Care Quality Commission

Greentree Enterprises Limited

Bablake House

Inspection report

Birmingham Road
Millisons Wood
Coventry
West Midlands
CV5 9AZ
Tel: 01676 523689

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

Overall summary

This inspection took place on 2 December 2014 and was unannounced. At the previous inspection in March 2014 the provider was meeting the required standards.

Bablake House is registered to provide accommodation for up to 46 older people who require personal care. At the time of this inspection there were 38 people living at the home.

The home had a registered manager. 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.

Although people who lived at Bablake House told us they felt safe, staff were not managing risks associated with people's care effectively. Staff were not using the appropriate equipment to move people safely and this placed people who lived at the home at risk of harm. The risk assessment tool used by the provider had not

Summary of findings

identified levels of risk appropriately to ensure risk could be managed safely. The provider could not be certain there were sufficient staff to meet people's needs as the tool used to calculate staffing was based on the risk assessment tool. You can see what action we told the provider to take at the back of the full version of the report.

Staff understood what constituted abuse or poor practice. There were systems and processes in place to protect people from the risk of harm. These included a thorough staff recruitment procedure and an effective procedure for managing people's medication. There was a staff training programme in place but some training required updating.

Staff understood about consent and respected decisions people made about their daily lives. The manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) but was not aware of a recent Supreme Court judgement for DoLs. A failure to take account of the judgement could result in people being restricted in how they lived their lives without a best interest decision being made.

People had sufficient to eat and drink. People were supported to manage their health care needs but people who had lost weight were not always referred to the GP promptly.

Everyone we spoke with considered staff to be kind and helpful. Staff we spoke with understood how to treat people with dignity and respect. People told us their relatives and friends could visit at any time.

People were treated as individuals and were encouraged to make choices about their care. People felt listened to and were confident they could raise any concerns with staff and the registered manager. There were processes in place for people to express their views and opinions about the home.

Care plans and assessments contained detailed information that supported staff to meet people's needs. Plans contained individualised information about how people liked to receive their care for example, people's preferences and choices.

People who lived at the home, relatives and staff said the home was well managed. People described the management of the home as open and friendly. There were systems in place to monitor the quality of the service. This was through feedback from people who used the service, their relatives and a programme of audits. Staff had their practice observed but the process for identifying poor practice was not thorough.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe**.**

People who lived at Bablake House felt safe but staff were not always managing risks associated with people's care safely. The level of risk associated with some people's care had not been appropriately identified. The provider could not be sure there were sufficient staff to meet people's needs as the tool used to calculate staffing was based on the levels of risk associated with people's care.

There was a thorough staff recruitment procedure and an effective procedure for managing people's medication.

Requires Improvement

Is the service effective?
The service was not consistently effective.

Staff had completed training to work with people in a safe way but some training was overdue. Our observations of staff practice showed not all staff used safe moving and handling procedures including how to use a hoist appropriately.

The registered manager's knowledge of Deprivation of Liberty Safeguards (DoLs) needed improvement to make sure there were no unauthorised restrictions on people living in the home.

People had enough to eat and drink during the day. People were supported to manage their health care needs but people who had lost weight were not always referred to the GP for assessment.

Requires Improvement

Is the service caring?
The service was caring.

People told us staff were kind and helpful. Staff had a good understanding of people's care needs and their individual preferences. Staff treated people with dignity and respect. There were no restrictions on visiting times

Good

Is the service responsive?
The service was responsive.

People were happy with their care and had no complaints about the service they received. Care plans were up to date and staff had a handover meeting at the start of each shift. This enabled staff to provide the care and support people required.

Good

Is the service well-led?
The service was mainly well led.

Requires Improvement

Summary of findings

People, relatives and staff told us the home was well managed. The registered manager and staff understood their roles and responsibilities. There were systems in place to monitor the quality of service people received. Observations of staff practice were not sufficiently effective to make sure poor practice by staff was identified and dealt with quickly.

Bablake 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 2 December 2014 and was unannounced.

The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has experience of using or caring for someone who uses this type of care service. The expert by experience had experience of caring for a relative who used this type of service.

Before the inspection we reviewed the information we held about the service. We looked at information received from relatives and other agencies involved in people's care. We looked at the statutory notifications the manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We contacted the local authority contracts team and asked for their views about Bablake House. They had no concerns about the service.

Before the inspection we asked the provider to complete 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 improvement they plan to make. A PIR was not returned, the provider told us they had not received this request.

During our inspection we spoke with the registered manager, six staff and the chef. We spoke with nine people who lived at the home, two relatives and two visiting health professionals. We observed how people received care and support in the lounge areas and the dining room. We looked at a range of records about people's care and how the home was managed.

We looked at care records for seven people to see how they were cared for and supported. We looked at other records related to people's care including the service's quality assurance audits, records of complaints and incident and accidents at the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

People we spoke with said they felt safe living at the home. A relative told us, "The family are happy with [relatives] care and she does feel safe here'. Another person said, "Yes I suppose I do feel safe here." Although people told us they felt safe we found staff were not consistently managing risks associated with people's care.

During our visit we looked at how risks were managed. We observed how people who required assistance to move, were supported by staff. People were not always supported to move or transfer safely. On several occasions staff had difficulty assisting people to move. We asked a person who was unable to walk how they were supported to transfer from their bed into their wheelchair. They said, "Two staff lift me" and indicated by raising both arms. We asked the person if staff used a hoist and were told, "They used to but not now." We looked at the records of two people who staff had assisted to move. Mobility care plans stated both people were unable to stand and two staff must use a hoist on every occasion when assisting them to transfer. We observed occasions when both people were transferred without the use of the designated equipment. When we asked, staff said people's mobility had improved but this was not supported by care plans, risk assessments or our observations.

We observed staff supporting one person to transfer from their wheelchair into an armchair. Staff initially tried to support the person without equipment, but this was unsuccessful as the person had difficulty standing and turning around. Four staff then attempted to use a rotunda. This is a piece of equipment that assists people who are able to stand to turn. The person was unable to use this safely. Staff then used a hoist. This procedure was not carried out safely as the sling that supported the person during the lift was not used appropriately.

Where risks had been identified, staff were not following care plans to manage the risks to keep people safe. Some people had restricted mobility which made them at risk of developing pressure ulcers. We looked at the records of two people at risk of developing pressure ulcers. The skin integrity care plan for one person stated they should sit on a pressure relieving cushion when at the dining room table. We observed the person sitting at the dining room table for 90 minutes and a pressure relieving cushion was not in place. In the other person's care plan the Tissue Viability Nurse had recommended they should not sit in their chair for longer than 2 hours and should be encouraged to have bed rest. The person sat in their wheelchair from 9.30am until 4.30pm. During that time we did not see staff encourage the person to move position to relieve the pressure on their skin. Staff told us the person was reluctant to move from their wheelchair or to go to their room for bed rest. However, no records were maintained to evidence staff had encouraged the person to comply with advice. The manager said they would put charts in place so staff could record all requests and any actions taken to relieve pressure.

We saw one person had a specialist chair to support their condition when sitting in the lounge. Their care plan stated the seat belt should be fastened to prevent them falling out. Staff told us the seat belt was not fastened because it could amount to a restriction. There was no risk assessment in place to support the decision not to use the seat belt. Not all decisions that could affect the safety of people had been appropriately risk assessed.

We looked at the mobility care plan for one person. This stated their mobility changed on a daily basis. Some days they were able to walk without assistance, some days they could walk with two staff supporting and some days they required a wheelchair to mobilise. The manager told us the information would indicate this person was at high risk of falls. The person's risk assessment stated they were at low risk of falls. We looked at the nutritional care plan for another person. They were on a soft diet and thickened fluids to reduce their risk of choking. Staff needed to monitor the person when eating because they were easily distracted and would not eat. The manager told us this information would indicate the person's nutritional needs were medium to high risk. The person's nutritional risk assessment stated they were low risk. The risk assessment tool used by the provider had not identified levels of risk appropriately to ensure risk could be managed safely.

We found that systems in place to assess, identify and manage risks were not robust enough to provide consistent and accurate guidance to staff to keep people safe. The provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered manager understood their responsibility for reporting safeguarding concerns and knew what action to take in the event of any allegations being received. Staff

Requires Improvement

Is the service safe?

told us they had completed training in safeguarding and knew what they should do if they had any concerns about people's safety or if they suspected abuse. One staff member told us, "It is about observing people and if you are really observant you will know something is wrong. You can see physical signs. I would inform my manager and you have to do a statement." Staff had an awareness of what constituted abuse or poor practice and said they would refer any concerns to the registered manager. We found staff did not always put this into practice. One staff member said they would be concerned if people did not receive their care as recorded in their care plan. We observed staff were not following people's care plans, for example moving and handling plans, but staff had not identified this as potential abuse and referred it to the registered manager.

We asked people and their relatives if there were enough suitably qualified staff available to meet people's needs. One person told us, "I think there are, you do have to wait if they are busy, it seems better in the afternoons." Staff said there was sufficient staff although they said the morning shift was very busy. One staff member told us, "There is enough staff to do what people need but it's full on from when you come in until after lunch." During the morning staff did not have time to sit and talk with people other than providing care tasks. We observed the support people received at lunch time. In the small dining area two staff supported four people who required assistance to eat by each helping two people to eat their meal at the same time. During the main meal one staff member, who was already assisting two people to eat, left what they were doing and went to another table to support two people who needed prompting to eat their meal. People did not receive individual support from staff to eat their meal. After lunch, some people sat for over 30 minutes waiting for staff to assist them to move away from the table. During this time one person got up from the table and tried to walk away unaided. The person was very unsteady on their feet and tried to grab the next table for support. There were no staff in the dining area as they were supporting other people back to the lounge. We had to ask a member of staff to support the person, as they were at risk of falling.

We asked the registered manager how staffing levels had been assessed to make sure there were sufficient staff to meet people's needs. We were told the provider used a dependency tool which calculated staffing levels dependent on the level of assessed risks to people's care. The provider could not be sure there were sufficient staff to meet people's assessed needs as the risk assessment tool had not identified levels of risk appropriately.

The system in place made sure care staff were recruited appropriately to ensure they were safe to work with people who lived at the home. All the staff we spoke with told us they had to wait until their police check and reference checks had been completed before they could start working in the home. One staff member told us, "I came for an interview and did not start until two months later because I was waiting for my CRB and references to come back."

We found medicines were administered safely and there was a safe procedure for storing, handling and disposing of medicines. People had medication administration records (MAR) completed and records showed people received their medicines as prescribed. There was a process in place to check MARs to make sure people had received their prescribed medicines. Only staff who had completed training in safe handling of medicines administered medication. Staff told us they had been trained to administer medication and had regular competency assessments to make sure they did this safely. Staff knew about medication to be given 'as required' and there was a protocol in place that informed staff how people were supported to take this.

Requires Improvement

Is the service effective?

Our findings

People told us staff had the skills to provide the care and support they needed. People said, "They are ok they know how to help me shower."

Staff told us they received regular training that supported them to meet people's needs. Three staff said they had completed training in dementia care, safeguarding adults, mental capacity, moving and handling people and completed National Vocational training (NVQ) in health and social care. A staff member told us, "[The registered manager] is always trying to update our training. We have manual handling next week." Staff said they had recently completed the "red skin" training through the local authority which is training in preventing pressure ulcers. Some people in the home were living with dementia and at times had behaviours that could be challenging to others. Staff knew how to respond to minimise the risk to the person and to other people living there.

Records seen confirmed staff were trained to work with people in a safe way but some refresher training was overdue for example, moving and handling people and safeguarding people However our observations of staff practice, showed not all staff used safe moving and handling procedures including how to use a hoist appropriately. The registered manager had identified updates in training was required and training to refresh staff skills including moving and handling and safeguarding had been arranged.

Staff said they were supported by senior staff to carry out their role and the tasks required. Senior staff said they had regular supervision with the registered manager. Other care staff said they had supervision but were not sure how often supervision meetings were happening. One staff member said, "Every three months to half year, it depends." Another said, "I couldn't tell you. I get an appraisal yearly." From our observations staff supervision was not effective in identifying and addressing poor practice of staff.

Staff asked people for their consent before supporting people with their care for example, before they assisted them to the dining room or to the bathroom. Staff had an understanding of the key requirements of the Mental Capacity Act 2005 (MCA). This legislation makes sure people who require assistance to make decisions receive the appropriate support. One staff member told us, "It is how to work with people with different mental capacities." Staff knew about capacity assessments and best interest decisions that support people with limited capacity to make decisions. There were people living at the home who required assistance to make certain decisions. There were no capacity assessments in the care files we looked at to show how these people would be supported to make decisions. The registered manager advised the service was in the process of implementing a capacity assessment.

The registered manager understood their responsibility to comply with the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards. DoLS make sure people in care homes are looked after in a way that does not inappropriately restrict their freedom. The registered manager was not aware of the recent Supreme Court judgement for DoLs and said she would make sure her knowledge was updated. The manager's lack of knowledge of the judgement could result in people being restricted in how they lived their lives without a best interest decision being made.

Staff we spoke with knew about Deprivation of Liberty Safeguards. We observed one person put in a recliner chair with the foot rest up. The person was unable to get out of the chair without assistance because the foot rest was up. We were told the reasons for raising the foot rest; however this was a potential restriction on the person's freedom. Although staff knew about DoLS they had not put this into practice as there was no evidence this had been assessed or a best interests meeting held.

People were provided with sufficient to eat and drink. People told us they had a choice of meals and enough to drink during the day. Comments included, "The food is okay, you get a choice. I don't have any problem with it". Another person said, "You get offered drinks and something to eat, they always ask if I want more". There was a notice in the entrance reminding people that "hot and cold drinks were available at any time, day or night – just ask". We saw people were offered a choice of drinks throughout our visit.

We observed the lunchtime meal which was relaxed and unhurried. People told us they could eat their meal where they preferred. People were shown the different options for lunch so they could choose which meal they preferred. Staff offered some people assistance and accepted people's decisions if they wanted to be independent. Some people had equipment to make it easier to eat independently, for example a plate guard. People were

Requires Improvement

Is the service effective?

asked if they wanted more to eat and drink. Staff supported people at their own pace, staff did not rush and asked people if they were ready for another mouthful before continuing. Although staff supported people at their own pace, people who required assistance to eat did not have individual attention from staff and had to wait during their meal while staff also supported other people. The evening meal was also relaxed with some people enjoying a sing-a-long with staff as they waited for their meals.

Care plans contained information about people's nutritional needs. Where risks had been identified, a nutrition care plan was in place to minimise the risk. For example people who had difficulty swallowing received pureed food and thickeners in their drinks. We saw where people had difficulty eating or drinking the Speech and Language Therapist (SALT) had been involved to offer professional advice. One plan stated the person was on a soft diet because of their teeth. At lunchtime the person ate braised steak and chips. Staff said "He is a good eater and eats everything. He is not on a special diet but I make sure he never has anything hard."

People told us they were supported to manage their healthcare and had access to health professionals when needed. Staff told us they monitored people's health and referred concerns to the GP. One staff member said, "If they are losing their mobility or losing weight it's a sign there is something wrong. We observe their skin as well." We saw staff recorded when health professionals, such as opticians, dentists and their General Practitioner (GPs) had visited the person to review people's care. We spoke with two district nurses who visited the home. We were told care staff referred people to them promptly and followed their advice.

However, we found staff were not following the home's procedures to ensure people who had lost weight were referred to the GP. People were weighed monthly to monitor their weight. People who had lost weight, were weighed weekly and a record of their food and drink intake was kept to make sure this was sufficient. One person's weight record showed they had lost 16kgs in a month since October 2014. The registered manager was not aware of this weight loss and no action had been taken. Although it was confirmed following our visit that there was an error in recording, we were concerned that no action had been taken to check whether the weight was correct or refer to the GP. Another person had lost 3 kg in a month. There was no evidence that this had been referred to the GP even though the care plan said any loss of 2kg or more should be referred.

Good

Is the service caring?

Our findings

Four people we spoke with told us staff were kind and helpful. Comments from people included, “They are all friendly and helpful.” A relative told us, “[Relative] is comfortable and well looked after.”

Throughout our visit, we saw staff were kind, caring and interacted positively with people. Staff knelt down when they spoke with people who were sitting down so they were at the same level and we saw staff hold people’s hands and gently stroke their arms while giving reassurance. People appeared comfortable approaching staff and moved around the home sitting in different areas if they wished. Staff were aware of people's individual communication needs and in the afternoon spent time sitting and talking with people.

People were listened to and staff understood people’s preferences, for example what they liked to wear, where they preferred to sit and by what name they liked to be called. We saw staff offered people choices particularly what people preferred to drink and eat and how they liked to spend their time.

We asked people if staff maintained their privacy and treated them with respect. People said they did. One person told us, “I have no concerns about the care staff, they are very kind.”

Staff we spoke with understood how to treat people with dignity and respect. They told us they shut doors and curtains when providing personal care and used towels to cover parts of the body not being washed to maintain people’s dignity. We saw staff knocked and waited for a response before going into people’s bedrooms. People were offered aprons to protect their clothes at mealtimes. A staff member told us, “We always make sure we never undress people in the lounge. We always go into private areas.” People were seen to be well presented and appropriately dressed.

People we spoke with could not remember being involved in review meetings about their care but said they had a ‘resident’s meeting’ where they could share their views and opinions about the home.

People and visitors told us there were no restrictions on visiting times.

Good

Is the service responsive?

Our findings

People told us there was a key worker system in place where staff had responsibility for identified people to ensure they received the care and support they needed. One person said they liked their key worker "She is very nice, she is off today."

People told us the home responded to their preferences. One person's care plan said they liked to dress in a certain way and we saw they were dressed in the way they preferred. We saw care staff responded to requests from people for assistance in a timely manner.

Staff had a handover meeting at the start of their shift that kept them up to date about changes in people care. Staff knew about people's preferences and choices. They said most people had "life books" completed which helped them to know more about people's backgrounds. One relative told us, "[The activity organiser] spent time with me and [relative] to find out their likes and preferences, she does this regularly." We saw a notice on the noticeboard asking relatives to input into people's care plans and asking them to speak to the registered manager or senior staff.

There was information in the foyer to inform people and their relatives about advocacy services and a support group available for LGBT, (Lesbian, Gay, Bi Sexual and Transgender) older people.

We looked at seven people's care plans. Care plans and assessments contained detailed information that supported staff to meet people's needs. Personal care plans clearly identified what people could do for themselves and provided staff with good information so they could promote people's independence where possible. There were plans in place to support staff to meet people's specific health needs, for example Parkinson's disease, and included signs for deterioration in health. Plans contained personal preferences and had been reviewed and updated regularly. Life histories had been completed with people and their relatives and provided information about people's hobbies, work history and memories from childhood. This information supported staff in providing individualised care and holding meaningful conversations with people.

We noted that although staff on duty knew how to manage people's specific behaviours, there were no written guidelines to ensure people's behaviours were managed consistently and effectively by all staff. This was a concern as the service used agency staff who were not always familiar with people's needs. The registered manager told us written guidelines would be put into place.

We asked people if there were things to do during the day. One person told us about the baking she had been involved in last week and the celebration on November 11th for Remembrance Day. They also said, "There is a pyjama and duvet day tomorrow, I'm joining in so I won't be getting dressed." Another person said, "[The activity organiser] is very good, I prefer not to participate most of the time but I do like to watch." There was an activity programme displayed on the notice board that included trivia quiz, bingo, armchair exercises and arts and crafts. There was a weekly 'Jumping Jacques' exercise class and notices were displayed to let people know there was a 'Pyjama day' planned for the next day. On the day of our visit the activity organiser was unwell so scheduled activities did not take place. The main activity in the morning was a visit from the hairdresser. Other than this, we saw no other organised activities for people to be involved in. We did see one person reading a newspaper and two other people took walks in the garden together. During the afternoon we saw staff had time to sit and talk with people.

The registered manager produced a monthly newsletter for people to inform them of things in the home. The newsletters for the past two months included; information about new staff that had started working in the home, training staff had completed that month, up and coming events including birthdays.

People told us they were happy with their care and had no complaints about the service they received. One person said, "I am quite happy here, I don't want to go anywhere else now." Three people said they felt listened to and told us they had residents meetings where they could share their views and raise concerns. Most people said if they were unhappy about anything they would let the staff know or talk to the registered manager.

We looked at how complaints were managed by the service. Some people at Bablake House had difficulty remembering information and not all the people we spoke with knew who they would speak to if they had concerns. One person said, "I'm not sure who I would complain to, I don't know their names." We saw information about making complaints was included in the monthly

Good

Is the service responsive?

newsletters to people and discussed at residents meetings. Complaints information was displayed on the notice board. This included the process for making a compliant, the timescale of investigations and where complaints could be escalated if the person was unhappy with the investigation. We looked at the record of complaints received. These had been recorded and investigated in line with the provider's complaints procedure.

Requires Improvement

Is the service well-led?

Our findings

People told us the home was well managed and the manager was always available. Comments from people and staff included, "[The registered] is a really good person. You can trust her. I feel really comfortable in her office." Another staff member told us, "She is fine. She seems fair. She helps out when we are short staffed."

The home had a registered manager. The registered manager understood their responsibility for meeting the Regulations, for example, submitting notifications to let us know when certain things had happened

People and staff told us the manager conducted a 'walk around' every day. Some people we spoke with did not know who the manager was while others knew her by name, "Yes she comes out quite a lot from the office." The manager explained they used the 'walk around' to observe staff practice and as an audit to check the environment. Staff told us the registered manager observed how they worked and would give constructive criticism if they noticed areas that needed improvement. We found some staff did not work in line with the provider's training for safe moving and handling of people. The registered manager had not identified this during their 'walk around' or observations of staff practice.

We identified a breach in the Regulations. Systems in place to assess, identify and manage risks were not always sufficiently robust to keep people safe. The provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff said the registered manager was knowledgeable and approachable. Staff told us they felt well supported by the registered manager and the senior staff. Comments included, "I love it here, my co-workers are so good to me, I feel very supported," and "It is about team work, we have got a really good staff here." Staff had a good understanding of their roles and responsibilities and what was expected of them.

Staff told us they had confidence to question the practice of other care staff and would have no hesitation reporting poor practice to the registered manager. A staff member told us, "I'm not afraid to say if I have got a problem." They said the registered manager would investigate any concerns thoroughly. However we found that staff had not reported the poor moving and handling practice of other staff to the registered manager.

Staff recorded when an accident or incident occurred and the registered manager reviewed these to identify patterns or trends, for example any falls people had or where falls had occurred. We saw that appropriate action had been taken following an accident to minimise further risk and to learn from incidents to avoid re-occurrence.

There were systems in place to monitor the quality of the service through feedback from people who used the service, their relatives, staff meetings and a programme of checks. Regular checks were undertaken on care plans, medicines management, health and safety and the environment to make sure it was maintained and safe for people. The registered manager told us that following observation in the home and feedback from staff, they had identified that the period between 5pm and 10pm was very busy. As a result they had increased staffing in the home during that period to ensure people received a consistent and safe quality of care.

We saw the registered manager worked in partnership with other professionals to ensure people received appropriate care and support. This included the local authority contracts team and the district nurse team.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The provider did not plan and deliver care to ensure the welfare and safety of people at all times. Regulation 9 (b) (ii)**