Premum Care Ltd

Serendipity Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Good

Overall summary

Serendipity Home is a privately owned care home situated in South Manchester close to a variety of local shops and other community services. The home is registered to provide nursing care and accommodation for up to 45 older people. This was an unannounced inspection of Serendipity Home on 18 and 19 January 2016. At the time of our inspection there were 42 people living at the home.

The home was last inspected on 23 September 2014. At that inspection we found the service was meeting all the essential standards and regulations that we assessed.

The registered manager had recently left the service and a new manager and deputy manager had been appointed.The new manager had submitted an application to register with The Care Quality Commission to become the registered manager for the service.

We found end of life care was not always planned in the correct way. **We made a recommendation that the service refers to NICE guidance for end of life care.**

People told us they were happy with how the home managed their medicine however we found the system for managing medicine needed to be improved. **We made a recommendation that the service revises its procedures for topical medicines and medicines taken 'as and when.'**

Summary of findings

During our visit we saw examples of staff treating people with respect and dignity. People living at the home and their visitors were complimentary about the staff and the care and support they provided.

People living at Serendipity Home were not always involved and consulted with on decisions about how they wished to be cared for. Systems needed to be improved to ensure people's rights were protected. **We have made a recommendation that the home ensures the rights of people are protected.**

People were offered adequate food and drinks throughout the day, ensuring their nutritional needs were met.

People told us, and records showed that people had regular access to health care professionals, so changes in their health care needs could be addressed.

Sufficient numbers of staff were seen to be available to respond to people's needs, however we received mixed responses from people who used the service about staffing levels within the home at evenings and weekends. **We have made a recommendation the home uses best practice guidance to ensure there are enough staff to accommodate all the needs of people living at the home at all times.**

There were a number of activities planned during the year which people said they enjoyed. Some people told us they would like to do more meaningful things each day. Other people told us they were satisfied with the activities on offer. **We have recommended the service considers current good practice guidance in relation to the choice of activities offered to all of the people in the home to help promote the well-being of the people living there.**

There was a system in place for reporting and responding to any complaints brought to the attention of the manager. The manager carried out regular audits and weekly checks to ensure people were happy with the level of care they received.

We found care and treatment was not always effective for some people because instructions in care plans were not always followed.

We found breaches in the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulation 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?

Requires improvement

The service was not safe in all areas.

We received positive and negative feedback about the staffing levels within the home. Most people said they were satisfied but others told us there were not enough staff at evenings and weekends.

Medicine administration needed to be improved to ensure people received their medicine safely.

Risk assessments were completed to help protect people's health and well-being. Suitable arrangements were in place to ensure the premises and equipment used by people was safe.

Is the service effective?

Requires improvement

The service was not effective for everybody who lived at the home.

The provider did not always work within the framework of the Mental Capacity Act 2005 to ensure people's rights were protected.

People told us they were happy with the food. There was a good selection and it was home cooked.

Is the service caring?

Requires improvement

The service was not as caring as it should have been at all times. This was because End of Life Care plans were not person centred.

People told us they were offered choices about most aspects of their daily lives and were happy with the support they received.

People were treated with dignity and respect. Staff were seen to be polite and respectful towards people when offering assistance. Staff we spoke with knew people's individual preferences and personalities.

Is the service responsive?

Requires improvement

The service was not always responsive to people's needs.

We found people were offered occasional activities but more meaningful opportunities could be provided. This would help to promote people's health and mental wellbeing.

People's care records did not provide clear information to guide staff in the safe delivery of people's care.

Systems were in place for reporting and responding to people's complaints and concerns.

Summary of findings

Is the service well-led?

Good

The service was well- led.

People we spoke with were complimentary about the management of the home.

Systems to effectively monitor, review and improve the quality of service

provided were in place to help ensure people received a good level of care and support within the home.

Opportunities were provided for people living and working at the home to comment on their experiences.

Serendipity Home

Detailed findings

Background to this inspection

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

This inspection took place on 18 and 19 January 2016. The first day was unannounced. The inspection team included an adult social care inspector, a specialist advisor and an expert by experience. A specialist advisor is a healthcare professional with relevant experience of the care setting being inspected; the specialist advisor on this inspection had been a nurse in a care home and a care home manager. An expert by experience is someone who has experience of, or has cared for someone with specific needs. On this occasion the expert by experience had experience of working with older people.

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 improvements they plan to make. We also reviewed the information we held about the home and requested information from other health and social care professionals including Trafford Council safeguarding team, Healthwatch Trafford and the Clinical Commissioning Group.

During the inspection we spoke with eleven people who used the service, five family members and four visiting professionals including two district nurses, a social worker and the infection control lead from Trafford Council. We also spoke with seven staff members including the manager and deputy manager, senior care workers, care workers and the activities co-ordinator.

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 also looked at four people's care records, four staff recruitment files, training records as well as information about the management and conduct of the service.

Requires improvement

Is the service safe?

Our findings

During the inspection we asked people if they felt safe living at the home. Nine people we spoke with told us they felt safe. Comments included, "Yes the home is safe for me", and, "I'm absolutely safe and so are my belongings." Relatives told us, "Yes both [family members] are safe here, there are no problems", and, "Yes my [relative] is safe here."

We saw that policies and procedures were available to guide staff in safeguarding people from abuse. An examination of training records showed that safeguarding training was provided every three years for staff. Records showed that the newer staff had completed the training when they had done the induction but staff who had worked at the home for a number of years had not. The manager acknowledged further training was required. Staff spoken with were asked to tell us how they would safeguard people from harm. Some staff were able to demonstrate their knowledge and understanding of the procedure. This training is important to ensure staff understand what constitutes abuse and

their responsibilities in reporting and acting upon on concerns so that people are protected.

We also asked people if they felt there were as enough staff to meet their needs. We were told, "There's usually enough of them to support my needs and the same ones each day. But evenings and weekends they struggle. There's sometimes only two care staff one on each floor." Another person told us, "Staffing not enough especially evenings and weekends", and a third person said, "There's never enough in the evenings and weekends." We spoke with six people and all told us there were not enough staff at weekends.

We carried out observations across the home and found there were enough staff to meet people's personal care needs but some people were left for long periods with little or no interaction from staff. We looked at the rotas and saw the staffing levels were reflective of what the home said they needed but this did not include planned activities or one to one time. **We therefore recommend the home uses best practice guidance to ensure there are enough staff to accommodate the needs of people living at the home to prevent social isolation and exclusion.**

We checked the systems for the receipt, storage, administration and disposal of medicines at the home. One person we spoke with said, "I always get my medication when I should. I am very happy", and another person told us, "Yes I get my tablets regularly. I get tablets when I should and pain relief when I need it."

We looked at a sample of the medicine administration records (MARs). The MARs showed that people were given their medicines as prescribed, ensuring their health and well-being were protected. We found that medicines, including controlled drugs, were stored securely and in line with clinical guidance.

We found that on the whole the home ensured medicine was managed safely but some areas of medicine administration needed improvement. For example, we noted there were no protocols in place for the administration of as and when required medicine (PRN). When people receive medicines PRN care staff need guidance on when medicines should be given, how much people can have and how often they can be given. These instructions are often called medicine protocols and are very important when the people prescribed PRN medicines have problems with communication or mental capacity. We also noted that topical medicines like creams and lotions were not marked with the date they were opened and there were no body maps to instruct staff as to where the cream or lotions should be applied. Staff we spoke with were able to tell us the about correct procedure and who needed creams and when however there was no clear record of when people had received this medicine. **We therefore recommend the home work within NICE guidelines to ensure the administration of as and when medicine (PRN) and topical cream is recorded**.

As part of our inspection we looked at the cleanliness of the home. On the first day of inspection we found some areas of the home were cluttered with wheelchairs and hoists. On the second day of inspection we found these had been removed and the home was clean and tidy. On the second day of our inspection the home was also being inspected by the infection control lead from Trafford council. We spoke with them and received positive feedback regarding the improvements made by the home. We saw staff wearing protective clothing, such as; disposable gloves and aprons when carrying out personal care duties. Hand-washing sinks stocked with liquid soap and paper towels were available in bedrooms, bathrooms and toilets.

Requires improvement

Is the service safe?

We also saw yellow 'tiger' bags, used for the management of clinical waste were also available. This meant people were protected from the risks associated with cross contamination as the home had appropriate systems in place in relation to infection control.

We looked at what systems were in place in the event of an emergency occurring within the home, for example a fire. The records we looked at showed that checks had been carried out with regards to the fire alarm, nurse call bell systems and the emergency lighting. On examination of people's care records we saw there was a personal emergency evacuation plan (PEEPS). This information assists the emergency services in the event of an emergency arising, helping to keep people safe.

We asked about the laundry service at the home and people told us, "It's clean and warm here and the laundry's done nice", and, "The laundry is well done and it's clean here."

We looked at four staff personnel files to check how the service recruited staff. The files contained an application form and any gaps in employment had been explored. There were copies of each employee's identification, written references and detailed interview records, evidencing the suitability of candidates. Records showed that the registration of the nurses was checked regularly with the Nursing and Midwifery Council (NMC) to ensure they remained authorised to work as a registered nurse. We also saw that checks had been carried out with the Disclosure and Barring Service (DBS).The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant.

We looked at risk assessments done by the home to ensure people's health and well- being was maintained. These included environment, falls, wound assessment, nutrition and catheter. We saw these had been updated January 2016. This meant the home had systems in place to monitor the risk to the health and safety of people who used the service.

Requires improvement

Is the service effective?

Our findings

As part of our Inspection we asked people their opinions about the skills of the staff. They told us, "Some staff are quite new; some have been here a long time. They seem to be well trained", and, "Some staff are more efficient than others, one or two try to pull the wool over our eyes."

We were told that nursing staff were responsible for the administration of medicines to people requiring nursing care and a senior member of care staff was responsible for the administration of medicine to people receiving residential care. We looked at records which showed us that four senior care workers had completed medication competency training and a senior care worker told us about the training they had done. This meant people were supported with their medicine by suitably trained staff.

During our visit one visitor expressed concern that their relative was frequently in the wrong position in their bed. They said due to their medical condition they should be nursed in bed at a 45 degree angle or upright. With their permission we visited the person who was being nursed in bed. We found that the person had slipped down the bed and was lying almost flat. There was a notice on the wall in the bedroom instructing staff to ensure this person was kept at a 45 degree angle. During our inspection we saw at least four people had a sign in their room instructing staff to ensure they remained at a 45 degree angle due to the risk of asphyxiation. When we spoke with care staff what they told us meant that they did not understand the risks to people who were nursed in bed as they were not aware why people needed to be elevated in this way. This meant some people were at risk of unsafe care and treatment.

This was a breach of Regulation 12 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulation 2014 because the provider did not ensure all staff were suitably trained to provide care and treatment safely.

We asked people their views about the food offer at the home. We were told, "The food is good. There is enough" and, "Food is good; I've not had a bad meal yet. We have two choices for a main meal. We have sandwiches at tea time." One person also told us, "We get plenty of snacks and enough drinks orange or blackcurrant at meal times and tea or coffee at other times."

We spent time talking to people at lunch time and had lunch with them to enable us to understand their experience. We found the food was good and people appeared to enjoy it. People were asked where they wanted to sit and seemed happy and relaxed whilst eating their meals. Meals were provided in two sittings. The first sitting was for people who could eat independently and the second was protected time for people who needed support. We spoke with the cook who told us about people's preferences and any special diets which were needed. We saw information was available for the cook in relation to the consistency of food for people requiring special diets should they need it. People's care records we viewed showed that people's nutritional needs were assessed and monitored to ensure their wellbeing. We observed people being supported to eat appropriately.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care 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.

We found twenty applications had been made to the local authority and two had been authorised in line with the legal framework. However, in all of the bedrooms we looked in we saw pressure mats were being used. Ordinarily assistive technologies such as pressure mats which sound an alarm when a person gets out of bed, are used where there is a risk identified to an individual. The use of a pressure mat in a bedroom usually indicates that the person is at risk of injury from falling. On all of the files we looked at there was no specific risk assessment in place

Requires improvement

Is the service effective?

to explain why a pressure mat was in place or how the decision to use them had been reached. We spoke with the manager who understood that a risk assessment would be needed to determine whether a pressure mat was appropriate and if it was in each person's best interest to have one. Two people we spoke with expressed some concern about the pressure mats which one reported they had "Nearly tripped on." This person told us the mats were more dangerous for them because they were partially sighted. **We therefore recommend the provider acts in accordance with the Mental Capacity Act 2005 to ensure consent is obtained or decisions are made in the best interests of people. This should include the appropriate risk assessments in relation to the use of pressure mats.**

We asked people who used the service if they were supported to access other healthcare services if they needed to, for example if their needs changed. One person told us, "They get the doctor if needed. All medical stuff is done here including my feet." Family members told us, "They get the doctor in for [my relative] if necessary, then let me know", and, "[My relative] had to go to hospital; they rang to let me know." We spoke with two district nurses who were visiting the service, one of which was a tissue viability nurse. They told us, "We have no problem here, everything is ok."

Requires improvement

Is the service caring?

Our findings

We asked people their views about the care and support offered by staff. People generally spoke positively about their experiences. People told us; "They [staff] help me in the shower, they respect my dignity and privacy", "I can shut my door and have privacy if I want." And, "They're really kind, they treat me like family."

We observed that staff cared for people in a respectful and dignified manner. We found from speaking with them that staff knew people's individual preferences and personalities and treated people with kindness. Interactions between people and staff we saw were pleasant and friendly. When people asked for support when they needed it care workers responded appropriately.

The care staff we spoke with were able to tell us how they would promote people's privacy and dignity when offering care and support. They told us they would knock on bedroom and bathroom doors before entering and ensure that personal care was provided in private.

Other things people told us included, "Staff are caring and kind, and they crack jokes and listen to me", and "They're mainly regular staff and know what I like and don't like. Most are kind and caring but some are a bit abrupt." This person went onto explain that it may be because of the different accents some of the staff had rather than anything intentionally disrespectful. One relative told us, "Staff are really helpful and are meeting [my relative's] needs."

We had received information of concern that people did not always have the correct care and support plan when they were at the end of their life. End of life care plans are designed to ensure people are supported in the way they want to be at the end of their life. We spoke with the manager, deputy manager, nurses and care staff about how people were supported at the end of their lives. What they told us demonstrated they understood the importance of the end of life pathway of care but there were no advanced care plans in place to direct staff in what to do support people as individuals at the end of their lives. We saw the home's care records were stored on an electronic system called 'care docs' which meant that although the home could monitor end of life care, the end of life care plans people had were not always person centred. The ones we saw contained little or no information about the person and were not always completed. The home had recently supported someone at the end of their life and we could see from daily logs that the person was supported appropriately, and with respect and with dignity. We spoke with the manager and deputy manager who agreed to ensure end of life care planning was improved and more person centred. **We recommend the service refers to NICE guidance for end of life care.**

Some of the people said they liked to go to bed early, but a couple said they did not feel they had any real choice about the time they went to bed as staff preferred them to go to bed early. They told us, "They like us to go to bed about 10 or 11pm, but I get the care I need", and "I go to bed when I want, usually early, and if I wake up early night staff gets me a cup of tea and toast." Another person told us, "I choose when I get up and go to bed, and have meals in my room if I want." We spoke with the manager about what people had said. They who told us this would be discussed at the next team meeting. This meant the home was committed to ensuring all people were involved in decisions about their care.

Policies and procedures were in place to ensure a consistent approach to dignity and respect, such as the equality and diversity policy and staff code of conduct. Staff had received training in equality and diversity. Staff we spoke with had a good understanding of how to ensure people were treated well and how to talk with people in a respectful and compassionate manner. People and their relatives reported their privacy and dignity was respected and they did not have any concerns about the staff who supported them.

The provider ensured that confidentiality was maintained. Care documents and other information about people were stored in secure cabinets within the nurse's office. Other documents were stored on the computer and were password protected. Copies of assessments, care plans and risk assessments were also maintained.

We viewed information that was provided to people who used the service and saw that this provided clear explanations of the service that was being provided. This included information about the standards of care and conduct that they should expect from staff. We found this was a good way to ensure people had the level of information they needed to make an informed choice.

Requires improvement

Is the service responsive?

Our findings

There was a complaints procedure in place which gave people advice on how to raise concerns and informed them of what they could expect if they did so. People we spoke with told us they knew how to raise concerns and said they felt able to do so. Family members who had made a complaint told us about a member of staff their relative had said they were frightened of. The relative told us, "I reported them to the manager and it was sorted, I never saw that person again."

Another relative who had complained told us, "The atmosphere here is okay. I wouldn't change [my relative] to another place but there's a few things need improving, for example making sure [my relative] is in the right position and making sure [their] fluid intake is okay."

During the inspection we spoke with people and staff and observed how people spent their time. Some people told us they took part in lots of activities; others said they were left for long periods of time throughout the day with not much to do

We saw photographs of activities which had taken place over recent months and these included a Christmas party, pet therapy and a visit by a donkey. The pictures showed people happily engaging with staff and taking part in each activity with enthusiasm. One person we spoke with told us, "I loved it when the donkey came; I like animals and enjoy those activities." Another person said, "The activities lady is lovely, she talks to me and asks me about what I like, I feel happy when we talk", and a third person said, "It's good here, I have good friends here."

Other planned events included Easter activities plus a St Patrick's Day party which was being organising after a resident of Irish descent said they enjoyed Irish music.

We saw individual 'pen pictures' done by the activities co-ordinator with people who used the service. Pen pictures record the likes, dislikes, hobbies and interests of each person and are a good way of staff getting to know the people they support. We saw people had been consulted about their favourite foods and that this information had then been passed onto the cook. As a result of the consultation there had been a change in the menu to accommodate the foods which people had said they liked. This was a good example of the home responding to people's preferences and offering them choices.

During the inspection we noted there were at least four people being nursed in bed at the home. With their consent, we visited two of these people throughout the course of the day. We noted that one person had little or no interaction with anybody other than care staff supporting them with personal care needs. We asked the person how they felt about it and they told us, "I do get bored but I don't complain, I don't know where my friends have gone in the rooms next to me, I might be on my own here, and I am not sure." We spoke with the manager who told us they had recently discussed this at a team meeting. They had agreed that a solution to alleviate people's anxiety was to play music throughout the home. We noted this was done on the first day of inspection but not the second. We also noted the atmosphere on the first day was more relaxed than on the second suggesting the music may have provided a certain amount of tranquillity. People were observed sitting by the music systems and they appeared content and people we spoke with in bed said they liked the music. The manger also told us that the activities co-ordinator was allocated an hour a day one to one to spend with each person being nursed in bed. We saw records to confirm that this had taken place on previous occasions and the manager assured us this was something they would ensure took place immediately.

We recommend the service considers current good practice guidance in relation to the choice of activities offered to all of the people in the home to help promote the well-being of those living with complex health and support needs, in order to promote their involvement and enable them to retain their independence.

The care records we looked at outlined the level of nursing support people needed. The records were kept electronically on a system called 'care docs'. Whilst the system contained lots of information about each person it was sometimes difficult to navigate, which in turn did not promote a person-centred approach to care planning. This was because it was difficult to see how specific risks were managed or how the home responded to a change in care need. For example, one care plan stated that a person was at risk of choking and asphyxiation and been referred to the Speech and Language Therapy team (SALT). We saw a letter from the SALT team outlining how staff should support the person to manage their risk, which included the use of

Requires improvement

Is the service responsive?

thickener in fluids. We checked the daily notes and found not all staff were following this procedure. We spoke with the deputy manager who agreed to investigate this immediately.

We looked at the file of one individual with complex health needs being nursed in bed. Due to this person's needs, they required assistance to change position in bed regularly to help prevent pressure ulcers. According to the care docs for this person the daily position record was not completed as instructed in their care plan. For example, we saw there had been entries made by night staff at 2.07am and 5am on the morning of the second day of our inspection. We checked the position record at two further intervals during the same day and no more entries were made, which meant there had not been any repositioning recorded for over 10 hours. We saw the pressure relieving mattress on this person's bed was set to support a person with a weight of 60kg, whereas the person currently weighed 53kg. This meant that the pressure relieving mattress may not be effective so the person was at risk of unsafe care and treatment. We noted in their records that this individual had a pressure ulcer to their left heel. We found evidence of tissue viability input from the nursing team in a separate paper file in the nurses' office but the records on the care docs records were last completed in August 2015 and did not state where the person's wound was and wound care records were blank. This meant that the person's care records were not updated regularly and information about them was kept in two different places, which could lead to mistakes and omissions being made in their care.

We found the above to be breaches of Regulation 12 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulation 2014. This was because the provider did not ensure care and treatment was provided in a safe way for all service users.

Good

Is the service well-led?

Our findings

At the time of this inspection the service had a new manager who had taken responsibility for the overall management of the service when the previous registered manager and deputy manager had left in December 2015. We were told there had been shortages in management support over the last few months due to unforeseen circumstances and the registered manager leaving.

Staff we spoke with had a good understanding of their roles and responsibilities and said they felt supported in their role by the new manager and deputy manager. One care worker told us, "Management are good now. They know what is going on. They are approachable. If I have any problems I would go to them"

Staff we spoke with were able to demonstrate their understanding of the home's whistle blowing procedure. They knew they could raise concerns in confidence or contact organisations outside the service if they felt their concerns would not be listened to.

We looked at how managers were monitoring the quality of the service provided. Information collected during the inspection showed that a range of audits were utilised, on-going staff training and development was provided, satisfaction surveys were distributed and staff and resident meetings were held. We asked to see completed audits done to measure the quality of the service being provided along with action taken where improvements had been identified as being needed. We saw a copy of minutes from a recent meeting which had taken place and included action plans on how the service would improve. Through speaking with the manager it was clear to us that they were committed to providing good care and treatment and they knew what was needed to ensure improvements were made. This included a complete audit of the care plans and training and development for all staff.

We saw opportunities were provided for people, their visitors and staff to comment on the service and share ideas. We saw records to show that relative and resident meetings were held as well as staff meetings; people, their relatives and staff confirmed that meetings took place.

People who used the service told us things had changed as a result of these meetings, for example, one person had asked for apples to be available and as a result more snacks were now provided throughout the day and they said the quality of food had improved. We were told that annual feedback surveys were also sent out to people, their visitors and health and social care professionals who visited the service. We saw information summarising the feedback received for 2014. We were told that due to the change of management these had been delayed in 2015, but that the provider was keen to ensure proper quality assurance systems were introduced. To do this, a business administrator had been recruited to support the manager with market oversight and staff development and training. We saw minutes of meetings which had occurred between the manager and staff team to outline what needed to be improved and who would be responsible. This meant the home was committed to ensuring people received good quality care.

There was a system in place to monitor accidents, incidents or safeguarding concerns within the home. The manager maintained a monthly record about the incidents which had occurred and what had been done in response. Additionally, there was a record of what the outcome was and any 'lessons learned' to help prevent future re-occurrences.

The manager, deputy manager, staff and provider were committed to providing all round high quality care. We saw that the service had a number five Food Standards Agency (FSA) hygiene rating. Five is the highest rating awarded by the FSA and shows that the service has demonstrated very good hygiene standards.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not ensure care and treatment was provided in a safe way for service users by: 2 (a) assessing the risks to the health and safety of service users of receiving the care or treatment; (b) doing all that is reasonably practicable to mitigate any such risks; (c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely;