Care Quality Commission

SHC Clemsford Group Limited

Upper Mead

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 caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Overall summary

The inspection took place on 10 February 2015 and was unannounced. We returned on 12 February 2015 for a second day and to complete the visit.

Upper Mead provides accommodation, care and nursing support for up to 48 older people. 11 of the places are within the Chestnut Unit, which cares for people living with dementia. There were 33 people in residence at the time of our visit, including nine in Chestnut Unit.

The service has 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.

We identified issues with the handling of topical creams and found some gaps in the administration records of medicines. We discussed our concerns with the registered manager who had resolved most of the issues before we returned for the second day of our inspection.

Staff knew people well and understood their needs and preferences. Where people may have been deprived of

Summary of findings

their liberty, proper processes had been followed that met the requirements of the Deprivation of Liberty Safeguards. We found, however, that improvements could be made in the way details about people's methods of communication were recorded. Where decisions had been made in a person's best interest, records did not always clearly evidence the process that was followed. **We have made a recommendation about how decisions are recorded to demonstrate that people's rights under the Mental Capacity Act have been respected.**

There were sufficient staff on duty to meet people's needs safely. Staff were clear on what was expected of them and received training and supervision to help them deliver care to an appropriate standard. Risks to people's safety were assessed and reviewed. Any accidents or incidents were recorded and reviewed in order to minimise the risk in future. Staff understood local safeguarding procedures. They were able to speak about the action they would take if they were concerned that someone was at risk of abuse.

People were treated with kindness and respect. One person told us, "It's nice here, the staff are very good". There was a friendly atmosphere at the home. People and staff enjoyed each other's company and were seen to share a joke and laugh together. People were involved deciding how they wished to spend their time and staff were quick to notice when people required assistance or reassurance. In the visitors' comment book we read, 'Wonderful home, great staff, great atmosphere'.

People enjoyed the meals and for many mealtimes were a social occasion. People who required assistance to eat or drink were supported. Care and support needs were reviewed on a regular basis and advice was sought from external healthcare professionals when required.

The service was well organised. The registered manager was well-respected and responded quickly to resolve any issues or to make improvements. A system of audits was in place to monitor and review the quality of care delivered and action plans were used to track the implementation of agreed changes. When we provided feedback after our inspection, the registered manager took immediate action to make improvements in the areas we had identified.

People, their representatives and staff were asked for their views on how the service was run and their feedback was acted upon. In a survey one relative had written, 'My mother is very happy here. Staff are friendly and aware of resident's needs and the care is excellent'. Another relative told us, "I'm very happy. I know (my relative) is safe and well cared for".

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of the report.

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 always safe. We identified issues with the management of topical creams. Other medicines were stored, administered and disposed of safely. People said they felt safe. Staff had been trained in safeguarding so that they could recognise the signs of abuse and knew what action to take. Staff numbers were sufficient to meet people's needs safely. Risk assessments were in place and regularly reviewed to ensure people were protected from harm.	**Requires Improvement**
Is the service effective? The service was not always effective. People's care had been planned and reviewed to ensure that it met their needs. Staff were knowledgeable about people's care needs and preferences but records lacked detail in some cases. Best interest decision making had not always been clearly documented. People were offered a choice of food and drink and supported to maintain a healthy diet. People had access to health care professionals to maintain good health.	**Requires Improvement**
Is the service caring? The service was caring. People were supported by friendly and supportive staff. People made decisions related to their daily needs and how they wished to spend their time. People were treated with dignity and respect.	**Good**
Is the service responsive? The service was responsive. The staff knew people well and understood their wishes and needs. They provided personalised care that anticipated and met people's needs. People, their representatives and staff were able to share their experiences and any concerns which had been responded to promptly.	**Good**
Is the service well-led? The service was well-led.	**Good**

Summary of findings

There was a friendly atmosphere at the home. People and staff felt able to share ideas or concerns with the management.

The registered manager was proactive and open to suggestions. Staff were clear on their responsibilities and told us they were listened to and valued.

The provider and manager used a series of audits to monitor the delivery of care that people received and to make improvements.

Upper Mead

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 10 February 2015 and was unannounced. We returned on 12 February 2015 for a second day and to complete the visit.

Two inspectors and an expert by experience in dementia care undertook this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

We reviewed notifications received from the registered manager before the inspection. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern.

We observed care and spoke with people, their relatives and staff. 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 seven care records, eight staff files, staff training and supervision records, medication administration records (MAR), monitoring records for food, fluid, weights and wound care, quality feedback surveys, accident and incident records, handover records, activity records, complaints, audits, minutes of meetings and staff rotas.

During our inspection, we spoke with 17 people using the service, three relatives, the registered manager, a representative of the provider, two nurses, four care staff, two activities staff, the chef on duty and the administrator. We also spoke with a specialist nurse who was visiting a person who lived at the service.

Upper Mead was registered on 19 November 2014 and had not yet been inspected.

Requires Improvement

Is the service safe?

Our findings

Some medicines were not managed safely. We identified issues with the management of topical creams, such as barrier creams, which had been prescribed to support people's tissue viability care. These were administered by the care staff and were not regularly recorded. This could mean that creams had not been administered in line with the instructions of the prescribing GP. We visited six bedrooms and checked the prescribed creams. In one person's room we found their prescribed cream but there was the name of another person on the tube. Creams were not dated when opened to ensure that they remained effective and were stored in line with the manufacturer's recommendations. There was a lack of clarity around the management of topical creams which meant there was a risk that people's pressure areas may not have been adequately cared for. We also noted a few gaps in the administration records of other medicines. There was no evidence that these had been identified and there were no supporting explanations in place as to why the medicine had either not been administered or recorded.

All of the above meant that there was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed our findings with the registered manager. Medicines audits were conducted on a monthly basis. We looked at the audits from the previous six months. This demonstrated that they were effective at identifying issues, including gaps in recording, and that action had been taken. The medicines audit for January 2015 had not been completed. When we returned on the second day of our inspection, the manager had carried out a medicines audit. The member of staff responsible for the gaps in the Medication Administration Records (MAR) had been identified and this was being followed up. Topical creams had been replaced, were clearly labelled with the person's name and were dated on opening. New Topical Medicine Administration Records (TMAR) were being agreed but were not yet in place.

With the exception of the above issues, medicines were administered by nurses safely and correctly. Where people had been prescribed medicine on as 'as required' (PRN) basis there were clear instructions for staff. This helped to ensure that PRN medication was administered consistently and not used as a long term treatment. People told us that they received their medicines regularly and that they were offered pain relief. One said, "I'm not on any pain killers as I've no pain but they always ask me about it". For people who required insulin there were clear records of the times for administration and regular checks to record blood glucose levels. We observed the medication round at lunch time and found that time specific medication such as 'with food' was adhered to. Medicines were securely stored in a locked cabinet inside a locked room. Only the nurses on duty had access to the keys. There was a clear system in place for the ordering of medication with two nurses counting and countersigning for incoming medicines. Medicines, including controlled drugs (controlled drugs are drugs which are liable to abuse and misuse and are controlled by legislation), were stored safely and accurately recorded. Records for the disposal of medicines were up-to-date.

People told us that they felt safe. They said that they felt happy and comfortable to speak to any of the staff and that their possessions were secure. Staff had attended training in safeguarding adults at risk. They were able to speak about the different types of abuse and describe the action they would take to protect people if they suspected they had been harmed or were at risk of harm. They told us that they felt able to approach the registered manager. One staff member said, "I wouldn't hesitate to say something". We noted that a representative of the provider had questioned staff about safeguarding procedures on a recent monitoring visit. A relative told us, "I have peace of mind about (my relative) in here".

Assessments had been carried out before people moved to the home. Where risks had been identified these had been detailed in the care plans and reviewed on a monthly basis, or more frequently if required. We saw examples of various assessments, including for the risk of falls, malnutrition, management of diabetes and development of pressure areas. Care plans included guidance for staff on how to keep people safe, whilst balancing this with their independence. For example, we saw that one person was at high risk of falls and walked with a frame. Staff supported this person when they walked to reduce the risk of them falling. A member of staff told us, "If they can do it for themselves, we encourage them".

Requires Improvement

Is the service safe?

Risks to people's safety were reviewed following incidents. The registered manager kept detailed records of any accidents and incidents that occurred. There were analysed monthly and sent to the provider to determine if there were any patterns or trends. Where people had been involved in an accident or incident, a review was carried out. When necessary this involved other healthcare professionals such as the GP, falls prevention or dementia crisis teams. There was evidence of positive changes, such as the introduction of a sensor mat to alert staff when a person got up, allowing them to offer assistance and help them to walk safely. In another case behaviour monitoring had identified the trigger for a person shouting at others. The care plan guided staff on how to support this person if they became anxious, including by providing reassurance and offering one to one support.

There were clear systems in place for the treatment of pressure wounds. Records contained a description and photograph of the wound, alongside a management and dressings plan to support care. Records showed that people with tissue viability risks were provided with pressure relieving equipment such as air flow mattresses. We saw that appropriate referrals were made, including to the Tissue Viability Nurse (TVN) for advice and support.

There were enough staff on duty to keep people safe and to meet their needs. People told us that the staff attended to them quickly if they requested support or rang for assistance. Staff were satisfied with staffing levels. They told us that they were able to support people appropriately and to keep them safe. The registered manager used a dependency tool as the basis of the staffing ratio. This was then reviewed in light of people's needs and increased if required. The registered manager said, "My main concern is the safety of residents and staff alike, I will just increase staffing levels if I feel I need to".

The service was currently recruiting. The registered manager employed agency staff to maintain safe staffing levels. The manager told us that they requested, and usually, received the same members of staff. This provided continuity for people. Staff confirmed this. We looked at four weeks of staff rotas. These confirmed the staffing levels and skills mix described by the registered manager.

Staff recruitment practices were robust and thorough. Staff records showed that, before new members of staff were allowed to start work at the service, checks were made on their previous employment history and with the Disclosure and Barring Service. In addition, two references were obtained from current and past employers. This helped to ensure that new staff were safe to work with adults who may be at risk. The provider had also introduced literacy and numeracy testing as part of the interview process. This helped to ensure that staff were able to communicate and work safely using English.

Is the service effective?

Our findings

People were generally involved in decisions relating to their care and treatment. Care plans included guidance on people's preferences and we observed staff asking and involving people in day to day decisions relating to their care. People were consulted on where they wished to eat, spend their time and if they wanted to participate in activities. We saw that one person had consulted a healthcare professional and had been involved in deciding the next steps. The notes recorded, '(Person) happy to continue with urinary catheter. Referral to kidney specialist. (Person) aware of this'. Staff had an understanding of how people's consent should be considered. One explained, "I will not stop her because it is her choice, it is her decision". Another said, "It has to be their choice". The registered manager was aware of a revised test for deprivation of liberty following a ruling by the Supreme Court in March 2014 and had taken action in respect of this. A deprivation of liberty occurs when the person is under continuous supervision and control and is not free to leave, and the person lacks capacity to consent to these arrangements. We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards.

Where people lacked capacity to consent to decisions, there was not always a clear record of how their capacity had been assessed and how best interest decisions had been made. Best interest meetings should be convened where a person lacks capacity to make a particular decision, relevant professionals and relatives invited and a best interest decision taken on a person's behalf. Capacity assessments did not always clearly state the decision to be made. For example, we read, 'Is unable to make decisions because of his condition' as the detail of the decision to be made. Records for one person indicated that treatment for cough had been delayed because, 'The family is not keen on active treatment'. The person had been referred to the GP on three occasions but there was no evidence to suggest that their capacity to decide on their preferred treatment had been assessed or that a best interest decision had been made.

People's assessments and care plans were recorded and had been reviewed on at least a monthly basis. Staff kept up-to-date with people's needs via a system of handovers. We could see that updates in people's health and advice from healthcare professionals were shared and that care records were updated to reflect any changes. Staff were knowledgeable about people's needs preferences and methods of communication. Some care plans contained a good level of detail, such as, 'Can scratch his face and cover his eyes if in pain'. In other cases, the records did not reflect the personalised care that people received. For example we read, 'Use my cushion when deemed fit' and, 'Can make some noises and express some of his needs through gestures'. There was no further guidance for staff to help them understand and provide consistent care. We spoke with one member of staff about a particular person's communication. They said, "His facial features change, he'll start doing this with his hands (demonstrated action), you know he's had enough and wants to go back to his room". When we asked if this would be written in their care plan they said, "It would be explained to you, I'm not confident it is in his care plan". We discussed this with the registered manager. When we returned on the second day of our visit, we saw that detail had been added to some care plans and others had been identified for review.

People were assessed for their risk of malnutrition and were weighed on a weekly or monthly basis. One person told us, "I've come here from hospital and I'd lost some weight so they're keeping an eye on me and weigh me regularly". Where undesired weight loss was noted, action was taken. This included the use of food and fluid charts to monitor a person's intake and referrals to healthcare professionals. We saw that these were kept up-to-date and fluid intake was totalled at the end of each day. We noted that while the target fluid intake was detailed in people's care plans it was not recorded on the fluid charts. This might mean that staff were not observing the target intake amount and we discussed this with the registered manager.

People were very complimentary about the food and told us that someone came round every day and explained what was on the menu. In the main dining room a menu was displayed and people were able to make their selection. One person explained, "We have freshly baked cakes every day and the menu board is up there so you know what choices there are". They said if they did not want the choice, an alternative would be provided. Kitchen records showed that people's likes and dislikes, allergies and preferences were recorded. We observed lunch being

Is the service effective?

served. People chose to sit with others in the dining room or have their meal in their rooms. People were offered drinks and the meal in the main dining room was a social occasion.

We also observed the lunchtime in the Chestnut Unit, which looks after people living with dementia. We observed that meals were served on small tables to people as they sat in lounge chairs. This meant that they were not afforded the choice of eating at a laid dining table. Their meals were already plated up, all of the same portion size. The style of the mealtime meant there were no visual clues or prompts to assist them. We asked the chef if there were support documents such as pictorial menus or 'sample plates' used to aid people in making a choice. We were told there were none at the present time. The registered manager later showed us some pictorial menus that were currently being reviewed and updated to reflect a change in the menu. This would help ensure that all people were supported to make a choice as to what they wished to eat or drink.

People had regular access to services including their GP, chiropodists and opticians. In the multidisciplinary notes we saw that people had attended external appointments, such as at the audiology clinic, and had been accompanied by staff if a relative was not available. A visiting healthcare professional said, "I can't fault them, people always seem to be well looked after and there is a homely atmosphere. From the nursing care side, appropriate referrals are made to us and the nurses are very knowledgeable about people. They inform and involve people and are always very respectful". A relative told us, "(My relative) has a catheter and got an infection. The got straight onto it and called the doctor, and contacted me as soon as they could too". We found that people were supported in their health needs and had access to healthcare services.

Staff had received training to help them carry out their roles effectively. When new staff joined, they attended a five day induction programme. This covered a wide range of subjects, including dementia care, epilepsy, dignity, moving and handling and nutrition. They also shadowed experienced staff. This helped them to get to know people and to understand what was expected of them. Staff then followed training that the provider had made essential for all staff and individual members of staff were supported to pursue further training, including diplomas in health and social care. One member of staff said, "Sussex Healthcare (the provider) seem to cover everything and they do offer a lot of training. I think they go above and beyond".

Staff attended regular supervisions and they had an opportunity to discuss further professional development. All staff had attended an appraisal in the previous year. Speaking about their appraisal, a member of staff said, "The manager gives us constructive feedback and she will ask you if there are any problems or if there is any specialised training we'd like to do". We saw that another member of staff had progressed to the role of team leader. There was a system in place to manage training and book staff on to refresher courses when they became due. This helped to ensure that staff members were supported to keep their knowledge up-to-date and help them to care for people appropriately. People spoke positively about the staff and told us that they were skilled and competent. One said, "They know what they're doing and are good at it". Another told us, "I can recommend their care".

We recommend that records relating to capacity assessments and best interest decisions are reviewed to evidence that assessments have been carried out in line with the Mental Capacity Act 2005 (MCA) and that people's rights have been protected.

Good

Is the service caring?

Our findings

People were very happy with the staff who supported them. One person told us, "I do get well looked after in here, they're just brilliant". Another said, "The staff are very kind and helpful to you". A relative described the care as, "Phenomenal". We observed that the staff had a good rapport with people. They knew them well and there were lots of smiles and laughter. We saw staff sitting with people, supporting them in activities or taking the time to chat. In a recent survey, one relative had commented, 'I cannot praise the staff enough. Nothing is too much trouble. My mother is very happy'. Another told us, "They're always smiling here and they have the patience of angels".

One relative we spoke with described the support they received from the registered manager and staff when their mother returned home to Upper Mead for end of life care. They spoke of how the staff were ready at the door to welcome them back from hospital and of all the ways that they had been looked after. They told us, "It's the small things; I just love the people here".

People could not remember being involved in drawing up their care plans but they all told us that staff knew them well and remembered their day to day preferences. We heard staff asking people if they were ready for their next course, which channel they wanted to watch on the television and if they wished to return to their bedrooms. One person told us, "They know I like a glass of milk for my supper and that's what they do. They just know". Another said, "I've got this mug with my name on it, they know I like my tea in this". In a recent survey people had responded positively to the question of, 'Can you decide what you do in the home'. We observed that people were offered choices and that their preferences were respected.

Staff that we spoke with described how they supported people to remain as independent as possible. One said, "If they are still able to comb their hair or brush their teeth, we encourage them to do it, even if it takes longer". Another told us, "I always given them a chance to do it first, we don't want them to lose their independence".

People told us that staff treated them respectfully. At lunchtime we observed a member of staff ask one person if they minded moving slightly to allow another person to pass and join them at the table. Another member of staff checked that a person was happy for them to place a napkin on their jumper to protect their clothes as they drank a cup of tea. On the first day of our visit a person was at the home for day care. We saw that staff took time to introduce them to people and ensure that everyone was at ease.

Staff had given consideration to the home environment. There were fresh flower arrangements with hearts in them to celebrate Valentine's Day. We saw that each person who had responded to a residents' survey had said that their privacy was respected. One relative said, "My son visited all the homes around here and chose this one because the care is so good and it's very true". A member of staff told us, "We (staff) are but visitors in their home".

Good

Is the service responsive?

Our findings

One person told us, “I’ve moved into this room today. I’m thrilled with what they’ve done. Look they’ve painted that wall there for me and put my great grandchildren’s pictures up for me. They’ve taken the time to do it. Its super here. I get my paper every morning and I read”. A relative described how the registered manager had found a solution to enable their mother to keep their upstairs bedroom. They said, “Mum loved the view with the trees but due to the risk of falling down the stairs she was going to move to a downstairs room. They didn’t just say ‘no, sorry’. They thought of alternatives which meant a lot to us”.

People’s care had been reviewed on a monthly basis and input had been sought from external healthcare professionals to help meet their needs. Throughout our visit we observed staff asking people how they were and if they required support. Staff were quick to act when people needed help. During the lunchtime, we saw one person wishing to get up and use the toilet. A member of staff assisted them and returned shortly afterwards to escort them back to the dining room. Another person was asked if they would like to move to another table for their dessert and coffee when a staff member had observed they were becoming distressed by the person next to them. Staff demonstrated skill and understanding in anticipating people’s needs and offering assistance.

People had been involved in choosing the activities they wished to participate in. We saw this had been discussed in residents’ meetings and that staff had responded to suggestions. In the minutes of one meeting we read, ‘Please remember if anybody wants to try something different please talk to me or any members of staff and I will see what I can do’. On the staff rota we noted that activities staff would be working at the weekend, starting the following week. This had been in response to feedback in a recent survey when a relative commented, ‘Activity staff are excellent but what a shame there is nothing for residents on a Saturday or Sunday. Why?’ People told us that they enjoyed the activities. One said, “There’s a nice man with a violin. I love knitting to music”. A comment from the residents’ meeting read, ‘I do enjoy the music that we have a couple of times a week and it is nice to see all the staff getting involved as we always end up having a good laugh’. Staff knew people well and understood their interests. We saw one person chatting with staff about the local area and village, another about rugby and a third about birds. A member of staff told us, “If you go in and chat they really embrace that”.

People and their relatives understood how to complain. The complaints procedure was displayed and was also available in an easy to read format. In the minutes of a residents’ meeting in December 2014 we saw that the registered manager had asked, ‘Would anyone like to ask about anything or even tell me what you are not happy with? Please remember my office door is always open if you need to talk to me and also any of our staff are always happy to help with any matters’. One person said, “They’re very approachable and no one causes me any bother”. A relative said, “I’ve nothing to complain, my family is very happy with the home…all of us are”. Where complaints had been received, these had been thoroughly investigated and responded to. The records included a summary of the complaint and the action taken.

Good

Is the service well-led?

Our findings

There was a happy and relaxed atmosphere at the home. People and relatives spoke of the friendliness. One person said, “Everyone has got the time for you. It’s a friendly place. Nothing is too much trouble”. A relative told us, “There is an amazing atmosphere, this place has soul”. Everyone we spoke with said that they felt able to speak up and would speak to any member of staff. This illustrated a culture where concerns or worries could be expressed freely. Relatives consistently spoke of being made to feel welcome and told us that communication was good. The registered manager had displayed a poster entitled ‘Our promise to you’. It read, ‘We at Upper Mead will listen to you and your families. We can support and help you by understanding what you need, and with this information create a friendly home that we can all be proud of’.

People told us that it was a well-run and organised home. The registered manager was well respected by people, relatives and staff. Staff told us, “She is very supportive of us. If we are busy she offers a hand” and, “She has an open door policy and will help you where she can”. A relative said, “She’s greatly appreciated for getting involved”. The registered manager said, “I feel I have the support of the staff team. It’s teamwork”. There was a daily operations meeting attended by the registered manager, heads of department and nursing staff. This meeting was used to discuss priorities and to update staff on people’s health, appointments, feedback, activities and staffing. The records of these meetings demonstrated that they were an effective management tool to help the smooth running of the service. The registered manager was supported by an area manager who visited on a regular basis and the provider was in the process of recruiting a deputy manager.

The registered manager used a system of audits to monitor the standard of care that people received. This included internal audits on health and safety, medicines and infection control, as well as monthly visits from a representative of the provider and annual audits carried out by an external contractor. After each audit, an action plan was produced. In each case we saw that this had been used effectively to deliver improvements in the service. The registered manager had updated each action plan to describe the steps taken and to show when each item was completed. For example, an external audit included an action on ensuring that individual slings were available for people who used a hoist to transfer. A monthly sling audit had been introduced and was used to ensure that individual slings were available and safe for use. This helped to ensure the quality of care to people and a consistent standard of support was delivered.

There was a system of gathering feedback from people, their relatives and staff to monitor the quality of the service. People were invited to provide feedback in residents’ meetings, surveys and also on specific points, such as their satisfaction with the food served. We saw that surveys sent by the provider to relatives received positive responses. In each case a representative of the provider had written thanking them for feedback and giving contact details should they have any concerns. The registered manager told us, “I’m open to what anyone has to say. If they’re not happy I’ll deal with it straight away”. We found that feedback provided following our visit was quickly acted upon and that steps had already been taken where possible before we returned to complete the visit.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person had not protected people against the risks associated with the unsafe handling and recording of medicines.** **This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**