manager if needed.

People and relatives said staff were kind and caring. All people felt happy with the care they received.

People's care plans were person centred and contained important information relating to their likes, dislikes and individual routines.

People were able to raise any complaints and numerous compliments had been received.

People felt safe, and staff were able to demonstrate different types of abuse and who to report it to.

People's choices were respected. Staff were able to demonstrate how they supported people to make their

own choices. People could choose how they spent their day and where they ate their meals.

People were supported with their medical appointments and these were arranged as and when required.

People could access a variety of activities throughout the month and people, relatives and staff had their views sought so that improvements could be made.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we 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 was not always safe.

People's specialist equipment such as bed rails were not always at the recommended safe height and cushions and bed sides were not always clean and free from stains and dirt.

People had mixed views on the staffing within the home.

People did not always receive their medicines as prescribed due to inadequate stock control.

People demonstrated a good understanding of abuse and who to report concerns to.

Is the service effective?

Good ●

The service remained Good.

Is the service caring?

Good ●

The service remained Good.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

Care plans did not always contain important information relating to people's diabetes, wound care and epilepsy.

People were able to complain and complaints were investigated and actions and learning taken when required.

People had access to activities and people could receive visitors as and when.

Is the service well-led?

Requires Improvement ●

The service was not always well-led.

The provider's audits had not always identified shortfalls relating to dirty equipment, incomplete care plans, shortage of medicines in stock, unsafe bed rails and notifications required.

People felt the management was good.

The service had systems to seek feedback from people, relatives and staff regarding their care experience.

The Russets

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.

The inspection was carried out by one adult social care inspector, two experts by experience and two specialist advisors on the first day and the two specialist advisors and the inspector on the second day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The specialist advisers were nurses.

During the inspection we spoke with 11 people living at the service and three visitors. We spoke with the registered manager, the nominated individual, the health and safety lead, and nine staff. Following the inspection, we contacted three health care professionals and we were unable to gain views from one of them.

We looked at ten people's care and support records and three staff files. We also looked at records relating to the management of the service such as incident and accident records, meeting minutes, recruitment and training records, policies and procedures, audits and complaints.

Before the inspection we reviewed the information, we had about the service including statutory notifications. Notifications are information about specific events that the service is legally required to send us. Prior to the inspection we did not request a Provider Information Return (PIR). This is a form that asks the provider to give key information about the service, what the service does well and improvements they plan to make.

Is the service safe?

Our findings

People were not always receiving their medicines safely due to inadequate stock control of their prescribed medicines. For example, we found one person who had epilepsy and had experienced seven seizures since 2018 had no specific medicine in stock should they experience a seizure and require their emergency medicine. There was also no care plan that confirmed how staff should support the person or what actions they should take if the person had a seizure and required their emergency medicine.

Where people had run out of their prescribed medicines the service was using the stock of homely remedies rather than ensuring the person had their medicines re-ordered as per their prescription. For example, one person was prescribed paracetamol two tablets four times a day for pain. We found on one occasion the person had been given only one tablet for their pain as the service had run out of paracetamol from the homely remedies supply. Another two people were found to have run out of Lactulose and Gaviscon. The provider's medication policy confirmed, 'That homely remedies should not be given for more than 48 hours without the medication being prescribed for the resident. Administration of these medicines is limited to a maximum of 48 hours any further doses will require consultation with the residents GP.' We found that on occasions the person had received the homely remedy for a total of four days before it was prescribed. Following the inspection the provider sent confirmation of the GP involvement and rationale for the four day administration. The provider's policy confirmed stock checks should be undertaken every month. We found on some occasions they had not been undertaken for three months. We also found one member of staff had been given a homely remedy but this practice was not included within the homely remedies policy. This meant the provider was not ensuring people received their medicines as required or that the provider's medication policy was being followed.

Some people required their medicines to be crushed to enable easier swallowing. The pharmacist had identified that the medicine could taste unpleasant and was available in liquid form. However, the person was still receiving the prescribed medicine in tablet form. The care plan did not contain detail of how the medicines should be crushed or administered with or without food or with what type of food.

One person also required two different barrier creams however these creams were not available for staff to use and their Medicines Administration Chart (MARs) had no record of the person requiring these creams, when, where or how often.

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

All medicines were stored safely and within the recommended storage guidelines. Medicines that required storage in a fridge had regular temperature checks and were clean and defrosted regularly.

People felt happy with the support they received from staff with their medicines. One person told us, "I am given support to have my medications, I don't remember what time but staff bring them to me and I take them".

People had risk assessments in place relating to moving and handling and the risk of choking. However, where people required bedrails these were not accurately set within the safety range determined by the Medicines and Healthcare Products Regulatory Agency (MHRA). For example, we found three people's bed rails that were unsafe due to them being set at an incorrect height. Their risk assessment confirmed their bed rails had been set to the correct height however this was not accurate. When we measured all three beds they were not set as per the recommended guidelines. We raised our concerns to the registered manager on the first day of the inspection. On the second day they actioned an external company to review all beds that had bed rails. Following the inspection, we received confirmation that action had been taken to replace all unsafe beds including their bed rails, risk assessments had also been updated to ensure all risks were identified and being managed.

People and relatives felt the home was safe. People told us, "I am perfectly safe." Another person told us, "I am safe." Another person said, "There is always somebody about. I walk with a frame because of poor balance but I feel safe enough." Relatives told us, "I am happy that [Name] is safe; the bed is safe and I am happy."

People were supported by staff who demonstrated a good understanding of infection control procedures. For example, people and staff had access to liquid hand soaps, paper towels and staff wore personal protective equipment throughout the home. However, during the inspection, we found equipment was not always at a standard that prevented cross infection. For example, one person used a cushion that had internal staining. We also found one person whose protective bed sides were dirty and stained. On the first day of the inspection we raised this with the registered manager. On the second day we found they had actioned the protective bedsides to be changed and they had arranged for a company to review all mattresses and cushions to ensure they were clean and up to the required standard.

People were supported during the inspection by enough staff to meet their needs although people and staff had mixed views on the staffing levels within the home. People told us, "Could do with more staff. We get agency staff at times. It doesn't bother me. I enjoy the banter with different people." Another person told us, "It is very rare that staff sit down and have a chat, they don't have the time, they are always busy but never too busy to help me." Another person said, "Not enough staff, they are always running around, they are all busy, at times it is hard to find a member of staff if you need them." Two people felt that there were enough staff they said, "Definitely enough staff, you just have to press the button and they come." Another person said, "Always seem enough staff, we see the same staff regularly, they are like family." Two relatives told us, "My [Name of relative] is safe because I trust the care, 80% of the staff have been here a long time so there is continuity" and "My [Name of relative] is safe, there are qualified nurses here day and night backed up by carers; there is an instant response if something is needed."

The registered manager confirmed they had increased the staffing within the home following the last inspection. They were also asking staff to fill in the dependence of what people's needs are daily so that they can review what support the person needs and adapt the staffing numbers to reflect people's changing needs. This meant the registered manager was monitoring and reviewing people's needs to ensure there were enough staff to support and respond to people's individual needs.

Staff were able to identify different types of abuse and who to report abuse to. One member of staff told us, different types of abuse are "Financial, institutional, sexual, physical, emotional, physiological. I would go to the manager, Care Quality Commission, safeguarding team. I feel people are safe here."

People were supported by staff who had checks to ensure they were suitable to work within the service. For

example, staff files contained references, an application form and a Disclosure and Barring Service (DBS) check. A DBS helps employers to make safer recruitment decisions by providing a check on the person's suitability to work with vulnerable adults.

The service had a visitor's book where a clear record of who was visiting was recorded. Visitor badges were also provided. There was a member of staff responsible for the health and safety within the home. They confirmed regular checks were undertaken relating to water temperatures, legionella checks and fire tests. Records confirmed this. Tests were also undertaken to portable appliance testing (PAT).

Is the service effective?

Our findings

The service remained Good.

The Mental Capacity Act (MCA) 2005 provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People's care plans did not always confirm if people lacked capacity. For example, we found one person who required a mental capacity assessment in place for all aspects of their personal care. Another person required a best interest decision in place for managing their medication and their diet that was being modified. We did however find some good examples of where the service had undertaken mental capacity assessments for people's individual care needs. We raised the shortfalls with the registered manager and the nominated individual for them to take the necessary action required.

People can only be deprived of their liberty so that they can receive care and treatment which is in their best interest and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met and they were. Applications had been made when required and records confirmed authorisations in place and those pending.

People were supported by staff who received regular supervision, training and an annual appraisal. For example, training was provided to ensure staff had skills and competencies for their role. Training provided consisted of, moving and handling, infection control and medication. The provider held mandatory training dates so that staff could receive refresher training when required. People were also supported by staff who received additional training to ensure they had skills and competency to support people's individual needs. This included, modified diets, Parkinson's training, tissue viability, wound care and supporting people with Dementia.

People who required their fluids to be monitored did not always have accurate and up to date records that confirmed what they had drank and when. For example, one person's care plan confirmed what they were recommended to drink each day. We found these records were unable to be located. One member of staff confirmed these charts were normally in the kitchen area but that they are thrown away after a few days. We reviewed another person's fluid chart completed for their intake the day before. We found the chart had been completed between 8am and 12 midday and confirmed a total of 1400mls had been taken within this 4 hour period. Their total for the day was 2500ml. This meant if the person continued to consume fluid at this 4 hourly rate they would exceed their maximum total. This could place the person's health at risk. This meant records relating to people's fluid intake were not always accurate and up to date. People had access to a selection of hot and cold drinks. These were available throughout different areas within the home. People could help themselves or staff were available should they require assistance from staff.

People were supported with a varied diet and there was plenty of choice and different options. People could choose where to have their meals, either in their room or in one of the main dining areas. People were given a choice of meals and puddings. There were also bowls of vegetables on people's tables so that they could help themselves. Most people were happy with their meals. They told us, "Food is pretty good on the whole." Another person told us, "Food is excellent." However, two people told us, "I would like to see improvement in the food; variety is poor, and meat often tough" and "Meals could be better, it's not the sort of food I have been used to." Relatives told us, "[Name] can always eat whenever they want. It is quite good here, as [Name] can [move] around they don't restrict their movement. Another relative told us, "[Name] has improved since coming in here. [They used to weigh] five stone [now they] weigh eight stone".

Tables were laid with table cloths, flowers and condiments. Where people required specialist equipment and cutlery this was provided to support and enable people to eat independently.

People were supported with medical appointments when required. Feedback from one health professional confirmed the service had effective communication and messages were passed onto them in a communications folder. They told us, "The ladies in the office are extremely helpful and fully support me in gathering together the information I need for my day. All staff that visit the office whilst I am there come across as very warm and friendly". The GP visited twice a week, or when required. People had access to nurse's day and night within the home. People's records also confirmed visits from a variety of other professionals such as dietitians and therapists. One relative told us, "If [Relative name] is poorly I get a phone call to update me on their condition. There is never any question about it."

Is the service caring?

Our findings

The service remained Good.

People were supported by staff who were kind and caring. All people and visitors felt staff were helpful and had a positive attitude. People told us, "(Staff) are friendly and helpful, they chat when doing personal care, I am very happy with it." Another person told us, "They are a wonderful crowd, I would like them all to have medals, they go over and beyond, I cannot praise them enough." One relative told us, "They support my [Name] with all their needs. I have never seen anything that bothers me, [Name] gets good care."

During the inspection we observed staff demonstrate a compassionate approach to people. For example, we observed staff talking to people by their preferred name as well as speaking to people in an appropriate manner. Staff had built positive relationships and people responded well to how staff supported them. People told us, "[Staff] are kind in the way they talk to us." Another person said, "Staff are lovely, I make them laugh, they love that." One relative told us, "Staff have a fantastic attitude, they treat my [Name] very well."

People received their care with dignity and privacy. For example, during the inspection we observed people receive their personal care with a 'do not disturb' sign placed on their door. This highlighted visitors and other staff that privacy was required. Staff knocked on people's door before entering their room. We heard staff ask before they entered the person's room. For example, "What can I do for you?" and "What would you like?".

People were encouraged to maintain their independence. For example, people could take a walk into the garden area, or around the other areas of the home. People could have their lunch where ever they choose, this included in their rooms, the dining area in which they lived or one of the other dining areas in the home. During the inspection we observed people walking between the differing areas of the home where they were offered something to eat and drink from the staff. One person told us, "They encourage me to do what I can for myself."

People were supported by staff who had a good understanding of equality and diversity. For example, one member of staff told us, "It is about treating everyone the same, regardless of their diversity, sexual orientation, race, religion. Everyone is equal in what they have a choice about." The member of staff went on to highlight an example of people being in a same sex relationship and that it is their choice. This meant staff were able to demonstrate a understanding of equality and diversity.

Is the service responsive?

Our findings

The service required improvement.

Care plans did not always contain important information relating to people's medical needs. For example, one person who had eight various pressure ulcers or wounds had no care plan that confirmed each wound, their size their location and what the current dressing regime was. There were minimal photos taken which could identify each wound, where they are and what size they were which meant reviewing any changes accurately would be difficult without this information. Another person who was at risk of developing pressure ulcers had no guidance for staff to follow on how staff should monitor the person's skin for any signs of redness or inflammation to prevent any future skin problems.

One person who had epilepsy had no care plan that confirmed what staff should do if the person had a seizure or what to look out for or when staff should seek medical advice and support. The person was prescribed medication should they require it whilst having a seizure. There was no guidance in place for staff to follow should this situation occur.

Two people who were diabetic had no care plan that confirmed what action staff should take to support them. Both people had type 2 diabetes which was controlled by medicines. Although both care plans confirmed they were diabetic there was no guidance for staff to follow about how to manage the person's diabetes, how often they should have their blood sugar levels checked. All blood sugars were being recorded on the vital signs record not on the blood sugar section of the person's care plan. This meant they were not being recorded on a form designed specifically for the recording of blood sugars. This could mean duplicate records could be completed due to the incorrect form being used.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where people required support with their catheter care, care plans contained information relating to how staff should support them. This included information about when to change the catheter and the date and technique required for changing it.

Care plans were person centred and contained personalised important information relating to people's likes and dislikes and support they required with their hearing or eyesight. For example, where people required glasses or a hearing aid their care plan confirmed this information. It also contained important information relating to their routines and their likes and dislikes such as if they preferred a wet shave, liked to have a shower or a bath.

Care plans were regularly reviewed. However, during the inspection people had mixed views on being involved in their care plan. All felt satisfied that their needs were being met however people told us, "I can't recall anything about a care plan and don't know anything about it." Another person told us, "I was able to say what I wanted in my care plan and have had it reviewed several times since." A relative told us, "My

[Name] had a review of their original plan. Nothing has been changed or added." Another relative told us, "I am always involved in decisions about [Name of relative's] care and support, and [Name of relative] is also involved as much as he can be so if any changes are needed these can happen quite quickly."

People had access to a variety of activities in groups and individually. This included musical memories where people and their relatives could enjoy hits from the past. There were visually interactive singing sessions with sensory lights where people could sing along. As well as people being able to tap along to 'Rock Around the Clock'. This was a positive activity that enabled people who had a sensory impairment to participate. There was also the Pet Assisted Therapy (PAT) and the 'butterfly moment'. The butterfly moment describes the moment a piece of music moves an individual or there is a connection to the music in their past.

The activities coordinator explained how they aimed to provide people with one to one activities. This included, knitting, reading postcards from family members who were on holiday. The 'band' would also visit people in their room and play a tune of their choice. The chaplain provided services and ceremonies and on the day of the inspection we observed people receiving holy communion. There was integrated projects with a local primary school and visits from a local brass band. Along with an opportunity for people to have a small project at the end of the individuals bed so that they could watch a film, or look at a photograph of their family. A copy of the activities planned for the month was provided to people however we found this could be difficult for some people to read due to the size of the print. We fed this back to the activities coordinator. Larger print would enable people with a visual impairment to view activities more easily.

People's rooms were personalised and outside their room was a memory box that identified important photos of themselves, hobbies and interests they had. Rooms contained personalised furniture, paintings, photographs and items that were individual to the person. One person had paintings and tapestries as well as framed medals. They were of great significance and sentimental attachment to the person. Providing people with a personalised space meant the environment was familiar and homely.

People had access to the providers complaint policy, all people felt able to raise any concerns should they occur. Two relatives for one person living at the home raised concerns regarding the lack of activities. We shared this with the registered manager for them to review and take the necessary action. Where complaints had been received these were recorded investigated and appropriate action taken including the outcome. The service had received various compliments. For example, compliments included, "We couldn't be anymore thankful to you guys, you guys are truly special and helped in many ways you all gave us your time. The most thankful gift of all, Thank-you." Another compliment included, "I write to express the thanks of all of us for the care and kindness shown to [Name of person] in the last months of her life."

Where people had received care relating to their End of Life Care (EOLC). Relatives had expressed their thanks. One compliment included, "At the end their last few days were treated with the utmost care and respect for [Name] as a person." Another compliment confirmed, "I would also like to take this opportunity to register my gratitude to the wonderful staff of Encore, who gave [Name] exemplary care in the last weeks of her life." No-one at the time of the inspection was on end of life care. The nurse confirmed where people were expected to require end of life support the home liaised with the person and their family if required. Where people were thought to be reaching end of life support an assessment was carried out and regular reviews were undertaken every two weeks.

Is the service well-led?

Our findings

At the last inspection we found audits had failed to identify areas of improvement during the last inspection. At this inspection we found some improvements had been made however we found audits and checks had not identified problems with medicines being out of stock and unavailable for people when required. Care plans and guidance that was required for people with diabetes, epilepsy and wound management. Risk assessments had failed to identify where the person's bed rails were the correct height. Along with equipment that was dirty and had internal staining and some mental capacity assessments and a best interest decision where people's capacity had changed.

The registered manager and provider were making notifications to the Care Quality Commission when required. A notification is information about important events which affect people or the service. Most notifications had been submitted when required although we found one notification was required where a person's skin had deteriorated beyond a grade three pressure sore. This meant notifications were not being made when required and the registered manager and provider had not identified these shortfalls prior to our inspection.

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

The provider's representative confirmed actions taken following the last inspection. This included a new quality improvement team that would be responsible for monitoring and reviewing the service. At the time of the inspection this team had not started to review the monitoring of the service but the nominated individual confirmed this would start soon.

Following the inspection, the provider sent us confirmation of what actions they had taken and what they had identified. They confirmed they had identified various mattresses that required changing and they also confirmed actions taken to replace the bed rails that were not to current guidance.

People and staff felt the home was a good place to work and that they could approach the management if they needed to. People told us, "Name is wonderful, she always listens and is responsive to [Name] needs." Another person said, "On the whole communication is good." Staff told us, "It is a relaxed environment, I enjoy working here it's a nice place to work." Another member of staff told us, "It's amazing, really good." One member of staff told us, "The management is there if we need them."

The registered manager held residents' meeting three times a year. People had the opportunity to discuss their experience within the service. Topics included the garden area, laundry, catering, activities and pastoral care. The nominated individual confirmed that different days and timings were being reviewed to enable a maximum attendance from people and relatives.

The providers statement of purpose confirmed, 'St Monica Trust's mission is to deliver well-being to all its service users. This emphasises their safety and safeguarding requirements; addresses physical, emotional,

spiritual and social well-being; ensures dignity and respect and give priority to choose and control for everyone. We continue to respond to the changing needs of older people. The organisation's mission is to achieve well-being through innovative care, support and accommodation wherever our services are being provided. Staff aimed to provide a service that encouraged choice and control'. One member of staff told us, "Everything we do is their decision and choice. It's their choice to have a shower or wash it depends on them. Where to sit and if to go into the lounge area. We can always guide someone to enable them to make their own decision."

Staff attended staff meetings. These were an opportunity to discuss areas of improvement for the service. For example, improvements to the recording of medicines, end of life care planning, the storage of people's individual items such as toiletries and the increase in the staffing within the home and the ongoing monitoring of this including the use of the dependency tool that staff needed to support with.

Staff, people and relatives had their views sought through an annual satisfaction survey. People and relatives felt from the 2018 survey improvements were required to the laundry, meals and pastoral care within the home. The staff survey identified that communication could be improved. The registered manager and nominated individual were aware of actions required to improve people and staff's experience. This meant staff, people and relatives views were sought so that the service was a better place to live and work.

The provider was displaying their rating for the service at the time of the inspection. This was accessible to people within the entrance lobby and on the providers website.

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 | Regulation 9 HSCA RA Regulations 2014 Person-centred care |
| Diagnostic and screening procedures | People did not always have personalised care plans relating to their wound care, pressure ulcers and diabetes. |
| Treatment of disease, disorder or injury | |
| Regulated activity | Regulation |
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment |
| Diagnostic and screening procedures | People's prescribed medicines were not always in stock as required. |
| Treatment of disease, disorder or injury | |
| Regulated activity | Regulation |
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance |
| Diagnostic and screening procedures | Audits had not identified shortfalls relating to medicines being out of stock, shortfalls in care plan guidance, incorrect risk assessments relating to bed rails and soiled equipment. |
| Treatment of disease, disorder or injury | |