The Orders Of St. John Care Trust

OSJCT Lake House

Inspection report

The Green
Lake Walk, Adderbury
Banbury
Oxfordshire
OX17 3NG

Tel: 01295811183
Website: www.osjct.co.uk

Date of inspection visit:
13 September 2017

Date of publication:
14 November 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected this service on 13 September 2017. This was an unannounced inspection. Lake House is a residential care home registered to provide accommodation for up to 43 older people who require personal care. At the time of the inspection there were 40 people living at the service.

There was a registered manager at Lake House. 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.

We found improvements were required in respect of ensuring a robust process was in place to check potential employee's employment history. Where there were gaps, there was no explanation of these as required by legislation.

We also found that The Trust had not communicated effectively about prioritising actions following a fire risk assessment. This meant it was unclear which actions should be completed by to ensure people's safety was optimised.

The provider's quality assurance system had not identified these issues prior to the inspection and therefore remedial action had not taken place.

.

Records relating to the administration of topical medicines were not always complete or accurate. We have made a recommendation about the management of some medicines.

People were supported in line with the principles of the Mental Capacity Act 2005 (MCA). Staff had completed training in MCA and understood the principles of the act. Staff understood how to apply the principles when supporting people who may be assessed as lacking capacity.

People felt safe and were supported by sufficient staff that had the skills and knowledge to meet their needs. People were positive about living in the service and about the caring nature of the management and staff.

Staff felt valued and were supported through regular supervision and team meetings. Staff had access to training to enable them to improve their skills and knowledge.

People and relatives were involved in decisions about people's support needs. People had care plans which detailed the support they required and how the support would be provided. Care plans were regularly reviewed and updated.

Where required, people were referred to health and social care professionals. Where guidance was provided this was followed by staff who knew people well.

People enjoyed the food. People who had specific dietary requirements received food to ensure their needs were met.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. You can see what action we told the provider to take at the end 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.

Improvements were needed to ensure systems were in place to ensure the service was operated safely.

People mostly received their medicines as prescribed. Action was needed to ensure topical medicines were applied and recorded appropriately.

There were sufficient numbers of staff and risks to people's safety related to their care and support had been assessed and plans were in place to minimise those risks.

Staff had a good understanding of how to keep people safe from abuse and their responsibilities for reporting accidents, incidents or concerns.

Is the service effective?

Good

The service was effective.

People benefitted from a staff team that was well trained. Staff had the skills and support needed to deliver care to a good standard.

Staff promoted people's rights to consent to their care and were aware of their responsibilities to ensure people's rights to make their own decisions were promoted.

People were supported to eat and drink enough and staff made sure actions were taken to ensure their health and social care needs were met.

Is the service caring?

Good

The service was caring.

People benefitted from a staff team that was caring and respectful.

People received care from staff that were compassionate and understanding of their known wishes and preferences.

People's dignity and privacy were respected and staff encouraged and enabled people to maintain their independence where they could.

People's right to confidentiality was protected.

Is the service responsive?

Good

The service was responsive.

People received care and support that was personalised to meet their individual needs. People's needs were reviewed and changes to the care provided made appropriately.

People were provided with opportunities to be involved with activities to avoid isolation.

People and their relatives knew how to raise concerns. Complaints were dealt with promptly and resolutions were recorded along with actions taken.

Is the service well-led?

Requires Improvement

The service was not always well led.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the service. However, the systems were not always effective in identifying non-compliance with the fundamental standards. Where non-compliance was identified, actions were not always taken to remedy the issues.

Relatives were happy with the service their family members received and felt the staff were approachable and professional.

Staff were happy working at the service. They felt extremely supported by the management and said the training they received helped them to meet people's needs, choices and preferences.

OSJCT Lake 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.

This inspection took place on 13 September 2017 and was unannounced.

The inspection was carried out by 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.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at notifications received from the provider. A notification is information about important events which the provider is required to tell us about by law. We sought feedback from professionals who support people in the service.

During the inspection we spoke with nine people who used the service, two relatives and one friend of a person in the service. We also spoke with one visiting professional. We spoke with seven members of staff including the registered manager, head of care, health care assistants and a housekeeper.

We observed practice throughout the inspection and 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 looked at six people's care records including medicine administration records, four staff files and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

Safe recruitment practices were not fully followed. Out of the four records we examined, two members of staff had gaps in their employment history which had not been explored in the course of the process of their recruitment. Providers must have effective recruitment and selection procedures and ensure they make appropriate checks for employees before they are employed. This enables the provider and registered manager to make safer recruitment decisions. The provider took action following our visit to put systems in place to ensure a full employment history would be obtained from applicants in future prior to recruitment decisions being made.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw other areas of the recruitment and selection process had been completed, including gaining two references from previous employers, photographic proof of identity, a job application form, a health declaration, interview questions and answers, and proof of eligibility to work in the UK (where applicable). Disclosure and Barring Service (DBS) checks had been completed. These checks identified if staff were of good character and were suitable to work with vulnerable people.

Topical MAR charts included body maps which guided staff on where to apply creams. However, we found topical MAR charts did not fully detail the type of cream. We also found signature gaps on three charts. Therefore, we could not be sure people received their creams as prescribed. The registered manager addressed this issue on the day of the inspection.

We recommend the provider accesses appropriate guidance in relation to the completion of records for topical medicines.

People received their medicines as prescribed and the home had safe medicine administration systems in place, including secure storage. We observed staff administered medicines to people in line with their prescription. There was accurate recording of the administration of oral medicines. Medicine administration records (MAR) were completed to show when medication had been given or if not taken the reason why. We checked three people's medicine stocks and these were all correct. Medicine fridge temperatures were checked daily and were within range. There were no medicines stored in the fridge at the time of our inspection.

We spoke with staff about what actions may need to be taken to ensure people were protected from abuse. Staff were aware that incidents of potential abuse or neglect should be reported to the local authority. We had comments from staff including, "I would report this straight away to my manager. If she did nothing about it I would report this further to the head office" and "I would go straight away to the manager. If she is not in, I would report this to the most senior member of staff. If she did nothing, I would report this matter to (the CQC)."

Risks to people's health and wellbeing were appropriately managed. For example, when one person's health had deteriorated, a range of risk assessments had been produced. These risk assessments covered the areas of mobility, communication, manual handling and personal hygiene. Risk assessments were in place to help identify risk factors specific to each person, such as manual handling, bathing and showering, fire, falls or pressure care. This helped to provide staff with information on how to manage and minimise these risks and provide people's care safely. For example, one person's breathing assessment stated that the person suffered from blackouts which could re-occur anytime. The person was likely to get short of breath when having seizures. Staff were instructed to ensure the surroundings did not pose any threat to the person's health, to give the person reassurance and to monitor their breath. Another person was prone to falls and prescribed with a walking frame. The person often left the frame and attempted to walk without it, requesting no aid. Staff were instructed to prompt the person to use the walking frame but also to support the person to put their footwear on properly to avoid any falls. Staff we spoke with could describe how they would support people to stay safe in accordance with the guidance in their care plans.

People were protected from the risk of choking as thickening agents for fluids were administered and stored safely. Staff knew how to support people on thickened fluids and guidance was sought from the Speech and Language Therapy (SALT) team whenever a choking risk was identified.

Where people were identified as at risk of pressure sores, staff had sought professional advice and pressure relieving equipment put in place. This included pressure mattresses, cushions and inflatable booties. We saw a person who used a full hoist for transfers had their own hoist slings in their room. This reflects good practice to reduce any chance of cross infection.

People felt there were enough staff to meet their needs. We had comments such as, "Yes, I feel safe it's the number of staff. If you want anything you shout" and "There's always seems like there's a lot of staff about so yes I think there's enough staff." Staff said they felt there were adequate staffing levels. A staff member commented, "We have enough staff. This was increased about two years ago from five to seven staff members on shift." Another member of staff said, "Staffing levels are appropriate. We have never failed our residents and the workload is not too bad." On the day of the inspection we noted one call bell sounding for eight minutes. When we investigated there was no-one in the room. However, we fed back to the registered manager about this who said they would investigate and discuss with staff.

People's safety was enhanced by the maintenance and monitoring of systems and equipment. Infection prevention and control was effective. Equipment checks, water testing, fire equipment testing, electrical and gas certification was monitored by the maintenance staff and where required work was carried out by certified external contractors. A grab bag containing personal evacuation plans (PEEPs) were kept in a prominent position for use by the emergency services. There were details of people in the home and the suggested means of evacuation should the need arise.
However, improvement was needed to ensure actions to reduce the risks of fire were taken promptly. We saw a fire risk assessment had been carried out by an external consulted in March 2017. This had actions, some of which had been completed. These included ensuring fire drills were regularly completed on each shift and fire doors were checked regularly.

However, required actions such as installing a smoke detector inside a store cupboard and having suspended fire exit signs were still outstanding. We were told after the inspection that the risk assessment had not been received by the service until August 2017. The Trust later informed us that the actions identified in the fire risk assessment were currently being prioritised by the Trusts Central Property Team along with other premises. Any urgent actions had already been addressed.

Good

Is the service effective?

Our findings

People's needs were met by staff that had the relevant skills, competencies and knowledge. Newly employed staff members shadowed their more experienced colleagues for two weeks and had their competencies assessed in areas such as administering medicines. A member of staff told us, "I shadowed more experienced staff for the first two weeks. This helped me a lot as this was my first time in a caring job. I really enjoyed the induction period." The induction programme was linked to the Care Certificate. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life.

We looked at the training records which showed staff had completed a range of training courses which included: medicine administration, infection prevention and control, moving and handing; first aid, food hygiene, Control of Substances Hazardous to Health (COSHH) awareness, pressure care, falls prevention, fire safety and health and safety awareness. The registered manager and maintenance person had also undergone training in safe management of legionella and health and safety. A member of staff told us, "The training is okay. Mostly face to face."

Staff told us they felt supported by the manager. Records showed staff received regular six monthly supervision sessions and staff confirmed this while talking to us. The supervision sessions enabled staff to discuss their personal development objectives and goals. A member of staff said, "I feel supported by the service. I have my supervision every six months. We discuss everything related to the service like training, errors and our expectations." Another said, "Supervision meetings take place every six months. We discuss things like if I had a problem or they had a problem with my performance. Also, we talk about training opportunities and if I like the job."

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.

We noted that care plans contained information about people's mental state and cognition. We spoke with people and all felt they were able to make their own decisions. Some people were unable to give their verbal consent in some areas of their care. Records showed that in such cases the person's next of kin and health professionals were involved to ensure decisions were made in the person's best interest.

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, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had made applications to the local authority when people had needed to be deprived of their liberty for their own safety. We saw that any conditions were being met and staff were providing care in the least restrictive way. Staff had received training regarding the

MCA and DoLS, and demonstrated an understanding of the principles of the MCA and how it applied to their work. A member of staff said, "The MCA is about assessing people's capacity and best interest meetings. This is all in people's care plans."

People's health was optimised as the service ensured relevant health professionals were consulted when needed. For example, we saw that people's GP's were contacted when necessary and guidance sought from professionals such as speech and language therapists (SALT) or a dietician. People had visits from chiropodists and were supported to attend the opticians. The home's PIR stated 'The home also benefits from the regular input from the Trust's admiral nurse who offers a huge catalogue of support, ideas and expertise to the care and senior staff at Lake House. We work in partnership with GP and the admiral nurse in order to reduce and / or avoid prescriptions of anti-psychotic medication.'

People were supported to maintain a healthy and enjoyable diet. Comments about the food included, "The food is very good and we get a good choice and our favourite meal is fish & chips and we also like roast dinners. No, never get hungry at night as we can order sandwiches at night and we can always get a drink at any time and we have water in our room" and "I had soup today the food is pretty good and we get a good choice but I didn't like what was on the menu today. I never get hungry at night but if I did I would ask for a sandwich." A visitor told us, "The food here is excellent and I eat here four or five days a week and it only cost me £2.00 per meal which is fantastic."

People's needs relating to nutrition and hydration were monitored when required to ensure people ate sufficient amounts of food and drank enough fluids. The care plans clearly stated the level of assistance people required with their food or drinks. For example, one person required a soft diet and a beaker cup to be used with all drinks, while another person needed their fluids thickened. During lunch we observed that the care provided to people matched the instructions contained in the care plans. The service used a nutritional monitoring tool in order to determine if people were at risk of malnutrition. When people lost weight, the service took appropriate steps. For example, when one person lost weight over three consecutive months, the service had introduced a three day food chart to check the consistency of food offered by staff. The care leader reviewed and analysed this food chart and, when needed, informed the GP about the concerns.

We observed the lunchtime period and saw that people were shown a choice of meals which they could choose. Staff asked or used gestures and other prompts to ensure people understood them and could make their choices. People were sensitively supported with eating their lunch if required. There was good interaction between people and the carer supporting them. We observed one carer who spoke and smiled at the person all the time to encourage them. Staff worked well as a team; there was frequent communication among staff members who shared all information needed to ensure people's needs were met. Staff took their time and encouraged people to eat and drink sufficiently and in line with their diet.

Good

Is the service caring?

Our findings

People told us they were supported by caring staff. We had comments such as, "Yes, the staff are good and kind and we feel safe" and "Yes, we do feel very supported by the staff and we can talk to them if something is bothering us. They care."

We observed staff assisting people and taking time to talk to people to make them feel supported and comfortable. We saw lots of conversations taking place and people were treated with dignity and respect. We saw one person looking a bit lost and asking for someone. The carer approached them and said, "I'm looking for someone, you can help me if you like." The person was visibly reassured by this.

During the inspection we observed that staff not only provided prompt assistance but also encouraged and prompted people to build and retain their independence. For example, people were encouraged to choose what they wanted to do and where they wanted to go throughout the day. One person told us they were encouraged to maintain their independence. They said, "I have a bath a week and a strip wash every day and the staff make sure I'm ok and I try to do it myself. It's my independence." A member of staff said, "I prompt them to do the things themselves rather than do things for them if they are still able to do so."

A dignity champion had been appointed from the staff group. A dignity champion is someone who ensures that people are treated with dignity and respect and they act as a role model for their colleagues. One person said, "Yes, they always knock on my door and they always close the curtains and the door when they're doing anything for me." Another said, "Always they knock on my door as I always keep it closed. If they're doing anything for me they always close the door." We observed that staff respected people's dignity and privacy. Staff knocked on people's doors before entering their rooms. They also ensured the curtains were pulled and the doors were closed while they provided people with personal care. A member of staff said, "When providing people with personal care, I always shut the window, draw the curtains and close the door."

People were supported to express their views and staff were skilled at giving information and explanations. Some people living with dementia were not able to communicate verbally. We asked staff how they knew what people liked to eat/drink and find out their choices. A member of staff said, "I will show them what I'm offering to them. For example, if we are offering three different juices, I will show them three different jugs. I will point at all the jugs, one after one, to give them choice so I'll know which one they like. Some of the residents will push my hand away if they do not want something." People were encouraged to take part in voting and express their opinions and views.

Staff were discreet and respected people's confidentiality. We saw that records containing people's personal information were kept in the main office which was locked so that only authorised persons could enter the room. Some personal information was stored within a password protected computer.

People's relatives could visit when they liked. One person said, "Yes, my [relative's] take me out of the home to lunch and yes I go out into the garden when I like."

People had advanced care plans detailing their preferences at end of life. These contained information about wishes and funeral plans so they reflected their requests.

Good

Is the service responsive?

Our findings

People were positive about living in the home and told us they were supported in a way that suited them. Comments included, "Yes, I'm well looked after the people are nice", "Well under the circumstances I would rather be at home but as a home it's very good" and "Yes, we do well. The staff are very nice and the building is all on one floor and we get to know everybody."

Care plans were in place to give staff guidance on how to support people with their identified needs in areas such as personal care, medicines management, communication, nutrition and mobility. We saw care being delivered in line with guidance in people's care plans. For example, whilst a person was being transferred using a hoist from wheelchair to recliner chair, staff engaged with the person and explained what they were going to do. The person's care plan stated they hated the hoist. Staff knew this and took their time to ensure the person was comfortable talking to them throughout the process. We saw this was reflected in the person's care plan and evidenced staff followed the care plan guidance on how to mobilise this person. We also observed staff supporting a person to stand up from a chair using a standing support belt. Staff were very patient and prompted the person to do more. Staff then guided the person to walk across the room to sit on a lounge chair.

Records showed there were regular formal review meetings with people using the service and relatives. At these meetings people's care was discussed and reviewed to ensure people's needs were being met effectively. The home had recently adapted their review paperwork using symbols and faces to assist people who may struggle to understand written questions. This ensured they had a meaningful way of providing feedback on their experience.

There was a wide choice of activities offered to people, ranging from visits of entertainers to daily activities people could attend in the house. These activities included games, listening to music and art and craft. We saw people sat in the communal areas listening to music and enjoying an art and craft session with the activities co-ordinator. Others stayed in their bedrooms, watching television, reading or being visited by their relatives.

We heard that an ice cream van came around in the summer and a themed tea was arranged one day a week, which could originate from another country or could be related to a special date on the calendar. For example on Burns night, people enjoyed haggis and a tipple of whisky.

We heard that the home had been given the John Monkton Award in recognition of 'Innovative ways to engage others in developing life stories.' Reminiscence sessions had been held using a map of the world to trigger memories. This included discussions on places people had visited, lived and where they came from. Strings were used to link places to people. A food festival had taken place with dishes from the UK, Philippines, India and Thailand. Some employees wore their traditional clothes and a sing along in Hindi.

A member of staff said, "Everyone has a chance to be involved in activities. The activities co-ordinator rotates the activities, everyone is involved." Another said, "We are offering a wide range of activities. For

example, painting or arts & craft. We are also visited by entertainers and last time we had a visit from the zoo with some of their animals. Outdoor activities are offered as often as possible. Approximately once a week a group of residents go out in the minibus. We are not able to take everyone at the same time so we are rotating the residents." A relative told us, "Yes, they have just recently started to take [relative] out which has been good for her."

The home kept rabbits which the residents enjoyed watching. There was also a pet cat. Animals are used in the care environment as they can stimulate social interaction and ease agitation. In addition to stimulating a social response, people living with dementia may benefit from the presence of therapy animals because of reduced agitation, increased physical activity, improved eating and pleasure.

There were records of people's concerns and evidence showed the service had responded to these concerns in line with procedures. There had been six complaints since the last inspection in September 2015. Concerns and complaints were monitored and appropriately investigated. We saw evidence that concerns had resulted in internal investigations, suspensions and issues such as medicine errors being discussed at team meetings.

People felt they could express any concerns if they had any. Comments included, "No I've had no concerns but if I did I would speak to direct to the carer", "No never had to, but if I did it would be to the carers" and "No, we have no concerns here but if we did we would go to the office." A relative told us, "No never complained but we have mentioned things to them and they acted upon them very quickly."

We also saw letters of appreciation from relatives. These comments stated they were grateful and thankful as people at the service were well looked after and safe, and could rely on staff's constant support. We saw recent feedback from visiting professionals with comments such as "Always a pleasure coming to this care home. Staff friendly and happy and residents look happy and well cared for" and "All assistance was appropriate. Good written and verbal history."

Requires Improvement

Is the service well-led?

Our findings

Quality assurance systems were not always effective. Some actions had been taken where needed but other identified issues had not been addressed. For example, a fire risk assessment in March 2017 still had outstanding actions present. Records did not evidence what action was being taken to ensure actions were completed in a timely manner.We also found audits had not identified the employment gaps on staff applications. The medicines audit had not identified gaps on the topical medicines charts prior to the inspection. This meant the systems in place to ensure the service was safe and of a high quality, had not effectively identified or monitored improvements required.

However, other audits had been acted upon. We saw audits completed on care plans, infection control and prevention, catering and health and safety. An unannounced night visit had taken place to assess safety which was mostly positive. Where necessary, actions had been implemented including updating the grab pack which would ensure people's information would travel with them if they were to be admitted to hospital at short notice and completion of repositioning charts.

The Trust had an equality and diversity policy and procedure in place. However, the Trust had not always ensured terminology in documentation was in line with meeting the needs of people. For example, those with protected characteristics under the Equality Act 2010, in respect of sexual orientation. We saw an assessment tool that was used when people moved to the service made reference to 'Normal sexual conduct and orientation?' The use of the word 'Normal' was not representative of equality and was unclear. We discussed this with the registered manager and area operations manager who said they would feed this back to the Trust who produced the assessment tool.

Lake House had a registered manager in place. 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.

People and relatives were positive about the management of the service. Comments included; "Oh yes she's lovely, she's alright. She's doing a good job but I do think it's a bit expensive here but what can you do" and "Yes, we have met the manager and she is doing a good job and the staff like a good laugh and that's not just because you're here."

The registered manager and staff had a good knowledge of all people living at the home. They were familiar with each person's individual needs. Both the manager and the head of care had a clear understanding of their roles. Staff understood their roles and appreciate what was expected from them. Staff were positive about the home and described their team as friendly and supportive. There was a relaxed and friendly atmosphere and staff told us they were happy to work there. Staff described a well-managed service and that they considered the management to be accessible and supportive. Comments included, "This is my first job. I have been here for [number of] years and never changed the job", "I do like it here. The home is well run by the manager", "I get on really well with the manager. They would listen to me if I disagreed with

something" and "I find them really good. Everything is taken care of. They are quite supportive."

Staff told us there were, and we saw records of, regular team meetings. These were an opportunity to discuss any concerns and issues. Topics of recent meetings included, audits, accuracy in documentation, changes in procedures and maintenance issues. If necessary, additional meetings were organised to discuss important issues. For example, in response to incidents in other services. A staff member said, "We have our staff meetings every other month or earlier in case of an emergency. We discuss policies, rules but also discuss problems and solutions from other homes." Another said, "Team meetings are organised on a regular basis or when there is something important like a major incident in one of the other homes." We saw meetings took place for all staff groups including, kitchen staff, domestic staff and managers meetings.

There was a system in place to seek feedback from people and relatives in order to evaluate and improve the service. We saw feedback had been acted upon around more meal choices and trips out.

Senior staff completed incident forms following accidents and incidents and these are followed up by the registered manager and head of care. Accidents and incidents are analysed on a monthly basis where numbers, trends are evaluated and necessary actions put in place. One member of staff told us, "We've discussed specific incidents from other homes. For example, a fire incident or an incident where a wire trapped in one of residents bedrail. If there is something in the news related to our job, this is also addressed at team meetings."

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 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not ensure information was available as specified in Schedule 3 19(3)(a)