Barchester Healthcare Homes Limited

Atfield House

Inspection report

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13 July 2016

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 12 and 13 July 2016. The first day of the inspection was unannounced and we told the provider we would be returning the next day.

The last inspection was carried out 1 May 2014 at which time the service was meeting the assessed regulations.

Atfield House is part of Barchester Healthcare Homes Limited and provides care with nursing for up to 63 people. The home has three units consisting of two units for physically frail and older people and a third unit for people living with dementia. There were 62 people using the service but two people were in hospital on the days we inspected. One bed was being held for respite.

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.

In 11 of the 12 records we looked at, we saw people were receiving care and treatment in line with their care plan. However in one care plan the tissue viability nurse's guidance was not acted upon by the staff, which meant the person did not receive the treatment they required.

There was a lack of recording for people who required regular monitoring.

We observed that some risk plans required people to be monitored as they were unable to summon help from their rooms but there was no record of when people were checked on during the day. Additionally we saw call bells behind beds could be difficult for some people to reach.

The service employed two activity co-ordinators but activities were not always meaningful to the people who used the service. We have made a recommendation that the provider review activity provision in line with the NICE guidelines.

Medicines were administered and stored safely but not always recorded correctly. During medicines administration, we observed a PRN (as required) medicine was recorded in the medicine notes and not in the PRN section of the MAR chart. We have made a recommendation for the proper and safe management of medicines at all times.

Staff were sufficiently deployed and appropriately trained.

The service had safeguarding policies and procedures in place.

The environment was clean and well maintained.

Staff were suitably supervised and appraised.

Healthcare needs were being met through assessments, monitoring and support from the relevant professionals.

Staff were kind and caring. They knew the people who used the service and were able to meet their needs.

Most people who used the service, staff and relatives told us the manager was approachable and they could raise concerns with them.

Monitoring and auditing records were well maintained.

We found one breach 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.

The service had risk assessments and management plans that identified and minimised risk to keep people safe. However, people were not always supported in line with their care plan and the action taken was not always recorded.

Medicines were administered and stored in a safe way but were not always recorded correctly.

The service had safeguarding and whistleblowing procedures in place and staff were trained appropriately to safeguard the people who used the service.

The service followed a safe recruitment procedure to ensure staff were suitable to work with people who used the service. Staff were sufficiently deployed to meet people's needs.

Is the service effective?

Good

The service was effective.

Staff had up to date training that was relevant to the needs of the people they provided support to.

Staff were suitably supervised and appraised.

The service was working within the principles of the Mental Capacity Act (2005).

People's nutritional and dietary requirements were assessed and met.

People's healthcare needs were met and we saw evidence of involvement of relevant healthcare professionals.

Is the service caring?

Good

The service was caring.

People who used the service and their relatives found staff to be

caring and kind.

People's privacy and dignity was respected.

We saw family and friends visiting people and made to feel welcome.

Is the service responsive?

Good

The service was not always responsive.

The service employed two activity co-ordinators. We saw activities but these were only meaningful for some people who used the service.

Care plans indicated people's preferences and we saw some evidence that people and their families were involved in the planning and reviewing of these.

The service had an evaluation record of daily tasks which indicated that care was delivered in line with the care plan.

Residents and relatives' meetings were held monthly.

The service had a complaints procedure and we saw evidence that complaints were recorded and investigated by the registered manager.

Is the service well-led?

Good

The service was well-led.

The registered manager had a number of different audits in place to monitor the effectiveness of the service.

The registered manager was approachable and regular team meetings provided support to the staff.

Atfield House

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 took place on 12 and 13 July 2016. The first day was unannounced and we told the provider we would be returning the following day to complete our inspection.

The inspection team on 12 July 2016 included an inspector, a nurse specialist advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience on this inspection had experience of care homes. The inspection on 13 July 2016 was carried out by an inspector only.

Prior to the inspection, the service completed a Provider Information Return (PIR). This form asked the provider to give some key information about the service, what the service did well and improvements they planned to make. Additionally we looked at all the information we held on the service including notifications of significant events and safeguarding. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We also contacted the local authority's Commissioning Team and Safeguarding Team and there were no concerns raised in the feedback they provided.

During the inspection we spoke with five people who used the service, three relatives and one friend. We carried out a Short Observational Framework Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not speak with us. We interviewed eight staff including the registered manager, two nurses and care staff and we spoke with a visiting healthcare professional.

We looked at the care plans for 12 people who used the service. We also saw files for eight staff which included recruitment records, supervision and appraisals and we looked at training records.

We looked at medicines management for people who used the service. Additionally we looked at the environment, maintenance, servicing checks and audits.

After the inspection we spoke with three more healthcare professionals to gather information on their experience of working with the service.

Requires Improvement

Is the service safe?

Our findings

The service did not always follow safe practices. We saw that the wound management care plan for a Grade 3 pressure ulcer was not being followed as directed by the tissue viability nurse. The registered manager was not aware of what the nurse had recorded in the care plan and therefore had not raised a safeguarding alert as required for a Grade 3 pressure ulcer. When we informed the registered manager, they took appropriate action and contacted the local authority, notified the Care Quality Commission and advised they would begin a management investigation into the incident.

We saw that some people required monitoring as part of their risk assessments for falls. We noted some people did have infrared monitors with motion sensors designed to alert staff if they fell, however we did not see any formal record that people were monitored by staff. We also observed that call bells located behind beds could be difficult to reach if people fell. Two people's files noted there was a risk they could not use the call bell. When we spoke with the registered manager, they showed us a record of people being monitored hourly between 8pm and 8am and said that people were monitored during the day but it was not recorded. The registered manager acknowledged the need for monitoring to be formally recorded during the day to evidence that there were measures in place to minimise identified risks to people. These practices placed people at risk of receiving unsafe care.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we observed the morning medicines round and reviewed four people's case notes. We looked at medicines administration records (MAR) and the controlled drugs administration. Information contained within MAR charts included people's photos, identified allergies, medicines profiles, medicines difficulties and guidance for home remedies. The initial drug quantity was recorded, dated and signed. Topical creams were written on the MAR charts and signed for by a nurse. Not all people's prescribed creams had body maps to show where creams should be applied, nor was it documented when creams were meant to be applied which meant people were at risk of not receiving their treatment correctly. Medicines were dispensed from blister packs which had a pharmacist's label detailing people's name, drug name, dose and frequency. During the medicines round when people requested the nurse to come back to administer medicines, for example after breakfast, they did.

Medicine audits were undertaken monthly. The audits on 28 April 2016 and 6 July 2016 noted that PRN (as required) medicines were not always documented in the PRN section of MAR chart when PRN medicine was administered. During the inspection we observed the nurse recorded the PRN Paracetamol they administered in the medicine notes and not in the PRN section of the MAR chart.

We recommend that the provider ensures there are robust systems in place to ensure the proper and safe management of medicines at all times.

Controlled drugs were stored safely and we saw two signatures when these drugs were administered. We

counted medicines stocks, and they reconciled with the records of administration. This indicated medicines were being administered as prescribed. We also saw a home remedies book which detailed what quantities were given to whom. The stocks tallied with what was recorded in the book. There was evidence drugs were disposed of safely.

People who used the service and their families told us they felt the service was safe.

The service had procedures in place to safeguard the people who used the service. In addition to the safeguarding and whistleblowing policies, we saw information visible on staff notice boards about what to do if someone was abused or if staff suspected any type of abuse taking place . The training matrix showed staff had completed safeguarding training within the last year and staff we spoke with were able to identify types of abuse and knew how to report any suspected abuse. This meant that people who used the service were protected by the provider's procedures for safeguarding adults.

We saw risk assessments that identified and minimised risk. The files contained charts detailing blood sugar results, weight charts and medicines notes. Risk management plans included nutrition, pressure sores and falls. People who were at a high risk of pressure sores had equipment such as pressure relieving mattresses. Pressure ulcers and skin integrity were noted in the morning handover with the nurses. We also observed that people, or their relatives, had been involved in the care plans. The plans provided staff with guidelines to reduce risk and were reviewed monthly. We saw evidence the registered manager had raised safeguarding alerts with the local authority and notified the Care Quality Commission of their actions. They undertook management investigations and worked with the local authority to respond effectively to safeguarding alerts. The service responded appropriately to incidents and accidents and we saw an analysis completed to inform future practice and reduce the likelihood of harm. The information we received from the local authority indicated that overall there were no concerns.

The service had a business continuity plan that set out arrangements for emergencies. The fire policy provided staff with instructions of what to do in the event of a fire. Most staff had fire drill training and people who used the service had a Personal Emergency Evacuation Plan (PEEP) completed by room number. Fire alarm tests were undertaken weekly and fire equipment was checked monthly. There was an up to date boiler and gas safety certificate. Other checks included a lifting equipment check and an infection control audit. We saw general cleaning schedules and schedules for cleaning equipment such as hoists, however there was a slight malodour in some areas.

The service followed a safe recruitment procedure to ensure staff were suitable to work with people who used the service. Each of the staff files we reviewed included an application form, interview notes, proof of identity, references and Disclosure and Barring Service (DBS) checks. Additionally we saw evidence the nurses were registered with the Nursing and Midwifery Council. This meant that the likelihood of staff who were inappropriate to work with people who used the service was reduced.

The service used a computer programme called the Dependency Indicated Care Equation (DICE) to determine the levels of staffing required. We observed on the days we inspected that there were a sufficient number of staff deployed to meet people's needs. However, we received variable feedback in relation to staffing levels within the service. People who used the service said, "They could do with more staff, they have to do so much. I have to wait sometimes", "I have no problems" and "They have a terrible staffing problem." Relatives and friends told us, "They seem to cope" and "If they had more staff, they would have more time for conversation. Most of their time is spent on personal care and medication." Staff we spoke with indicated when the service was not at full capacity and therefore staffing was reduced, it could put a strain on the remaining staff. The registered manager noted that according to the DICE tool there were extra staffing

hours currently in place.

Good

Is the service effective?

Our findings

We saw evidence staff were supported to have the skills and knowledge they required to carry out their role through training, supervisions and appraisals. Staff were provided with an induction when they began working for the service. The training matrix indicated staff had training in the last year on safeguarding, the Mental Capacity Act 2005, fire safety, infection control, manual handling and food safety. It also showed when refresher courses were due or overdue. The service had an in house trainer and the registered manager and deputy manager were registered nurses who could provide support with clinical supervision. Nurses undertook yearly competency testing with the deputy manager. The registered manager and deputy observed people while they were working. Staff had one to one supervisions every two months and yearly appraisals, which were in the process of being completed for all staff, to develop their knowledge and skills. Additionally we saw team meeting minutes for January and May 2016 which included discussions about complaints, communication and care plans.

The service was participating in a research project run by Bradford University and Kings College studying how to improve the quality of life of people who were living with the experience of dementia. As part of the study, interactions between the staff and people living with dementia were observed and observations were fed back to the staff. A member of staff told us the feedback provided a different perspective and the study contributed to ongoing professional development and improving staff interactions with the people they provided care to.

Relatives and healthcare professionals told us communication with the service was good. A relative who visited the service two to three times a week said if there were any issues the service would ring them, or if they were unhappy about something, they would say. Healthcare professionals told us, "Communication is good. If I ask could x or y happen, that gets passed on and they have a report for me each time I come in" and "They definitely communicate very well and if they are concerned they always ring with their concerns."

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. The registered manager understood their responsibilities under the MCA. We saw evidence of 18 approved DoLS applications and nine applications pending. One person's file had a record of decision to administer medicines covertly and we saw mental capacity assessments for people who used bedrails. Pre-assessment forms recorded if people had capacity. Staff had undertaken MCA and DoLS training and understood the principles around choice and consent.

We saw people were involved in their care plans and reviews and that these were signed by people who used the service. One review had very specific information and a drawing of exactly how the person wanted their pillows arranged to provide comfortable support. A friend told us the person they visited had a review and a report from the review.

People we spoke with said they liked the food provided. Comments included "I'm very satisfied with it. There is a good choice and the portions are good" and "The food is generally very good." A relative told us, "The food has improved. It's now back to normal." Menus were well displayed and clearly showed what was on the menu that day. Each day the care workers recorded people's meal choices on a form that also recorded any specific needs, for example if the person was diabetic or required liquidised food. The chef told us that every day they spoke to a different person to get feedback on the meals that were served. They noted there had been staff changes in the past year causing some initial problems but these had now been resolved and the quality of the service had improved over the last few months.

We observed lunch in the Courtyard Unit where people lived with the experience of dementia. There were enough staff present to support people and people were smiling and talking during lunch. Food came to the dining room in trollies and people were asked what they would like to eat. We also saw a choice of drink, which included alcohol at people's request.

Some people raised with us that the dining room had been closed at times. The registered manager explained that the dining room had been closed two or three times in the past several months. This was the result of host/hostesses not being available and people were served meals in their rooms. Additionally there was long term sickness absence affecting the kitchen staff. The registered manager was addressing the issue by following the correct procedure for sickness absence and in the interim, other members of staff in the kitchen had acted up. The registered manager was also very open to suggestions and positive about engaging with the recently formed food committee that consisted of three people who used the service and three relatives.

In line with the National Institute of Care Excellence (NICE) guidance about environments for people with dementia, the Courtyard Unit had bright, wide corridors with tactile pictures on the walls, and toilets and bathrooms had clear pictures on the door to make it easier for people to know what was behind the door. People's rooms had personalised pictures on the door and rooms were decorated to reflect individual personalities. The other two units cared for people who were frailer and less mobile and people in these units spent more time in their rooms, although there were communal rooms. We saw the garden had raised flower beds so people could reach them without bending down. A second garden had a covered area with tables, chairs and a barbecue. One relative told us when they requested new garden furniture it was provided.

People's healthcare needs were met and we saw evidence of involvement with relevant healthcare professionals. The care plans included information about their nutrition, weight and wound care. One person said that appointments could be made to see the doctor and optician and staff had supported them to go to the dentist. Two people we spoke with were less satisfied with the healthcare support they received from the GP. We spoke to the allocated nurse and the registered manager about these concerns and were satisfied that these were being addressed and that both people had regular visits from family members who could advocate on their behalf if required. A relative told us the nursing care was "very good. (Person) had a serious soft tissue injury in January and the nurses looked after that very well." Two healthcare professionals said staff provided a good level of care in the two areas they monitored and followed through on any instructions for care provided.

Good

Is the service caring?

Our findings

People who used the service and their relatives we spoke with considered staff to be caring and kind. Comments included, "The staff are very friendly", "I have a laugh with a couple of the girls", "The staff are very pleasant", "They're very good, very nice, very friendly, very kind", "Generally the staff are obliging and helpful. The staff are polite and kind in the main" and "The staff are very good. They even help us too much at times. A couple of them are a bit bossy..." One person said sometimes when English was the staff member's second language, they were difficult to understand. Relatives said, "They're caring, very friendly, good with the patients. I wonder how they can be so good with people who are so difficult", "The staff are excellent" and "The staff are very nice and there isn't a huge change over. There is a good feeling between the staff and the patients."

Health professionals we spoke with observed that staff tried to engage with people and said, "On the whole I think they go out of their way to help people. It's very welcoming and very professional. Staff are always courteous and polite." People who used the service were "always very well presented" and staff "are always very caring." Another professional said there were no areas of concern and the service's paperwork was "very person centred". They observed families made positive remarks about staff being available and that they felt listened to.

The registered manager was aware of people's individual needs and said, "It's the residents' home. We try and involve them in everything." Staff spoke positively about the people they supported and said they tried to encourage independence by providing people with choices. For example people chose what they would like to eat, and if required, staff used visual cues by showing people two meals to choose from. They encouraged people to do things independently such as walking instead of using a wheelchair and helping with their personal care as much as possible.

In the Courtyard Unit, we observed staff offered people choices and saw they were responsive to what people wanted to do. We saw a staff member folding napkins into shapes and setting the tables for lunch. A person at the table took an interest in how the staff was folding napkins, so the staff stopped to show the person how to fold them and encouraged the person to do the ones for their table.

Staff said people's privacy and dignity was respected. A care worker told us that when they supported people with personal care, they knocked on the door and greeted the person. They didn't talk over people. They gave people the opportunity to make decisions and asked people what their preferences were.

Most people told us they were cared for with dignity. One person said staff knocked on doors before entering and another person said they preferred their door open but staff always knocked before entering. Feedback from relatives also indicated people were treated with dignity and respect.

We saw files contained preferences and choices for end of life care. The service worked with palliative care professionals from the community and one healthcare professional told us there was "a high standard of care" and "staff are very attentive". The registered manager told us most people chose to stay at the home

for end of life care and the service was very good at preparing and supporting people and their families at this time. This was confirmed by written correspondence from a number of relatives commenting positively on the quality of care their relatives received.

During our inspection we saw family and friends visiting people. Advocacy information was displayed on a notice board in the communal area and we saw one person had an advocate who ensured the opinion of the person they supported was heard and helped them to understand their rights.

Good

Is the service responsive?

Our findings

The service employed two activities co-ordinators one of whom is a trained massage therapist who provided hand massages and painted people's nails. Activities included gentle exercises, quizzes, musical bingo and scrabble. The physiotherapist noted that they had a good working relationship with the activities co-ordinator and if they asked for specific exercises to be incorporated into the exercise class, the co-ordinator did this. They also observed that although people were encouraged to attend the exercise class, they were given a choice. Each file had a daily record for activities which noted by code what the person did each day. Examples included reading, a visit from the Pets as Therapy (PAT) dog, attending parties and gentle exercises. Activity plans were not very detailed or reflective of the person's individual interests. This meant people's social needs were not always met in a person centred way.

During our inspection, we saw the activity co-ordinator engaging five people to play Scrabble on a very large board, however, feedback about activities from other people indicated less engagement. Three people we spoke with said they tended to stay in their rooms and read or watch TV in the lounge. A fourth person told us, "I find it very boring." The person said they mainly stayed in their room, watched TV, read the paper and sometimes their relative took them out to eat. They said the home did gentle exercise but they would like something more energetic. They also said they liked gardening and had been given a small area to tend at the home but then said this was not enough and had stopped tending it.

A visitor said that they had not seen any activities recently, but in the past they had seen people coming in and playing musical instruments and people would dance. A relative told us there was a lot of live music, which was very good, and they did musical bingo and quizzes which were stimulating, but they would like to see more activities in the upstairs sitting room. A staff member from that floor noted that staff did not always have time to support people with activities. The needs of the people in the service meant that people often preferred small or individual activities and if staff were unavailable for activities, it meant not everyone's needs were being met. Some people preferred to stay in their rooms, but overall we observed a lack of meaningful and interesting activities particularly in the two units for people who were more frail and less mobile.

We recommend that the provider review activity provision in line with the NICE guidelines.

Pre-admission assessments were undertaken which included people's medical background, legal status and whether or not they had capacity. We saw information recorded on preferences, family networks, previous occupation and social interests. People we spoke with were not sure if they were involved in their care plans, however staff told us people were involved in their care plans and two relatives we spoke with said they had also been involved in discussions around care plans. Care plans were regularly reviewed but not consistently signed by the people who used the service. They included a nutritional profile that recorded weight and dietary needs. Food preferences were recorded and we saw one person had a very specific list of foods including the brand they preferred. A professional told us they were aware of staff buying food from a specific shop for a person who preferred that brand to the food from the kitchen. We saw plans for wound care treatment and records of how they progressed.

Care plans were reviewed on a monthly basis and recorded any changes in people's needs. A monthly care profile review checked that all the care plans and risk assessments were correct and up to date. We saw a progress and evaluation record of daily tasks completed by staff to indicate what the person did that day. These records showed that care was delivered in line with people's preferences and care plan.

Residents and relatives' meetings were held monthly. Topics discussed included food and activities. Minutes indicated both people who used the service and relatives contributed to the meetings. People who used the service said, "I think I went to one meeting, but I can't remember" and "I go to the meetings if I'm asked, but I'm a bit blunt." Another resident said the meetings took place every two months. They had not been to one but would like to attend them. These meetings gave people the opportunity to share feedback and give their opinion on how the service was run.

Three of the four people we asked about complaints said they did not have a reason to complain but if they did, they would speak to the manager. One person said they had not complained to the manager because they felt the nurses would not like this. They said, "Management don't usually get involved in medical matters, they'd probably like to but they don't." We made the manager aware of this concern, to ensure when they did speak with this person they gave the person the opportunity to voice any concerns. A relative told us "I have never had any reason to complain." Another relative said a new system of complaint cards and a suggestion box had been introduced. The service had a complaints procedure and we saw a copy in the reception area. The registered manager recorded and investigated complaints and the resulting action taken. We saw appropriate feedback from the registered manager to the person making the complaint. Complaints were analysed by the parent organisation.

Good

Is the service well-led?

Our findings

People who used the service told us, "The manager comes up occasionally", "The management are affable. Management will pop their head round the door" and "The manager is very good. They come round and say a few words. They're very friendly, and deal with complaints." Relatives said, "The manager is very pleasant", "The manager is excellent, you can approach them any time you want. There is an open door policy. If anything is wrong they're prepared to listen and sort it out. They're prepared to accept criticism" and "The manager is good. They're always very helpful if you want anything." A friend said they were impressed when on one occasion, a woollen jacket was put in the wash and shrunk. The friend mentioned it to the manager who immediately reimbursed the person. The friend said this reaction "reinforced their confidence in the home." Another visitor said the service was "really well managed". A family member said the manager was "fully aware" of their views and they felt listened to. Staff mostly felt, but not always, that the managers listened and acted on their concerns. One staff member told us "(The registered manager) would listen to concerns. I've put that to the test" and another said, "Of course (the registered manager) is approachable."

The service gained feedback through surveys. The parent organisation used an app to undertake staff surveys and analysed the information as part of the larger organisation. We saw the service took part in an independent My Care rating survey for residents and relatives. Nineteen people took part in the survey which indicated overall, people were satisfied with the care they were receiving. However the people we spoke with during the inspection were not aware of being asked for their opinion on how the service was run.

The registered manager and the deputy manager had a good knowledge of the needs of the people using the service. They spent time on the floor observing staff and talking to people. We observed a handover meeting which was held every morning with the nurses from each unit to give a brief update on individual people.

The service had systems to monitor the quality of the service delivered to ensure the needs of the people who used the service were being met. Checks included quality audits by other managers from within the parent organisation. These were recorded and included action plans for service improvements. We saw evidence of maintenance and cleaning checks and monthly medicines and care plan audits. This provided the registered manager with an overview of the service and highlighted areas that required improvement.

The service kept up to date with current best practice and legislation through emails from the parent organisation, reading professional magazines such as the Nursing Times and by speaking with other healthcare professionals. The service had good working relationships with a number of different community based professionals that contributed to them being able to meet people's individual needs with the appropriate health care professionals. The service also had Keeping in Touch (KIT) volunteers come in three times a week to spend time with people in the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not ensure that care and treatment were provided in a safe way for service users because they did not do all that was reasonably practicable to mitigate risk by correctly following health care plans and risk assessments. Regulation 12 (2) (b)