Abbey Ravenscroft Park Limited

Abbey Ravenscroft Park 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?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 23 and 24 May 2017 and was unannounced. At the last inspection we found three breaches of legal requirements relating to staff recruitment, consent and quality assurance. We found that improvements had been made with staff recruitment and consent and the home was no longer in breach in these areas. We found that sufficient improvements had not been made in the area of quality assurance.

Abbey Ravenscroft Park is a 67 bed nursing home registered to provide accommodation and nursing care to older people. At the time of our inspection there were 61 people living there.

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. There was a registered manager employed at the time of our inspection and they had been registered there for over 17 years.

Staff had a good understanding of safeguarding and knew what abuse might look like and how to report it. However, we found that safeguarding concerns were not always reported to the local authority or investigated.

Where an incident had taken place the home could not show that they had learned how to manage the risk to reduce the chance of the incident reoccurring.

We found the premises unsafe with windows on upper floors not having window restrictors, putting people at risk of falling out and sustaining a serious injury.

Medicines were mostly managed safely, but there was not sufficient oversight of medicines audits and competency testing for staff did not always take place.

The principles of the Mental Capacity Act were being followed and staff had an understanding of seeking consent.

Staff training was robust and regular supervisions were taking place which staff said they found helpful.

People and relatives told us staff were kind and caring, and people's privacy and dignity were respected.

Care plans were not person centred and some needs were not assessed or reviewed. Staff knew people and their likes and dislikes but this was not reflected in care documentation.

People knew how to complain and felt comfortable doing so but complaints were not always not

investigated fully.

Quality assurance was not robust, mistakes were not always picked up and some of the same issues were found in this inspection as in the last.

We had concerns about the management culture in the home and staff and people had heard shouting in the wake of incidents or mistakes.

We found three breaches of regulations at this inspection in relation to premises and equipment, safe care and treatment and a repeated breach in governance relating to quality assurance.

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?

Inadequate

The service was not safe. Windows were not secured with window restrictors putting people at risk of falls from a height.

Staff knew how to report safeguarding concerns and the signs of abuse but safeguarding procedures were not always followed.

Medicines were stored safely. However, the staff were not always competency tested in the administration of medicines and audits in medicines were not robust.

The home was not able to show it had learned from incidents and could reduce the risk of them happening again.

People were not always supported to move in a safe way.

Is the service effective?

Good

The service was effective. People felt confident staff knew what they were doing.

Staff knew about the Mental Capacity Act and consent.

Referrals to health services were made in a timely manner.

Weight records were completed.

Staff were receiving regular supervision and had training which was suitable to their roles.

Is the service caring?

Good

The service was caring. People said staff were kind and caring and relatives said the care was of a good standard.

The atmosphere on some floors was jolly and people were laughing and chatting at intervals.

People said staff respected their dignity and privacy. On one floor we saw a screen being used when people were being supported to move with a hoist.

Families felt welcome and found staff consistent, but were restricted in their visiting and were told to visit in bedrooms, especially during mealtimes.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care plans were not person centred and often did not reflect changing needs or preferences.

People said they wanted more stimulation and to go out more. Activities were provided but needed to be reviewed to meet people's needs and preferences.

People and relatives said they would be comfortable to complain if they needed to. Complaints records were disorganised and complaints not always managed or investigated in line with the provider's policy.

Is the service well-led?

Requires Improvement

The service was not well led.

Audits were not always robust.

Some staff felt supported while others found the management style unsupportive.

People and relatives told us they had heard raised voices from management staff.

Abbey Ravenscroft Park 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 23 and 24 May 2017 and was unannounced.

The inspection team was made up of two adult social care inspectors, one nurse specialist, one pharmacist inspector and two experts 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.

Prior to the inspection we gathered information from previous inspections, notifications submitted to us regarding important events such as a serious injury, complaints, and feedback from relatives, and social care professionals.

During the inspection we spoke with 24 people who lived in the home and nine of their relatives and visitors. We interviewed nine care staff and three nurses and also the area manager and registered manager. We looked at eleven care files, four catheter care records, and five staff personnel files and training records. We also looked at key policies and procedures and records kept around safeguarding, incidents, complaints, medicines and the Mental Capacity Act.

Inadequate

Is the service safe?

Our findings

People said they felt safe, they said "I feel everything here is safe, including me", "I feel safe" and "I do not worry. I can have all my things around me and they are very careful with them." Relatives told us "I'm completely happy leaving her here. I'm bringing a few more belongings each day and they are kept neat and tidy" and "She is safe I have no doubts there"

We found the premises were not safe. Providers have a legal responsibility to ensure they mitigate the risk of serious injury occurring. We checked windows for window restrictors on each of the floors. A window restrictor is a mechanism on a window to ensure it cannot be opened over a certain amount to prevent people falling or climbing out. We saw for the first and second floors there were windows that did not have restrictors that met legal requirements and that people were at risk of falling from a window. One of these windows was in a hallway away from staff supervision. We opened the window fully and it was at a height that no climbing would be required to fall out of it. We showed a staff member another window on the first floor in the lounge area; they said it had a restrictor on it. When we checked this, the window restrictor was easily opened by pressing a button down and the window could be opened far enough to pose a risk to people. Another window on the second floor had no restrictor on it and could be opened wide. We saw that a person could climb on a chair and climb out of the window if they were determined to do so. We fed this back to the registered manager and asked for immediate action to be taken as we felt there was a serious risk to people's safety. We found there had been a previous incident several years ago where a person had fallen out of a window and sustained an injury requiring them to be taken to hospital. Despite this incident occurring the registered manager and provider had not taken sufficient action or learned from this incident to improve safety at the home. We fed this back to the registered manager and said we did not feel the windows were safe. We sent information to the registered manager on safety of window restrictors and within 24 hours of the inspection they had fitted new restrictors.

For one person who had fallen in their bathroom a few days previously, they sustained a head injury and were taken to hospital. We looked where this person had fallen and saw there was an uncovered radiator. Hard metal edges were exposed putting the person at risk of a serious head injury or a burn if they fell against the radiator. We fed back this concern to the registered manager and asked them to make this safe immediately. We were informed that the radiator cover had been replaced within 24 hours to mitigate the risk of a more serious injury.

The above evidence is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked further at how the home kept people safe in their environment and how lessons were learned after incidents such as falls. We saw where people had had a fall, actions were not often completed on incident and accident forms. Where actions had been described these were often unrealistic and did not give sufficient direction to staff on how the person could be individually supported. For example "close supervision and not to be left alone." We asked if these people were now on one to one staffing arrangements as this was what the action suggested. The registered manager told us they were not. The

area manager said the home would review how they learned from incidents. The actions were not sufficient to reduce the risk of the incident happening again or show any learning had taken place. We saw that key documentation such as risk assessments and care plans were not always updated after a fall.

During the inspection we witnessed two instances where staff had not supported people to move safely putting both themselves and the person they were supporting at risk of injury. The first example was where one person had chosen to crawl on the floor, one staff member offered assistance but the person gestured they did not want it and wanted to stay where they were. Another staff member entered and ignored that the person wanted to stay where they were. This staff member put their arm underneath the person's chest and lifted them by pulling up at their belt and waist of their trousers until they lifted from the floor into a sitting upright position in a chair. The second example of unsafe practises being used was in a communal lounge with lots of other people and three staff members. A person indicated they wanted to leave the room. They were supported to stand by their arm being pulled by a staff member. We fed this concern back to the registered manager and they said they would look in to it.

The home did not always report safeguarding concerns. We found details of a complaint whereby there was an allegation of financial abuse. We asked the registered manager if this had been investigated internally and reported to the safeguarding authority or a notification sent to us. The registered manager said they had not taken any action around this issue and did not understand that it needed following up. After our suggestion the registered manager instructed staff to report the safeguarding concern, and after prompting from us, some investigation documentation was written.

The above evidence is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Care staff and nurses we spoke with had a good understanding of safeguarding and what abuse might look like for the people they supported and how to report it. They had attended training and knew what the home's procedure was for passing on any concerns.

Medicines were not always managed safely. We saw good practice in some areas of medicines management but also clear areas for improvement. We saw evidence that staff that administered medicines had been trained. However records showed that not all staff responsible for administering medicines had completed their competency assessment. This meant that the registered manager may not have had a good clinical over sight of medicines management which could undermine the safe management of people's medicines.

Medicines received from the pharmacy were recorded on the medicines administration record charts (MARs) and the quantity was reconciled with the administration records which were clear and accurately documented. Medicines were stored safely and securely including controlled drugs (CDs - medicines which are more liable to misuse and therefore need close monitoring).

We checked the medicines disposal records and found unwanted items were documented before they were returned or destroyed. There were records of fridge and room temperature monitoring daily and within the recommended limits. Although on one of the floors, there were gaps on daily temperature checks, staff told us that this was because the fridge was not working. We noted a new fridge was supplied during our inspection.

Staff told us they carried out regular medicines related audits at the end of every MAR cycle using the home audit checklist. However, the audit checklist contained information that was not relevant to the home. For example, some of the data collected in audits related to residents that administered their own medicines, although the registered manager told us that nobody administered their own medicines. This means the

audit tools were not specific enough to effectively identify medicines related errors.

We saw evidence that people who had their medicines administered covertly had appropriate documentation. This is when medicines are administered in a disguised format, for example in food or in a drink, without the knowledge or consent of the person receiving them. An appropriate assessment must be performed by a medical practitioner to establish whether the person lacks mental capacity. If it is determined that the person does lack mental capacity to consent, a multidisciplinary discussion should follow to establish whether covert administration is in the service user's best interest. Paperwork was in place to document the process with the covert medicines decision had been made with review dates.

There was evidence that people receiving medicines that needed regular blood monitoring and dose changes were appropriately managed, also those with medical conditions such as raised blood pressure and diabetes were appropriately monitored.

There were specific risk assessments for a person who was diabetic and a behaviour chart for a person with challenging behaviour. Risks were reviewed and calculated using scores but actions not always put into place so that the risk could be mitigated. We saw risk assessments for the use of bed rails, moving and handling, physical health and mental health and other relevant areas of risk for individuals. On one diabetes care plan the actions were to "watch out for signs of hyper glycaemia", they did not specify what the signs were and did not explain in detail to staff how to prevent this person from becoming unwell with their diabetes.

Turning charts and hourly check charts were in place where needed. However these were not always consistent. One moving and handling care plan said a person needed two hourly turns however the turn charts showed variable turning times between three and six hourly. Another person's turn chart for one day stated they were repositioned at irregular intervals ranging between one and a half and three and a half hours despite this person having developed a pressure sore. We asked the nurse about this and they said it was a recording issue but that people were being turned. We did see that specialist airflow boots were in place to protect their heels as recommended by the tissue viability nurse. We also saw that hourly checks were completed every hour for people in their rooms.

Where catheters were in place staff were aware of the frequency of catheter drainage bag change and catheter change dates, although this was not always documented. On two floors we were concerned that people with catheters did not always have the drainage bag on a stand whilst in bed to encourage drainage. The frequency of catheter change was not documented. One care plan read, "Ensure catheter is changed as per home's guidelines" but these were not readily available in care plans. We were also concerned that one person had had their catheter changed five times in March and twice in April instead of the recommended 12 weeks. We asked the nurse about this and they said it was because the catheter bypassed. However these frequent changes increased the risk of infections. We made a recommendation that best practice guidelines be sought and a referral to a relevant specialist be made.

There were enough staff in the service on the day of inspection to meet people's needs. We looked at the rota and this matched up to staffing when we visited. Some staff told us they were sometimes short staffed and needed more people at busy points. People told us they were having their needs met. Relatives said they were not concerned about staffing levels but there could "be a few more staff to sit and chat with."

There were personal emergency evacuation plans in every person's room in case of a fire and staff said the fire alarm was tested every Wednesday; this was recorded in fire logs. Staff were aware of the assembly point should a fire occur but were not always able to explain the evacuation process. We did not see any records

of a recent fire drill and asked the registered manager to follow this up.

Good

Is the service effective?

Our findings

One relative said "I have got enough confidence to know that they [staff] are doing their best and they know what they are doing". One person told us "I feel they have the right skills and training, yes."

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

DoLS applications were being made where appropriate. We saw that mental capacity assessments were not always completed fully or accurately. For example, one person with a learning disability had been assessed as having no capacity to make decisions about food and personal care. However we saw the person choosing what they wanted to eat on the day of inspection. Staff had a good understanding of consent and had been on MCA training. We saw staff asking for consent during the day when using the hoist and supporting people to eat. One staff member said "you must always ask, so they give you consent, even if people can't talk they use facial expressions." Do Not Attempt to Resuscitate forms were filled out for people that needed them.

We observed meal times on the ground floor and found there was an organised way of serving so people did not have to wait too long for their food. When we asked people what they thought of the food they said "I like the food here, it`s got taste", "I think the food is good, well I manage to eat it all the time" and "I do like it, the chef seem to rotate the meals." We saw that people in their rooms were served and assisted in a timely manner. One person said, "I don't like chicken." We saw staff come back with an alternative meal. We saw staff assist people in their rooms to eat at an appropriate pace with intermittent conversation where appropriate. We saw water in rooms and orange or blackcurrant squash in rooms and communal areas. These were offered to people at regular intervals. Fluid balance charts for those who needed them were not always totalled or completed properly and did not always indicate why fluids were being monitored or the daily fluid targets. For example one person with a catheter on one day had an input of 1150ml but no output recorded. On another day the input was recorded as 2200ml but output significantly lower at 300ml. Staff told us that this was likely an omission in recording the output. This showed documentation did not reflect actual fluid balances which may have put them at risk of dehydration.

People were supported to access healthcare services. We saw evidence of medicines reviews, chiropody, tissue viability, and dietitian reviews where required and staff recorded when health professionals visited. Staff also showed us a transfer form they used when transferring people to hospitals so that people's needs were communicated to hospital staff. We looked at weight records and saw they were up to date and completed so that any risk of malnutrition or sudden weight loss was monitored.

Staff told us they had regular supervision and said the training was good with regular refreshers. One staff member told us "I do feel supported, supervision helps me to express myself" and another said "the training here is very good." Nurses told us they had attended relevant training and received annual appraisals. They received regular supervision to ensure they were up to date with best nursing practice. They were aware of the nurse revalidation process and had started to compile portfolios to evidence professional development. We asked the registered manager what their approach to staff training and development was. They said they completed face to face classroom training and said "I don't believe in e-learning." We saw the provider's appointed staff trainer visited the home once a month to complete refresher training and support new staff. We looked at the training matrix and saw there were good records of training that staff had attended.

Good

Is the service caring?

Our findings

People told us staff were caring and kind. They said "They always ask how I am doing and stuff like that, they are caring" and "They are caring, I don't think they can do anymore, I am happy here." Relatives felt the same and said "The staff now in general is very caring, I have seen how they assist him and it makes me happy" and "Yes, they are very caring, but also towards visitors."

Staff said they enjoyed their jobs and spending time with the people they cared for. They said "I enjoy my job, I treat people like my family", "I love my residents" and "Care wise it's very good here." We saw caring interactions throughout the day with staff speaking to people in a gentle manner and making eye contact. The atmosphere on the ground floor was jovial and staff made jokes and laughed with people. Relatives said of the atmosphere in the home "well most days it is friendly" and "Atmosphere is great [on the ground floor], in other floors not so much."

People were treated with dignity and respect and we saw on the ground floor a screen being used for people's privacy when they were supported to use the hoist. People said "They always protect my privacy and dignity and they always knock on my door too, they are also very professional" and "I couldn't be happier about privacy and dignity." In care files we saw people's religion and cultural background recorded. For an Italian speaking person they were supported by an Italian speaking staff member. We saw that for one person their cultural and language needs were considered by staff. They had printed out a guide to key phrases so they could communicate in this person's mother tongue, as they no longer spoke English.

We observed people being offered choices, staff told us how they offered choice through daily interactions and said "we always offer a choice, and ask people what they want", "if people don't want to be disturbed, we must respect that" and "when they are getting up we show them items from the wardrobe so they can choose what to wear." Although we saw these choices being offered people didn't always feel they were or didn't know if they were involved in decisions about their care. For example one person said "Not that I am aware" and another said "Well I think I am, but they haven't asked me an awful lot."

People and relatives mentioned there was good consistency of care staff with few agency staff, which meant staff could build up relationships with people. Staff felt they knew people's needs well and said "we know their likes and dislikes well." People said "they know me well and how I like things" and "they know me quite well and what I need help with." We saw this reflected when we spoke with staff as they were able to tell us what people's needs were and how their relationship had built up over time.

Nurses told us they used the gold standards framework to support people receiving palliative care. The gold standards framework is a programme of care designed to support people through the time leading up to the end of their lives. We saw preferred priorities of care in care plans we reviewed outlining peoples last wishes. Nurses told us they had been trained on how to set up syringe drivers in order to deliver continuous pain relief. They worked closely with district nurses and the visiting Macmillan team to ensure people were comfortable and pain free during their last days.

Relatives told us staff were welcoming when they came to visit. Some relatives fed back that visiting times were sometimes restricted. "They told us we have to have visits in her room and not in the lounge and we can come in mealtimes but only if we will be feeding her in her room" and
"They told me when I came that visits are in the room and not in the lounge." We asked the registered manager why visits were restricted and they said for privacy and that mealtimes can be busy.

Requires Improvement

Is the service responsive?

Our findings

We saw some evidence of person centred care in records. However, care plans were not personalised. For example in some care files there was a life history page written in the first person which helped staff know peoples likes and dislikes and preferred wake up and sleep times. One of these read, "I like to watch animal programs. I like to drink whisky." We didn't see this information reflected in their care plan or how they would like their care to be delivered. Care plans were generic and did not always reflect the individual preferences of people. For example we saw instructions for staff such as "encourage choice of clothes" and "oral care four hourly" repeated in care plans we looked at rather than stating what people's preference for clothing and oral care were.

Care records did not always reflect people's current needs and had not been updated, putting them at risk of inappropriate care. One person's care plan consistently referred to a grade four pressure sore that had been healed since February 2017. The same person's communication care plan was not comprehensive and did not detail that the person had hallucinations or how to communicate effectively with them. On the day of our visit the person was shouting and hallucinating with no behavioural charts completed. We asked staff about the person's behaviour and they told us the shouting and hallucination still occurred but were much better than before. This meant there were inaccurate records of behaviours which could lead to inappropriate reviews as records were incomplete. Another person's spiritual needs care plan had not been updated to reflect the current support received from the local place of worship. Their communication and night care plan were generic and had been last written in February 2016.

Care records were not always timed and sometimes not dated. This made it difficult to see exact time lines of when care was delivered or had been reviewed. For example, one person had undated mobility, breathing pressure area and medication care plans.

People told us there was not much to do during the day and they were bored sitting around in communal areas. They said "I watch television and listen to music in my room. I would like to go out, we don't really. I would like to sit in the sun in the garden sometimes", "I think everyone tries really hard here and I cannot point any fingers you know but maybe we do need some more activities", and "I think they could do with more activities." Relatives felt the same and said "I saw it once, not since he has been here, we take him out to the garden when the weather is nice but that`s about it" and "I am sure dad does some activities but I see him in same place all the time."

Activities were limited, especially for people living with dementia. This was also confirmed within the activities records logs we reviewed. For example one person who stayed in their room most days had only had activities offered seven times in March and nine times in April. The rest of the daily activity logs just said "sleeping". Another person only had six activities recorded in March one of which read "very happy smiling" but no detail of what they had done. We observed in communal lounges people were interacting with the activities co-ordinator but in one lounge there were three other staff members in and out of the room regularly. Their interactions were limited to offering drinks and moving people around. In another lounge we observed staff sitting with several people but not making conversation, we checked this lounge twice more

and there was still no positive or social interaction. We heard shouting coming from one lounge and walked towards it. The person was shouting out and becoming distressed but we did not see or hear the staff member in the room attempt to communicate with or offer comfort or reassurance to the person.

People and relatives said they had no major complaints and would feel happy talking to the nurse or care staff if they had an issue. From records we saw that complaints were not always investigated. Complaint records were disorganised and did not reflect what had happened, who had completed actions when and whether they had been resolved or not. We asked the registered manager if they had a central log where they recorded the progress of complaints, they said they did not. The provider's complaints policy stated "Every written complaint should be acknowledged within seven days" and "Investigations into written complaints should be within 28 days." We asked the registered manager why several complaints did not have evidence they had been responded to within the specified timeframe or in writing. They said "I try to resolve these things informally."

People told us they did not know if there were meetings for them to express their views and give feedback. Relatives said "I think they do have these meetings, but some people are not aware", "I don't think they do meetings. We get told things on arrival and there are posters around and an activity board in reception" and "They have the odd meeting for relatives and they tell us about any changes and if we have anything to add or any ideas."

Requires Improvement

Is the service well-led?

Our findings

Abbey Ravenscroft Park Home had a registered manager who had been in post for over 17 years.
Services that provide health and social care to people are required to inform the Care Quality Commission of important events that happen in the home. We found that the registered manager was not always informing us of events, for example a safeguarding concern we found had not been reported to us or the local authority.

At the last inspection there was a breach in requirements around the governance of the service, we saw that quality audits were not always picking up gaps in records or errors that may have had an impact on people. At this inspection we found that quality assurance was not robust. We were told by the registered manager that audits took place regularly with infection control, care plans and medicines audited monthly. However, we saw that the infection control audits had not been done for February, March or April this year for two of the floors and for one floor there were no records of any taking place so far in 2017. Care plan audits did not pick up that care plans were not personalised and did not always have emerging needs in them or that behaviour recording was inconsistent and dates and time were often missing from documents. We looked at a health and safety audit completed by the provider's head office and saw that it was noted hot surfaces were exposed and an action deadline to rectify this of December 2016 had not been met. Health and safety audits had not identified the risk posed to people through window restrictors not being in place or being ineffective.

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

Some people told us they had heard the registered manager shouting at staff, one person said "people fear her because she shouts a lot." Other people told us they did not always know who the registered manager was and did not see them often, they said "I used to know who the manager was, but not now unfortunately", "I don't know who is in charge at the moment" and "To be honest I don't know."

Staff gave us mixed views on the support they received, they said supervision was helpful and if they had any personal issues the registered manager was flexible with working hours. One staff member said "she is approachable, I feel I can speak freely to her" but the majority of staff we spoke with felt the management style was not supportive at times. They said the "manager can be approachable sometimes, depends on her mood", "if an incident takes place, she doesn't check what's happening, she screams and shouts", and "she shouts, even in front of the residents." Staff said they enjoyed their jobs because of the people they were supporting but that morale went up and down, "in meetings we are just told what to do, we don't feel able to speak. This makes us feel unmotivated." We saw that records for staff meetings were kept.
We saw that the home worked in partnership with key health professionals such as tissue viability nurses, GP's, and the local authority quality team to help improve care and outcomes for people living there.

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 15 HSCA RA Regulations 2014 Premises and equipment The premises and equipment used by the service provider was not secure.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure systems or processes were be established and operated effectively to ensure compliance. There was a failure to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services) and did not assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. The provider failed to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider and registered manager did not ensure care and treatment was provided in a safe way for service users. The risk was not always assessed to the health and safety of service users of receiving the care or treatment, and the provider failed to do all that is reasonably practicable to mitigate any such risks.

The enforcement action we took:

Warning notice