Harpwood House Limited

Harpwood Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection was carried out on 4 June 2018. The inspection was unannounced.

We undertook an unannounced focused inspection of Harpwood Care Home on 4 June 2018. The team inspected the service against three of the five questions we ask about services: is the service well led, is the service effective and is the service safe. This was due to the concerns that had been raised, and the potential risk to others living at Harpwood Care Home. At this inspection the service was rated as requires improvement in safe, effective and well-led, therefore the overall rating for the service is now requires improvement.

Harpwood Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Harpwood Care Home is a privately owned care home providing accommodation for up to 50 older people some of whom live with dementia. The service had three double bedrooms; the remainder of the rooms were single, some with ensuite facilities. There was a large garden for people to use with seating and pathways. There were 43 people living in the service when we inspected.

The service had a manager in post who had started after the full comprehensive inspection in July 2016. The manager had applied to become registered with the Care Quality Commission to manage the service. The manager had attended their registration interview in the week prior to our inspection. 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.

Some people's care plans were detailed and gave staff guidance regarding how to meet people's needs. However, some care plans were not always complete and, some contained conflicting information. One persons' care plan recorded that they did want to receive medical attention in the event of an emergency; however, another page within their plan stated they did not want medical attention. Another persons' care plan stated there was concern regarding the person's weight loss, and that meals should be offered frequently. However, in practice staff were supporting this person to manage their weight and offering a low fat diet.

Risks posed to people had not been consistently assessed, recorded and monitored. Some people were at risk of skin damage and used specialist equipment to reduce this risk. However, the equipment had been incorrectly set, leaving these people at risk of skin damage. Another persons' care plan stated they were at risk of falls; guidance was available for staff to follow to reduce this risk. However, the guidance was not consistently followed by the staff team, leaving the person at risk of falling. Other risks to people had been properly assessed and action was taken to mitigate the risk.

People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice. People were encouraged to make their own choices and staff gained people's consent prior to any care or support tasks. However, people's capacity to consent to specific decisions had not always been sought in line with the principles of the Mental Capacity Act 2005 (MCA).

People felt safe with the staff at Harpwood Care Home. Staff understood their responsibilities to safeguard people from potential abuse. There were enough staff deployed to meet people's assessed needs. Recruitment procedures had not consistently been followed; gaps in employment had not been explored or recorded. We have made a recommendation about this.

People received their medicines from trained staff as prescribed by their doctor. People were supported to maintain their health and attend appointments with health care professionals as required. The manager had developed professional relationships with external agencies to promote people's health. People's nutrition and hydration had been assessed, however, records showed inconsistent guidance for staff. People were offered a range of meals which they enjoyed and were offered regular drinks.

The quality and monitoring systems in place were not always effective. There were regular audits carried out by the manager and senior manager, however, these had not always identified the concerns that were found during this inspection.

The building and equipment was suitably maintained to make sure it was in good working order. Regular checks were made to the fire alarm system and emergency fire-fighting equipment. People's ability to safely evacuate the building in the event of an emergency had been recorded. The service was clean throughout and people were protected from the potential risk of infection.

Staff were supported in their role by the management team. A variety of training courses were available to enable staff to meet people's needs, including their specialist needs. New staff completed an induction and worked alongside experienced members of staff before working as part of the care team. There was a visible management team who promoted an open culture within the service.

We found four 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 this report.

Full information about CQC's regulatory response to any concerns found during inspections is added to the back of the full version of the reports after any representations and appeals have been concluded.

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 consistently safe.

Potential risks to people had not always been assessed with action taken to minimise the risk.

Recruitment procedures had not always been followed to ensure staff were safe to work with people. There were enough staff available to meet people's needs.

People received their medicines safely as prescribed by their doctor.

The building was maintained and checks were made to promote people's safety. The service was clean and systems were in place to reduce the risk of infection.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's nutrition and hydration needs had not always been met.

People's consent had not always been assessed and recorded in line with MCA.

People were supported to attend medical appointments and remain as healthy as possible.

Pre-admission assessments were completed with people prior to them receiving a service.

Staff were trained to meet people's needs. Staff received support and supervision from their line manager.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Governance systems were not always effective at identifying shortfalls within the service.

There was an open culture where staff were kept informed about any changes to their role.

The staff team worked in partnership with external health care professionals to maintain people's health.

The manager understood their responsibilities and had applied to become registered with the CQC.

Harpwood Care Home

Detailed findings

Background to this inspection

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

We carried out an unannounced comprehensive inspection of this service on 1 and 6 July 2016. After that inspection we received concerns in relation to a person staying at the service for a period of respite. The concerns related to meeting people's nutrition and hydration, the lack of staff skills and knowledge and insufficient staffing levels. As a result, we undertook a focused inspection to look into those potential concerns. This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Harpwood Care Home on our website at www.cqc.org.uk.

The inspection team consisted of three inspectors 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 for this inspection had experience in care for older people.

This was a focused inspection, carried out following concerns; as a result a Provider Information Return (PIR) had not been requested. This is a form that asks the registered manager to give some key information about the service, what they do well and improvements they plan to make. We gathered this information during the inspection. We looked at other information we held about the service. This included previous inspection reports, concerns that had been raised and notifications. Notifications are changes, events or incidents that the service must inform us about.

Some people were unable to tell us about their experiences. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed staff interactions with people and observed care and support in communal areas. We spoke with 16 people about the care and support they received. We spoke with ten relatives to give their feedback about the service. As part of the inspection we spoke with the practice development manager, the manager, the deputy manager and two care staff.

We reviewed a range of records. This included eight people's care plans and records including care planning documentation, risk assessments, nutrition and hydration information and medicine records. We looked at documentation that related to staff management and training. We also looked at records concerning the monitoring, safety and quality of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe with the staff at Harpwood Care Home. Relatives told us they felt their loved ones were safe. One relative said, "I don't have any concerns, I am very confident in the care and support provided." However, despite the positive feedback, we found that the risks to people's safety had not always been minimised. Some people were at risk from thinning/weak skin and had special air-filled mattresses on their beds. These mattresses needed to be pumped up to a level set in line with people's body-weight to reduce the risks of people developing pressure ulcers. Two people's mattresses were found to be set at incorrect levels, meaning they were which placed their skin at risk of developing pressure sores.

Other people were at risk of falls and care plans detailed the actions needed to prevent these happening as far as possible. One person had experienced a number of falls and their care plan about mobility said they should have their walking frame close by and be supervised by staff when walking about. However, our observations found that this person did not always have their walker in reach and that they sometimes walked without it when there were no staff around to see them and help prevent them falling again. We brought this to the immediate attention of senior staff and the manager who brought the person's walker to them from their room. However, the person continued to get up and walk without it when staff were not nearby. The manager told us they would investigate what else could be done to reduce the risk of falls for this person.

Many of the people using the service had impaired mobility and some used walking aids to move around. The floor in one of the main downstairs corridors was extremely uneven in one place, creating a large hump in the carpet. Two of the inspection team tripped more than once on this area of floor and the manager confirmed that staff sometimes did so too. They assured us that none of the people using the service had tripped or fallen because of the hump in the floor. This did however present a risk to people, staff and visitors; which had not been sufficiently addressed at the time of our inspection.

Some people were able to use call bells to summon staff assistance and others were not. One person's care plan recorded that they should be reminded how to use the bell and it should be left in their reach, but when we visited the person in their bedroom the call bell was attached to the wall some distance from where they lay in bed. Another person was heard shouting and asking for help from their bedroom for more than ten minutes before staff came. This person's care plan documented that they did call out and staff should offer reassurance when this happened. There was no assessment about whether this person could use a call bell or instructions for staff about how to reduce the risk to them. However, the manager told us that hourly checks were made on those people who stayed in their rooms or could not use a call bell. These checks were not documented by staff.

Risks had not been appropriately assessed or mitigated which is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Other risks to people had been properly assessed and mitigated. Where people lived with epilepsy or diabetes there were clear, individual care plans to guide staff in how to recognise any changes in people's

conditions and how to address these safely. Staff were able to tell us which people were affected by epilepsy and/or diabetes and describe how they would react to seizures or changes in blood sugar levels.

Records about people's care and treatment needs were not always up to date or accurate; creating potential risks to them. One person's end of life care plan had two entries about Do Not Attempt Cardiopulmonary Resuscitation orders (DNACPR). The first of these said that there was a DNACPR order in place and the second said there was not, and that 'In case of collapse, staff must resuscitate and dial 999'. It was crucial that staff had clear instructions about DNACPR status so that the correct response happened if necessary, and we made the manager aware of this immediately.

Another person's care plan stated that they should drink thickened fluids. These are produced when special granules are added to liquids to make it easier for a person to swallow; and reduce the risk of choking. However, there was a beaker of unthickened orange juice and a jug of unthickened water in this person's bedroom and within their reach. Staff and the manager told us that this person no longer needed thickened drinks, but there had been no update to the care plan to detail when this instruction had been received and from whom. Another person had tubs of thickening agent in their bedroom but their care plan made no mention of them having drinks prepared in this way or to what consistency drinks should be thickened. Staff told us that they added "a scoop when [Person's name] is unwell, just to help them out". During the inspection the manager called the GP and confirmed that thickened fluids were no longer required for either person, but the conflicting information and lack of up to date records created risks that people would not receive appropriate care and treatment.

A further person's care plan about nutrition showed that they should be receiving a high-calorie diet, with snacks between meals because they had lost significant weight. However, when we spoke with the manager they said that the care plan was "All wrong" and that this person was on a weight-reducing diet and did not need supplements to their meals as described. This person lived with diabetes and it was important that their diet was suitably managed for them.

The incomplete, inaccurate records about people's care and treatment were a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff had not always been recruited safely. Potential staff are required to explain any gaps in their employment history since leaving school. All of the four recruitment files we checked contained gaps in the member of staffs' employment history, which had not been explored by the manager. Other recruitment procedures had been followed such as, obtaining references from previous employers, identity check and completing a Disclose and Baring Service (DBS) background check. These check employment histories to help ensure they were safe to work at the service. A record was kept of the answers that had been given during the interview; these were used to compare potential candidates to one another.

We recommend that the provider explores any gaps in employment in line with schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were protected from the potential risk of abuse. Staff understood the potential signs of abuse, and had been trained to understand and follow the provider's policy. Potential safeguarding concerns had been reported to the local authorities safeguarding team, and these were monitored on a monthly basis by the manager and senior manager. Policies and procedures to reduce discrimination were actively implemented.

There were enough staff deployed during the day and night to meet people's assessed needs. The manager

used a dependency tool to determine the level of staff that were required, this had been reviewed monthly. Staffing levels were kept under review and changes were made if required. For example, staff had fed back that they were particularly busy during the morning; as a result an additional member of staff had been put on shift. Records showed a consistent level of staffing prior to and following our inspection. The manager and deputy manager were available five days a week within the service if any additional support was required.

People received their medicines when they needed them and staff giving out medicine had received appropriate training and competency supervision. There were clear protocols in place to make sure people received the right amount of medicine safely and on time. Established pain assessment processes supported the management of pain to help reduce symptoms and distress. Staff were aware of people's conditions and the medicines they received. All medicines were stored securely in line with current guidance. Appropriate arrangements were in place for ordering, recording, administering and disposing of prescribed medicines. Clear records were kept of all medicine that had been administered orally; these were up to date with no gaps and showed which staff had administered them. Guidance was in place for people who took medicines prescribed 'as and when required' (PRN), for example, paracetamol. The manager and other key staff completed regular medicine audits; this helped to ensure people received all medicines safely.

Systems were in place to ensure the safety of people, staff and visitors within the building. The provider employed a maintenance person who was available within the service five days a week, and on call for emergencies. There were up-to-date safety and maintenance certificates for equipment. Regular checks were carried out on the fire alarm and emergency lighting to make sure it was in good working order. Records showed the maintenance person followed a programme of weekly and monthly checks. Any issues that were identified were acted on quickly. However, the potential risk with the uneven floor had not been acted on.

Accidents and incidents involving people were reported by staff in line with the provider's policy. The manager investigated any concerns, and changes to care and support were communicated to staff. The manager and senior manager completed a monthly analysis of all incidents and accidents, this enabled any patterns or trends that had developed to be identified and acted on promptly. Each person had a personal emergency evacuation plan (PEEP) in place, which provided guidance to staff on how to support that person to evacuate the building in the event of an emergency.

People were protected by the prevention and control of infection where possible. The service was clean and hygienic throughout and food safety checks had been carried out and recorded in line with legislation. Staff used protective aprons and gloves, and antibacterial hand gel was available for people, staff and visitors to use. Infection control audits were carried out by the management team and action had been taken when shortfalls were identified.

The management team learnt from errors and made changes to improve the service. For example, following an emergency hospital admission staff did not have the full documentation to handover to the paramedics. As a result a 'hospital grab sheet' was introduced, this contained the essential information that was required about the person. Another example related to a concern that had been raised from the doctor's surgery, they were concerned about the frequency of phone calls they were receiving about the same issue. As a result a designated member of the team was assigned daily to be the point of contact for any medical concerns. This enabled one person to track the progress of any medical support that was required, and reduced the numerous phone calls to the surgeries.

Requires Improvement

Is the service effective?

Our findings

People spoke highly of the food they received. One person said, "Mealtimes are pleasurable, the food is hot and good." Another person said, "I just love to sit around the table with everyone, it's nice." Observation showed a relaxed atmosphere during the lunch service, where people were offered a choice of two hot meals followed by dessert. However, despite the positive feedback we found that action had not always been taken to reduce the risk of malnutrition and dehydration. Consent to care and treatment had not always been sought in line with the Mental Capacity Act 2005.

Risks to people in connection with eating and drinking had not been consistently minimised. One person's weight records showed they had lost around 12kgs since January 2018. Care records documented that the GP had been contacted in May 2017 about this person's previous weight losses. They advised that food and fluid charts should be completed by staff but felt that the person's declining mental health was the cause of the weight loss. The manager confirmed that there had been no further discussion with the GP or a dietician about this person's significant further weight losses since this time; over a year ago. At the time of our inspection, no detailed records of food or fluid intake were being maintained for this person, but staff had completed a check sheet to indicate that this person had eaten all of most meals. Despite this the person had continued to lose a lot of weight. Their care plan about nutrition stated that they ate independently but sometimes required support from staff. During the inspection we observed that this person's lunch was left by staff on the over-bed table, but the person was asleep and had not eaten any of the meal. After 15 minutes the deputy manager visited the person in their room and supported them to eat their lunch. It was not until the person was offered assistance that they ate; and by this time their meal was likely to be at best lukewarm. Although the manager and staff told us this person could drink independently there was no drink placed within their reach; until we raised this as a concern. As fluid intake was not being recorded by staff there was no reliable way to know if this person had enough to drink.

Another person's care plan stated that their urine output should be recorded as they had a catheter. Fluid charts had no specific column for staff to document fluid output and the charts presented an unclear picture of what had been offered, drunk and passed as urine. In some cases the urinary output was significantly lower than the amount recorded as intake, but this had not been identified as a possible cause for concern. There was no target amount recorded in either the care plan or on the fluid chart and daily intake had not been totalled up on a number of occasions. The manager told us that senior care staff were supposed to check fluid charts on a daily basis to see that staff were completing them properly and also to pick up on any issues of concern. This process had not been effective and people could be at risk because of it. Although care of the catheter was mainly undertaken by a visiting district nurse, the manager told us that staff changed the catheter bag weekly. There was no information or guidance for staff in the person's care plan about bag changes or the need for hygienic practice when doing so. The person could have been at risk of infection.

Failure to minimise risks to people in relation to nutrition and hydration and health needs is a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

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 make 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 are called the Deprivation of Liberty Safeguards (DoLS). Restrictions could include, for example, bed rails, lap belts, stair gates, restrictions about leaving the service and supervision inside and outside of the service.

There was a mixed picture of how well the MCA was operated in the service. In the case of a person who was receiving their medicines without their knowledge or consent, all the appropriate actions had been taken. The person's capacity to understand the decision to take their medicines and the risks of not doing so had been formally assessed and a best interest decision documented to show that other, less-restrictive approaches had been considered. Approval from a GP had been sought and recorded so that medicines could be safely crushed and mixed with food or drinks.

Another person had bed rails in place which prevented them from leaving the bed on their own. A MCA assessment had been carried out to determine that the person lacked capacity to make a decision about the use of bed rails themselves, but there had been no best interest meeting or discussion to determine that their use was appropriate and the least-restrictive option.

Staff sought verbal consent from people routinely as they supported them. They were observed asking people where if they were happy to sit in certain places for lunch and whether they could help them to adjust their clothing. Formal, written consent to care and treatment had been given by people when they moved into the service. However, there was no record of people being asked for permission to use their photos; which were seen in albums in communal areas and on computer systems used for medicines administration.

Failure to act in accordance with the Mental Capacity Act 2005 is a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The manager understood their responsibility for making applications to the local DoLS team, when a person was bring deprived of their liberty. A tracking system was used to record all applications that had applied for, the date the authorisation was granted or refused, the expiry date of the authorisation and the date CQC had been formally notified via a statutory notification.

People had access to a range of health professionals such as GPs district nurses, podiatrists, hearing specialists and opticians. The service had forged working relationships with the local hospice; who were able to provide advice and guidance for people receiving palliative or end of life care. The manager told us that they and staff had taken part in a bespoke end of life care training course provided by the hospice. They said that work was underway to enable people to receive regular dental treatment in the service and in the meantime, regular mouth care was given and documented to highlight any emerging problems.

Hospital 'passports' were being produced for all people at the time of our inspection to ensure that people's individual needs and personalities were clearly communicated to hospital staff when people were transferred to their care for any reason. This helped to ensure continuity of their care and treatment.

The manager and the deputy manager undertook a pre-admission assessment with people prior to and

when they started to use the service, for respite or on a permanent basis. The pre-admission assessment took into account the persons care and support needs, mobility, nutrition, communication, physical and social needs. This information was then transferred onto the electronic care plan system. People's protected characteristics, such as their race, religion or sexual orientation, were recorded during the assessment, and this was then transferred in the care plan. There were equality, diversity and inclusion policies in place for staff to follow, and staff received training in this subject as part of their induction.

People knew their way around the service; they were able to move around freely. We observed people walking from their bedroom, to the lounge and to the dining room. The manager had used signs and pictures to promote people's independence and freedom of movement.

Staff told us they felt supported in their role by the management team. Staff received supervision meetings with their line manager in line with the provider's policy. Supervision meetings reviewed work performance, discussed any training needs, support and development, work targets and standards required. Annual appraisals were completed with people, this enabled the member of staff and the supervisor to reflect on the previous year; and plan for the forth coming year.

Staff had the skills, knowledge and experience to deliver effective care and support. People told us they felt the staff were trained and able to meet their needs. One person said, "They seem to be well trained." Another person said, "The staff know what they are doing." Staff told us they received the training and guidance to meet people's needs including their specialist needs.

The provider used a number of training courses which they considered as mandatory; these were monitored by the manager. The manager used a training matrix to plan training courses throughout the year. Staff were offered the opportunity to complete a formal qualification during their employment. For example, QCF in Health and Social Care, this is an accredited qualification. The provider had a process for all staff to follow during their induction, depending on their role within the service. New staff completed the Care Certificate (this is a set of standards for health and social care workers) during their induction, this gave staff the knowledge they required to complete their role. New staff also worked alongside experienced members of staff before working as part of the care team.

Requires Improvement

Is the service well-led?

Our findings

People, their relatives and staff told us they felt the service was well-led. Observation showed people knew who the manager was and approached them throughout the inspection, to ask questions and talk about any concerns they had. Staff spoke highly of the management team. One member of staff said, "These are the best managers we have had." However, despite the positive feedback we found that the areas for improvement we found during this inspection had not previously been identified or acted on.

There were systems in place to monitor the quality of the service that was provided to people. However, these audits had not always been effective at identifying and acting on the concerns we found during this inspection; such as, the shortfalls in care records and assessing risks. The concern relating to one of the four staff files had been identified during a recent audit by the senior manager, however, this was still incomplete at our inspection. The senior manager completed a monthly audit where samples of documents were audited such as, care records, staff files, health and safety and general observations of the care delivery. The audits generated action plans which were shared with the provider at monthly managers meetings. The manager and then practice development manager held responsibility for completing and monitoring any actions.

The lack of oversight and failure to identify, and act on shortfalls were a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The manager had worked at the service since October 2017 and had applied to become registered with the Care Quality Commission. The manager was supported by a deputy manager within the service; both were available five days a week. There were governance systems in place to support the manager, through an area practice development manager and regular contact with the provider. The manager told us they felt "very supported by the provider, and said that nothing was too much trouble." Staff told us they were aware of their role and responsibility and who they were accountable to. Each employee had been given a job description and person specification, this outlined their job role and purpose.

People were actively involved in the development of the service and the care they received. Regular resident meetings were held which gave people the opportunity to give feedback and make suggestions. Regular team meetings were held so staff could discuss practice and other topics such as, policies and procedures and training needs. Staff meetings gave staff the opportunity to give their views about the service and to suggest any improvements.

Staff told us they felt there was an open culture and visible leadership. Staff were kept informed about people's care needs and about any other issues. Staff handover's between shifts and communication books highlighted any changes in people's health and care needs, this ensured staff were aware of any changes in people's health and care needs. A member of the management team attended the handover meeting to keep informed about people and observe the day to day culture and practice.

The manager promoted a culture of partnership working with external agencies, such as, the local GP

surgery and local hospice team. This enabled people to receive a joined up service with external health care professionals. The manager had also used these links to create a bespoke training package for the staff team regarding end of life care.

The manager had an understanding of their role and responsibility to provide quality care and support to people. They understood that they were required to submit information to the Care Quality Commission (CQC) when reportable incidents had occurred. For example, when a person had died or had an accident. All incidents had been reported correctly. The manager had a vision for the staff and the service, to develop staff skills and provider additional opportunities for people using the service.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed their rating in the hall way and on the provider's 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 11 HSCA RA Regulations 2014 Need for consent Failure to act in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks had not been appropriately assessed or mitigated. Failure to minimise risks to people in relation to nutrition and hydration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Incomplete, inaccurate records about people's care and treatment. The lack of oversight and failure to identify, and act on shortfalls were a breach of Regulation 17