Craigarran Nursing Home

Craigarran Nursing Home

Inspection report

Cinnamon Drive
Trimdon
TS29 6NY
Tel: 01429 880550
Website:

Date of inspection visit: 13 and 17 March 2015
Date of publication: 19/06/2015

Ratings

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

Overall summary

This inspection took place on 13 and 17 March 2015 and was unannounced. This meant the staff and provider did not know we would be visiting.

Craigarran Nursing Home provides care and accommodation for up to 44 people, including people with a dementia type illness and nursing care needs. On the day of our inspection there were 31 people using the service.

The home had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Craigarran Nursing Home was last inspected by CQC on 9 August 2013 and was compliant.

There were sufficient numbers of staff on duty in order to meet the needs of people using the service. The provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

Summary of findings

Thorough investigations had been carried out in response to safeguarding incidents or allegations.

The registered manager conducted monthly audits to check that medicines were being administered safely and appropriately.

Staff training was up to date and staff received regular supervisions and appraisals, which meant that staff were properly supported to provide care to people who used the service.

The home was clean, spacious and suitable for the people who used the service.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. The provider was not meeting the requirements of the Mental Capacity Act (MCA) or the Deprivation of Liberty Safeguards (DoLS) and there was no evidence in the care records of consent being obtained. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People who used the service, and family members, were complimentary about the standard of care at Craigarran Nursing Home.

Staff treated people with dignity and respect and helped to maintain people's independence by encouraging them to care for themselves where possible.

We saw that the home had a full programme of activities in place for people who used the service.

Care records showed that people's needs were assessed before they moved into Craigarran Nursing Home and care plans were written in a person centred way however care records were not always accurate or up to date. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider had a complaints policy and procedure in place and complaints were fully investigated.

The provider had a robust quality assurance system in place and gathered information about the quality of their service from a variety of sources.

You can see what action we 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 safe.

There were sufficient numbers of staff on duty in order to meet the needs of people using the service and the provider had an effective recruitment and selection procedure in place.

Thorough investigations had been carried out in response to safeguarding incidents or allegations.

The registered manager conducted monthly audits to check that medicines were being administered safely and appropriately.

Good

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

The provider was not meeting the requirements of the Mental Capacity Act (MCA) or the Deprivation of Liberty Safeguards (DoLS).

There was no evidence in the care records of consent being obtained.

Staff training was up to date and staff received regular supervisions and appraisals.

Requires improvement

Is the service caring?
The service was caring.

Staff treated people with dignity and respect.

People were encouraged to be independent and care for themselves where possible.

People were well presented and staff talked with people in a polite and respectful manner.

People had been involved in writing their care plans and their wishes were taken into consideration.

Good

Is the service responsive?
The service was not always responsive as care records, risk assessments and charts were not always accurate or up to date.

The home had a full programme of activities in place for people who used the service.

The provider had a complaints policy and complaints were fully investigated. People who used the service knew how to make a complaint.

Requires improvement

Summary of findings

Is the service well-led?

Good

The service was well led.

The provider had a robust quality assurance system in place and gathered information about the quality of their service from a variety of sources.

Staff told us the registered manager was approachable and they felt supported in their role.

Craigarran Nursing 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 13 and 17 March 2015 and was unannounced. This meant the staff and provider did not know we would be visiting. One Adult Social Care inspector, a specialist advisor in nursing and an expert by experience took part in this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before we visited the home we checked the information we held about this location and the service provider, for example, inspection history, safeguarding notifications and complaints. We also contacted professionals involved in caring for people who used the service, including commissioners, safeguarding staff and district nurses.

For this inspection, the provider was not asked 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.

During our inspection we spoke with five people who used the service, seven family members and a visiting healthcare professional. We also spoke with the provider, the registered manager, the administrator, one nurse, two care workers and one domestic staff member.

We looked at the personal care or treatment records of five people who used the service and observed how people were being cared for. We also looked at the personnel files for three members of staff.

Good

Is the service safe?

Our findings

Family members we spoke with told us they thought their relatives were safe at Craigarran Nursing Home. One family member told us, “Oh yes. She has had two accidents and within a minute they were on the phone to me.” A person who used the service told us, "Yes, I most definitely do. If I press the buzzer they come immediately."

We looked at the recruitment records for three members of staff and saw that appropriate checks had been undertaken before staff began working at the home. We saw that Disclosure and Barring Service (DBS) checks were carried out and written references were obtained. Proof of identity was obtained from each member of staff, including copies of passports, driving licences and birth certificates. We saw copies of application forms and these were checked to ensure that personal details were correct and any missing information had been suitably explained. We also saw copies of signed code of conduct documents, health assessments for night workers, data protection consent forms and confidentiality statements. This meant that the provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

We observed sufficient numbers of staff on duty and call bells were answered promptly. We asked people who used the service, and their family members, whether there were plenty of staff. They told us, “They could do with more at night and first thing in the morning”, "No there are not enough I ring the buzzer and I can wait 15 minutes", "They could definitely do with more" and "Occasionally they are rushed but Mam does not miss out".

We discussed staffing levels with the registered manager, who told us there was a nurse, senior care worker and four care workers on duty during the day and a nurse and either two or three care workers on duty during the night, depending on need. The registered manager told us staffing levels were regularly revised base on people’s dependency needs. In addition, the home employed three domestic staff, five kitchen staff, who assisted at mealtimes, an office administrator and a maintenance member of staff.

The home is a two storey building, with accommodation for up to six people on the first floor. We saw that entry to the premises was via a locked door and all visitors were required to sign in. The home was clean, spacious and suitable for the people who used the service. People’s bedrooms were individualised with personal items and furniture. All the bedrooms, bathrooms and toilets we looked in were clean and suitable for the people who used the service.

The layout of the building provided adequate space for people with walking aids or wheelchairs to mobilise safely around the home. We saw window restrictors, which looked to be in good condition, were fitted in all of the bedrooms on the first floor however wardrobes in some of the bedrooms we looked in were not secured to the wall. Some had items placed on top of them, such as cardboard boxes, which could be a health and safety hazard if the person was to accidentally pull the wardrobe over. We discussed this with the provider and registered manager who agreed to look into it.

We checked maintenance and health and safety records and found all to be in order and up to date. These included electrical installation, emergency lighting, fire detection equipment, gas safety, hoist servicing records and portable appliance testing (PAT).

The service had Personal Emergency Evacuation Plans (PEEPs) in place for people, which included the mobility needs of the person, how many staff were required to assist, whether the person had any mental health issues and details of their next of kin.

This meant that checks were carried out to ensure that people who used the service were in a safe environment.

We looked at the provider’s ‘safeguarding details and outcomes’ book and saw records of safeguarding incidents, including those reported to the police, and those referred to the local authority safeguarding team.

We saw a copy of the ‘incident/unusual occurrence’ book, which recorded accidents and incidents that had taken place in the home. This included the date and time of the incident, name of the person, a description of the incident, name and signature of the member of staff, an action plan and whether an accident form was completed. For example, we saw that the previous year a person who used the service had left the home unaccompanied via a ground floor toilet window. We saw measures were put in place to prevent a recurrence, such as a restrictor was fitted to the toilet window, a Deprivation of Liberty Safeguard (DoLS) was applied for and family members were informed.

Good

Is the service safe?

We also saw the accident analysis file, which included monthly analysis of accidents within the home and recorded the number of falls, the number of transfer accidents, the number of self inflicted accidents, the number of injuries sustained and the number of staff accidents. We saw a chart had been created to show the number of accidents by time of day. We discussed this with the registered manager who told us it was used to identify some orientation issues, particularly after hospital visits. This meant that incidents and accidents were recorded and appropriate action taken by the provider.

We looked at the management of medicines and found that the service had up to date policies and procedures in place. This meant that staff were supported to ensure that medicines were managed in accordance with current regulations and guidance.

We discussed medicines with the registered manager, who told us staff had received medicines training approximately four months ago and they were waiting for the training certificates. The registered manager also told us that staff used a medicines workbook however the registered manager did not carry out observations to assess staff's competency when dealing with medicines.

Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines which may be at risk of misuse. The controlled drugs book was in good order and medicines were clearly recorded. Controlled drugs were stored in a separate locked controlled drugs cabinet, which was solely used for the storage of these drugs.

We saw all medicines were appropriately stored and secured within the medicines trolley and liquid bottles were kept clean and dated when opened.

We observed a medicines round on the ground floor and saw photographs were attached to people's medicines administration records (MAR), so staff were able to identify the person before they administered their medicines. We found staff checked people's medicines on the MAR chart and medicine label, prior to supporting them, to ensure they were getting the correct medicines.

Medicines were given from the container they were supplied in and we saw the staff member explain to people what medicine they were taking and why. Staff also supported people to take their medicines and provided them with drinks, as appropriate, to ensure they were comfortable in taking their medicines. We saw the staff member remain with each person to ensure they had swallowed their medicines and signed the MAR after administration. However, on three occasions we observed the staff member leave the trolley unattended, with the keys left in the trolley. We brought this to the attention of the provider and registered manager.

The registered manager showed us the systems in place to ensure that medicines had been ordered, stored, administered, audited and reviewed appropriately. They described how they ordered/checked people's medicines and showed us how unwanted or out-of date medicines were disposed of. Night staff undertook this responsibility and records confirmed this.

Medicines requiring cool storage were kept in a fridge. We saw there were some medicines out of date in the fridge and the registered manager placed them in the box for disposal. From a sample of opened eye drops we saw that some dates of opening were missing, which meant that it was unclear as to whether the medicine was within a shelf life of four weeks. The registered manager told us she would check expiry dates to ensure all medicines were in date.

The registered manager was responsible for conducting monthly audits, including the MAR charts, to check that medicines were being administered safely and appropriately. From the previous audit dated 26 February 2015 there were no actions noted.

Requires improvement

Is the service effective?

Our findings

People who lived at Craigarran Nursing Home did not always receive effective care. The provider was not meeting the requirements of the Mental Capacity Act (MCA) or the Deprivation of Liberty Safeguards (DoLS) and there was no evidence in the care records of consent being obtained.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. We discussed DoLS with the manager, who told us two DoLS applications had been authorised by the local authority and a further three had been applied for. We saw copies of DoLS records in people's care records however we saw that CQC had not been notified of these DoLS applications and authorisations. DoLS are a statutory notification, which means providers must notify CQC about any applications they make to deprive a person of their liberty under the Mental Capacity Act 2005 and about the outcome of those applications. This meant the provider was not following the requirements in the DoLS.

We saw one person who used the service had a mental capacity care plan in place. This described, "[Name] has a diagnosis of mixed dementia which is affecting her ability to understand information and retain it and to make decisions in her best interests" and "All decisions made on [Name's] behalf need to be in her best interests". A risk assessment was in place as the person was "At risk of wandering off the building if place not secure." Another person's mental capacity care plan stated, "[Name] lacks capacity to make decisions for himself", "[Name] cannot retain information" and "All decisions made on his behalf need to be in [Name's] best interests".

However, we did not find any evidence of mental capacity assessments or best interest decision making records for either of these people.

All the care plans included a section which stated, "I agree and am happy with the information in this plan". However, none of the care plans we saw had been signed by the person who used the service or a family member to say they agreed, and there was no evidence of best interest decision making.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (now Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

We saw 'do not attempt resuscitation' (DNAR) forms were included in the care records for one person and as the person lacked capacity to make this decision, a best interest decision had been made in February 2013. The DNAR had been reviewed in April 2014 so was in date.

We looked at the provider's training matrix to see whether staff were up to date with their training. We also looked at individual staff training records and saw copies of training certificates. These showed that staff were up to date with their training, including moving and handling, health and safety, nutrition, infection control, safeguarding, end of life care, risk assessments and fire awareness. However, we saw from the training matrix that several members of staff had not completed Mental Capacity Act (MCA) or Deprivation of Liberty Safeguards (DoLS) training for over four years. The administrator told us this training was planned for April 2015.

We saw from individual staff training records that staff completed workbooks as part of their ongoing training requirements. These included moving and handling, food hygiene, understanding dementia, safeguarding and equality and diversity.

We saw from the staff files that new members of staff completed an induction pack, which had to be completed within one month of the employee's start date. This included an introduction to the staff structure, orientation of the home, fire safety and health and safety, accident and incident procedures, communication, training, supervision and appraisals and operational policies and procedures. The induction pack also included an assessment, which we saw were completed and signed and dated by the employee and supervisor.

We saw records of staff supervisions and appraisals, which showed staff received a supervision approximately every three to four months. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. We also saw that annual appraisals had been carried out for each member of staff we looked at.

We also saw records of correspondence between one member of staff and the provider regarding

Is the service effective?

accommodating the member of staff's request to change their shift pattern for child care reasons. We saw the provider had offered two alternatives, one of which was acceptable to the member of staff and we saw their contract had been amended to reflect this change.

We saw the home had a large dining room on the ground floor. A large menu board, including photographs, was placed on the wall outside the dining room. This showed that alternative options to the daily menu were available, such as salads, sandwiches and jacket potatoes. Snacks were also available and included fruit, hot drinks and biscuits.

At lunch time we saw staff going around using hand wipes before the residents ate and politely asking the people who used the service if they wanted aprons on to keep their clothes clean. We saw the staff were very encouraging to try to get people to eat and one person was being fed by her son. We saw the GP arrive to see one person. She was taken to see him and her food was kept warm until she returned.

We asked people who used the service, and their family members, about the quality of the food at Craigarran. They told us, "The food is quite good, I get anything I want. There is a choice of two but I can have something else if I wish", "The food is lovely, it is all homemade. There are three courses at lunch time, sandwiches for tea and at supper too if I want them", "The food is very good", "If I don't like what is on offer, I can get something else" and "The food always looks and smells good".

We saw people who used the service had access to healthcare services and received ongoing healthcare support. Care records contained evidence of visits to and from external specialists including GP, consultants, district nurses and community psychiatric nurses.

We looked at the design and layout of the home for people with dementia and saw that people's bedroom doors displayed the person's name, a photograph and the room number. Bathrooms and toilets were appropriately signed and walls were decorated to provide people with visual stimulation. Corridors were clear from obstructions, well lit and handrails were painted a bright colour, different to the walls, which helped to aid people's orientation around the home.

Good

Is the service caring?

Our findings

People who used the service, and family members, were complimentary about the standard of care at Craigarran Nursing Home. They told us, “Absolutely brilliant”, “The girls are very helpful. I ring up every day and they always know me and have an update”, “I would recommend it to anyone”, "My mother gets individual attention, if I query anything they come immediately" and “I wouldn’t go out of here, I’m stopping here”.

A visitor approached us to tell us about a family member who had previously been a resident at the home. He told us, “When she came in she was given six months but she lived for eight years. This was because of the wonderful care she received. This is the best care home in the world. She had wonderful care and food. It is also good because it is part of the local community, everyone knows each other."

People we saw were clean and appropriately dressed. We saw staff talking to people in a polite and respectful manner and were attentive to people’s needs. For example, we observed the registered manager comforting a person living at the home, they told the person, “It’s nice to see colour in your cheeks, I’m so pleased I’ll ring your daughter and let her see how you’re doing.” We saw staff assist people when required and care interventions were discreet when they needed to be.

Staff were aware of people’s individual needs, choices and preferences. We saw detailed information about the person’s history in the ‘this is me’ document in the care records. For example, “[Name] was born into a close and loving family” and “[Name] likes staff to read her books; likes singing, music and television”. We also saw on people’s bedroom walls a laminated one page profile with key information about the person, for example, “Assistance with all personal care” and “Bath with lots of bubbles”. People who used the service told us, “I can have my breakfast anytime between 7am and 10am. I can have it in the dining room or in my own room" and “I can choose when I get up. The night staff will get me up at 7am but the other morning I was asleep so they left me and I didn't get up until 9am". People also told us staff supported them to be independent. They told us, "They encourage me to be independent" and "I am as independent as much as is possible".

We asked people and family members whether staff respected the dignity and privacy of people who used the service. They told us, “Oh definitely”, “If they [staff] are passing they always have words with them and ask them [people] how they are”, “They let her have a proper cup and saucer. They respect her dignity”, “They asked us if we could buy her some more clothes. They are very conscious on dignity”, “She’s always clean” and “She feeds herself, they let her. It helps keep her independent”. We observed staff respecting people’s privacy by knocking on doors and waiting before entering.

We looked at care records and saw that care plans were in place and included moving and handling, dependency, communication, personal hygiene, eating and drinking, mobility and falls, urine and bowel continence, pressure care, sleep, mental health and well being, activities, pain management/medication and end of life. Each care plan contained evidence that people had been involved in writing the plan and their wishes were taken into consideration, for example, we saw the care records included a section where the person could say what name they preferred to be called.

Family members told us, "We are kept fully informed. Mother had a fall she was not hurt but they phoned to tell us everything" and "We are always kept well informed, they are very approachable".

We saw there were many visitors to the home, particularly on the first day of our visit, as a coffee morning was taking place. We asked a visiting healthcare professional about their views of the home. They told us, “People seem happy and settled, it has a nice atmosphere. Carers come with me and write down what I have said and then write it in the care plans. They seem to know about the patients and don’t have to read the care plan first.”

Requires improvement

Is the service responsive?

Our findings

The service was not always responsive as care records were not always up to date or regularly reviewed.

Care plans were found to be detailed and gave a good overview of people's needs and the support they required. Care plans were easy to navigate however care planning was not reviewed on a regular basis, which meant that people's current needs may not be being met. For example, one person's care plans were last reviewed on 20 January 2015 and had not been reviewed in February 2015. A manual handling risk assessment for the same person had last been reviewed on 29 November 2014 and a people handling and falls risk assessment had last been evaluated on 29 October 2014 and stated "no falls this month". We discussed reviews with the registered manager who told us these should have been reviewed on a monthly basis.

We saw risk assessments and charts were not always regularly reviewed or kept up to date. For example, one person had a care plan in place for eating and drinking that stated, "[Name] is now on weekly weights" and "GP is aware of recent weight loss and requested we keep monitoring [Name]". We saw the person's weight was regularly monitored however the person was identified as high risk for undernutrition and the risk assessment, which should have been reviewed on a monthly basis, had not been reviewed since 10 January 2015. For another person, we saw charts in place to monitor pain, comfort, position and seizure, with guidance stating that charts should be completed every hour during the day and every two hours at night. However, for the previous two days the charts had only been completed at 1am, 5am and 9am on both days.

We also found bladder monitoring charts to be incomplete. When we asked the registered manager how they determined the urine output entered on the chart they told us staff had received a presentation on this, however she was unable to find the presentation/graphical information on the day which supported this.

We discussed reviews with a member of staff who told us, "We are probably being lazy" and "Been too busy".

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (now Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

We saw pre-admission assessments had been carried out before a person moved into the home. Following an initial assessment, care plans were developed detailing the care needs and support required to ensure personalised care was provided to all people. We also saw each person had a social history/personal profile, which described the person's history such as family, hobbies, employment, where they went to school and significant dates. We saw that this had been written in consultation with the person who used the service and their family members.

We observed activities taking place in the ground floor lounge and spoke with the activities coordinator. The activities coordinator told us he was at the home five mornings per week and activities included singing, papier mache, dominoes, textiles and local school children attending to entertain the people who used the service. The activities coordinator was knowledgeable about people's individual likes and dislikes and arranged personalised activities rather than just group activities.

People and their family members told us, "[Activities coordinator] is wonderful. He knows them all by name and knows all their idiosyncrasies", "They take them on bus trips" and "They have coffee mornings".

We saw the complaints and compliments book, which recorded the date and time of the complaint, the name of the complainant, to whom the complaint was made, the nature of the complaint and the outcome. The last recorded complaint was in February 2015 and had been made by a family member of a person who used the service. We saw the incident had been fully investigated, an explanation had been provided to the person and their family member, details of discussions with the staff involved and a record that the complainant was happy with the actions taken and the outcome. We saw the complaints policy was made available to people who used the service and visitors.

The registered manager told us that complaints were an agenda item at family meetings. People we spoke with, and their family members, knew how to make a complaint. They told us, "Yes we are definitely encouraged to do that" and "If there is anything wrong they come to me". This meant that comments and complaints were listened to and acted on effectively.

Good

Is the service well-led?

Our findings

At the time of our inspection visit, the home had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service.

People who used the service, and their family members, told us the home was well led. They told us, “It is a happy atmosphere, the staff are happy in their work”, “It is a steady place”, “The manager is always visible and approachable”, “She [the registered manager] is lovely and easy to talk to” and "We said we were going to buy a recliner chair for my mother but the manager said they had one she could have which was put in her room".

We looked at what the provider did to check the quality of the service, and to seek people's views about it.

We saw records of the provider’s monthly ‘mini inspection’, which included an audit of policies and procedures, menus, activities, training, fire drills, care plans, medication, staffing, kitchen, cleanliness, outside areas and personnel records. We saw actions were created for any identified issues, for example, some review dates and signatures were missing from care plans.

We saw the quality assurance file, which included a copy of the quality assurance policy and procedure, and the latest quarterly quality assurance audit that was carried out on 3 March 2015. This included staff observations and supervisions, complaints, health and safety, accident analysis, care plan reviews, environment, maintenance and audits of hand hygiene, medication and mattresses. We saw from the action plan that this audit had also identified that care plans required updating.

We saw records which showed that staff meetings had taken place at least twice per year. The minutes for the most recent meeting included team work, residents, staff, holidays, health and safety, safeguarding and training.

We saw a ‘service user annual questionnaire’ had taken place in 2014. 18 out of 36 questionnaires had been returned, analysis of the results had taken place and an action plan prepared for any identified issues. The questionnaire included questions on catering and food, personal care and support, daily living, premises and management. An example of an action from the questionnaire was to ask people who used the service at the next meeting what changes or alterations to the menu they would like. The registered manager also told us a newsletter was provided every month to people who used the service and their family members.

We saw the agenda for the next meeting for people who used the service and their family members. This meeting was due to be held on 20 March 2015 and include discussions on Easter activities, volunteering for trips, activities, the new menu, corridors and any issues or concerns.

Family members we spoke with told us, “We get a yearly survey” and “We get asked our opinions all the time”.

This meant that the provider gathered information about the quality of their service from a variety of sources.

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 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: Care and treatment of service users was not being provided with the consent of the relevant person. Regulation 11. (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Accurate, complete and contemporaneous records in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided were not being maintained. Regulation 17. (2) (c).