D W Robson and J R Robson

Close House Nursing and Residential Care Home

Inspection report

Close House
Hexham
Northumberland
NE46 1ST
Tel: 01434 602866
Email: nursing@hexhamshire.com

Date of inspection visit: 15 and 22 October 2015
Date of publication: 23/12/2015

Ratings

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

Overall summary

The unannounced inspection took place on 15 and 22 October 2015. We last inspected Close House Nursing and Residential Care Home in May 2013. At that inspection we found the service was meeting all the regulations that we inspected.

Close House Nursing and Residential Care Home is situated within a rural setting and was one of the first care homes to open in Northumberland. It is the only care home operated by the owners and provides residential and nursing care for up to 22 people, some of whom are living with dementia. At the time of our inspection there were 19 people living at the service, 13 of which had nursing needs.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found some shortfalls in the management of medicines and we have asked the provider to take action to rectify these. For example 'as required' medicines had no protocols in place for staff to follow.

Staff were aware of their safeguarding and whistleblowing responsibilities and knew how to report any concerns they had. They had received appropriate training in this area.

Accidents and incidents were recorded and monitored to ensure that any trends developing were spotted quickly and acted upon, for example people who had begun to have regular falls. Where risks had been identified, for example those at risk of malnutrition, risk assessments had been put in place and regularly reviewed.

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.

Staff had the skills and training required to adequately support the people in their care. Staff felt supported and received suitable and regular supervision and yearly appraisals.

Care Quality Commission (CQC) is required by law to monitor the operations of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. MCA is a law that protects and supports people who do not have the ability to make their own decisions and to ensure decisions are made in their 'best interests'. It also ensures unlawful restrictions are not placed on people in care homes and hospitals. In England, the local authority authorises applications to deprive people of their liberty. We found the registered persons were complying with their legal requirements.

Meals were appetising and people were offered a choice in line with their dietary requirements and preferences. Where necessary staff monitored what people ate to help ensure they stayed healthy.

People and their relatives felt the care team were good at their jobs and were very caring. People's dignity and respect were maintained and we saw examples of staff knocking on doors before entering and being discreet when offering to support them with personal care. People's independence was preserved. We observed one person making her way down the stairs on her own. Staff told us she wanted to do that and had been assessed as able to do it on her own.

People's needs were assessed and care planning was reviewed regularly and people's changing needs recorded. Where appropriate, relatives were included in the reviews.

A range of activities were completed with people and the registered manager was looking into more dementia friendly activities that they could implement, to ensure as many people as possible were included.

People and their relatives knew how to complain and told us they would if they needed to. One complaint had been raised formally and dealt with effectively. A range of audits and checks were completed at the service to ensure that they maintained good quality practices.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to the management of medicines. You can see what action we told the provider to take at the back of the full version of this 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 always safe.

We found some shortfalls in the management of medicines including for example how 'as required' medicines were dealt with.

Staff were aware of their safeguarding responsibilities and knew what to do if they had any concerns. All accidents and incidents were recorded and monitored and risks had been assessed appropriately.

Regular checks were completed to ensure that people lived in a safe environment.

There was enough staff to respond to the needs of people and robust recruitment procedures were in place to ensure suitable staff were employed.

Is the service effective?

Good

The service was effective.

Staff were skilled, knowledgeable and were supported by their line manager.

The manager and staff were aware of the Mental Capacity Act 2005 and of the Deprivation of Liberty Safeguards and worked within legal guidelines.

People were supported with a healthy diet and to remain hydrated.

Is the service caring?

Good

The service was caring.

People who used the service and relatives were positive about the service and the way staff treated the people they supported.

Staff were kind and compassionate and treated people with dignity and respect.

Staff respected people's wishes and provided care and support in line with those wishes.

Is the service responsive?

Good

The service was responsive.

People and their relatives were involved with people's care needs and were able to make choices and have control over the care and support they received.

Activities were provided for people to participate in, should they wish to.

People knew how to make a complaint and were confident if they raised any concerns these would be listened to.

Summary of findings

Is the service well-led?

Good

The service was well led.

People and staff were happy to approach the management team should they need to and staff felt adequately supported.

Audits and checks were in place to monitor the quality of the service and any issues arising were followed up with actions being monitored.

Close House Nursing and Residential Care 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 15 and 22 October 2015 and was unannounced. The inspection was carried out by two inspectors, one specialist advisor and one expert by experience. A specialist advisor is a professional who specialises in a particular area of health and social care, for example, medicines, moving and handling or quality assurance. This specialist advisor was a qualified nurse with experience of working in a care home environment. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience focused on talking to people and their relatives and gaining thoughts on their experiences of living at the service.

The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed other information we held about the home, including the notifications we had received from the provider about any deaths, injuries or other incidents they are legally obliged to send us. We also contacted the local authority commissioners and safeguarding teams for the service, the local Healthwatch, the clinical commissioning group (CCG), infection control nurses and community nurses. We used their comments to support our planning of the inspection.

During this inspection we carried out observations using 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 spoke with ten people who used the service and eight family members and visitors. We spoke with the registered manager, two nurses, two senior care staff, four care staff, the cook, the handyman, the administrator and the newly appointed administration apprentice. We observed how staff interacted with people and looked at a range of records which included the care and medicine records for five of the 19 people who used the service, four staff personnel files, health and safety information and other documents related to the management of the home.

Requires improvement

Is the service safe?

Our findings

We found some shortfalls in the safe management of medicines. We observed medicines being administered to people by the nurse in charge. She followed safe practices, although the care plans regarding medicines had no supporting risk assessment. This meant staff may not have had all the detailed information they should have had. Some medicines are more 'risky' than others. For example Alendronic Acid, where there is a higher risk of harm to people if it is not administered in a particular way. The registered manager told us that they would put these risk assessments in place immediately and we saw some evidence of this before the inspection was completed.

Many of the people at the service were prescribed 'as required' medicines. These are medicines that are taken at a particular time, for an ailment which may be intermittent and the medicine is not needed all the time. We found that people were offered their 'as required medicines, but information had not always been provided in the records about what the specific medicine was for. This meant people were at risk of receiving inconsistent care as staff did not have information about why they should offer 'as required' medicines. There was no guidance included within the providers medicines policy about the use of 'as required' medicines. The registered manager told us they would look into this.

Topical medicines are usually creams or ointments that are applied to a particular area of a person's skin. Topical medicine applications were mainly administered by care staff; however, they did not have direct access to medicine administration records (MARs). Although the nurse did not usually apply this medicine, they were responsible for recording its administration on the MARs. This meant staff had no written documentation to confirm with nurses if topical medicines had been applied as prescribed.

Disposed medicines were logged and kept in a box in a secure room separate to the medicines room. However, the arrangements for disposed medicines did not meet NICE guidance, which states the medicines disposal box should be tamper proof and held within a locked cabinet. The National Institute for Health and Care Excellence (NICE) is an organisation which provides national guidance and advice to improve health and social care.

These were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All nurses had undertaken medicine competency assessments completed by the pharmacist supplying the service. One of the nurses was responsible for training care staff in the application of topical medicines and also how to witness controlled drugs being administered. Controlled drugs are prescribed medicines used to treat severe pain, induce anaesthesia or treat drug dependence.

People told us they felt very safe and happy in the service and liked the staff. One person told us, "Yes I am perfectly safe here and the staff look after me well." Another person said, "I feel as safe as houses, more safe than when I lived at home really."

We noted close circuit television (CCTV) had been installed which covered the entrances to the service and outside areas. As the service is in a rural location with few nearby houses, this provided an additional level of security for the people living at the service. When we arrived the majority of people were still asleep with one or two just beginning to stir. Staff had seen our headlights as we parked our cars and came to investigate at the front door to see who we were, and protect the safety of people living at the service.

Staff had received training in safeguarding and whistleblowing procedures and understood what these terms meant. They told us they knew how to report any concerns they had. One staff member said, "I have never been involved in anything like that, but know what to do and would do it."

Care plans contained risk assessments for a range of circumstances including moving and handling and the likelihood of falls. Where a risk had been clearly identified there was guidance for staff on how to support people appropriately.

Accidents and incidents were recorded and monitored for trends, including the prevalence of falls. This ensured that any issues identified were quickly acted upon, for example, a referral to the falls team to support someone who was becoming a high risk of falls. There had been a recent incident at the home which was currently being investigated by the local authority safeguarding team under their normal procedures and we will continue to closely monitor this. Procedures in connection to the incident were checked as part of this inspection.

Requires improvement

Is the service safe?

Checks were completed to ensure that the environment was safe and any equipment was in working order for people to safely use. Window restrictors had been fitted to all windows that posed a risk and they complied with Health and Safety Executive (HSE) guidance. The five year electrical safety check had been completed and regular testing was carried out on portable appliances to ensure electrics were safe and in good repair. Call bells were tested every month to ensure they were working effectively and could be triggered by someone needing additional support or help in an emergency.

Fire safety checks had been completed, including servicing of the fire system and regular monitoring of the fire alarms, extinguishers and emergency lights. An appropriate fire risk assessment was in place.

There was a programme of ongoing refurbishment. One staff member told us one person had a loose cupboard below their sink unit and that it was on the handyman's list for repair. They said, "He's usually very quick to fix things or put them right."

Assessments of people's needs were carried out to determine suitable staffing levels. The registered manager told us that a nurse was on duty at all times and said he was in the process of recruiting additional staff. During one observation we saw that two people sat in a lounge for over 45 minutes before staff came to check on them. When we asked about this, staff told us the two people could attract the attention of staff should they need anything and also that kitchen staff were close by. On a second observation, we saw that staff reacted promptly when people called for assistance.

Safe recruitment procedures were followed. Staff were vetted prior to starting work, which meant Disclosure and Barring Service (DBS) checks were completed and references were obtained. Nurses at the service had their PIN numbers recorded and the provider checked these regularly to ensure they were up to date. All nurses and midwives who practise in the UK must be on the Nursing and Midwifery Council (NMC) register and are given an identifying number called a PIN.

The service was clean and tidy with no malodorous smells. Staff told us that they had access to personal protective equipment, such as aprons and gloves and staff were observed using them appropriately.

Good

Is the service effective?

Our findings

People we spoke with told us they felt their care needs were met and that staff knew them well. One person said, “Staff do all the things for me that I cannot do myself, they are great.”

New staff completed a thorough induction programme. Induction included shadowing existing staff and remaining under the supervision of a more senior staff member until they were competent in personal care duties. One staff member told us, “You are never left alone when you first start, that just would not be right. The nurses and manager make sure staff are properly supervised.” As part of the provider’s improvement programme, we were told that any new starters would complete the new Care Certificate induction training within three months of their start date. The Care Certificate was officially launched in March 2015.

Staff had completed a range of training and we were shown the training matrix. It confirmed staff had either completed or were booked to complete, fire safety, food hygiene and end of life training for example. Nurses, care staff and other staff had also received additional training in dementia to support those people living with condition.

We observed one person being lifted with a hoist and this was done sensitively with the procedure being explained to the person throughout. All nurses and some of the care staff had received first aid training. As the service was in a rural setting this meant, should an incident occur that required first aid, staff would be able to support the person until ambulance crews arrived, this included the act of performing Cardio Pulmonary Resuscitation (CPR).

Nurse competencies were regularly checked and staff told us they received appraisals, supervision and support from their line manager. Records confirmed that this was done regularly. The registered manager told us they were reviewing nurse’s mentorship, clinical supervision and training suitable to their professional development.

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 is called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The service had applied for three applications to be authorised which were still being considered by the local authority.

We found consent had been obtained for the use of bedrails from particular people and where this was not possible a ‘best interest decision’ had been made. One person’s lasting power of attorney had been involved in the best interest decision and had signed to agree the final decision.

The National Institute for Health and Care Excellence (NICE) states, "Health and social care managers should ensure that built environments are enabling and aid orientation."[NICE, Dementia - Supporting people with dementia and their carers in health and social care, November 2006:18]. There was poor visual signage as there were no names or photographs on the doors of rooms to identify whose bedroom it was or what the room was used for. We spoke to the registered manager about this and they said that while they wished to retain the ethos of the service and remain homely, they also recognised that people who lived with dementia now lived at the home and this would support them with their orientation around the building. The registered manager told us he would look into this matter.

One person who had been identified as at risk of malnutrition had increased their weight since they moved into the service. Staff worked closely with people’s GP’s when a risk had been identified. Kitchen staff knew which people were on soft diets and who suffered from diabetes. They had a list of people’s dietary needs and were able to explain how they ensured people received the correct food and refreshments. Care staff monitored people who were at risk of malnutrition, which included regular weighing, nutritional risk assessments and referral to a GP if required. Staff told us they often worked closely with the speech and language team (SALT) when there had been concerns over a person. One member of kitchen staff told us, “We have worked with them [SALT] when [person’s name] became at risk of choking. They helped us manage that better.”

Good

Is the service effective?

We found a good range of menus available and people were given a wide choice of good quality food and refreshments. There was a coffee machine available which made a variety of types of coffee, for example, latte and cappuccino. One visitor said, "You get a nice cup of coffee if you want one. They have a great machine, it's really nice." One person told us, "The cook is very good and will do anything you want. She knows what everyone likes." The cook said, "I am totally flexible. People can have what they want." We observed the cook taking the skin off sausages she was preparing for the evening meal and when asked, she explained that people preferred them without their skin. She explained she was also making curry for a number of people who were not keen on sausage. People told us a cooked breakfast was available at 9am when the cook came on duty and they were able to have a snack if they wanted one before then. We noticed that some food taken to people in their bedrooms was not covered to protect the food and to keep it warm. We asked one of the staff about this and they told us that the food is normally covered with a protective lid.

People told us that if they needed staff to call a GP, they were supported with that request. People's records confirmed that when they were in need of a GP or other healthcare professional, for example a chiropodist or dentist that appropriate measures were taken.

The provider followed best practice and we saw evidence of this. For example information was displayed around the service on the "Position Right to Outsmart Pneumonia" [PROP] pilot. This pilot was aimed at helping to reduce the risk of acquiring pneumonia and involved staff raising the heads of people's beds to 30 degrees. Staff were knowledgeable about the correct positioning of people in bed when we asked.

The provider was registered with the Registered Nursing Homes Association (RNHA) and had attended various seminars with them to remain up to date with research and current guidance. The RNHA was formed to improve the standards in nursing home care and produces a wide variety of information to support its members. The administrator told us they had previously attended equipment trade fairs, including a large one which is held every year and is designed to promote the latest designs and adaptions for people with disabilities. They reported this was to ensure the service was up to date with the latest equipment and any new innovations.

Good

Is the service caring?

Our findings

People's bedrooms contained personal possessions with most having a lovely outlook over the countryside. People and relatives we spoke with were extremely complimentary about the staff and the caring approach they provided. One person stated, "This is a good home and I am happy here. Staff are very caring." Another person said, "I am happy in the home, staff are courteous and friendly and my privacy and dignity is respected." A third person said, "The care is very good and staff are so helpful. The only little thing for me would be that the nearest toilet is sometimes being used but that is a small price to pay as I love the home."

One relative told us, "I would give this home a 100% rating. [Relative] is looked after carefully and they are kept clean and tidy. It is home from home." They also added, "Do you know that the cook often brings up extra tasters for my [relative] which encourages them to eat, and when they were poorly and I stayed in the home they brought in a mattress for me to have a sleep. They did offer me a room but I wanted to be near my [relative]. Also, when I was poorly at home they sent meals for me. That is what I call going the extra mile."

During our inspection we saw lots of 'thank you' cards which had been sent to the provider and its staff. The vast majority of the cards were to compliment the staff on the way they had cared for a relative who had passed away.

People and their visitors told us they were kept up to date and any issues were brought to the attention of the person or their relative. One relative told us about a time where communication had not been very good recently and when we asked staff about this, they told us they would look into the issue as they prided themselves on keeping families up to date.

Visitors told us they could call at any time and did so, and were always made welcome.

The registered manager and staff had sourced a variety of ways to allow people with different needs to be able to keep up to date with local information and be able to read if they wished. The provider had library books available with large print to assist people with poor vision. The registered manager told us they had facilitated the use of a recording of the local weekly newspaper. He told us, "There are a few people who listen to it." We also noted copies of the local area newspaper held within the service. One person told us, "I love reading the Courant, I always have done. It keeps me informed and even though I am not like I used to be, I still want to see what is going on."

People's dignity and respect were maintained and we saw examples of staff knocking on doors before entering and being discreet when offering to support them with personal care. We observed staff asking permission before carrying out particular tasks, for example, using a hoist or supporting people to the toilet. One person stated, "I am very happy in the home. Staff are excellent, polite and respectful, and look after my privacy."

People's independence was preserved. We observed one person making her way down the stairs on her own. Staff told us she wanted to do that and had been assessed as able to do it on her own.

Advocacy information was available in the reception area. An advocate is someone who represents and acts as the voice for a person, while supporting them to make informed decisions. Staff told us no one currently was using this type of service, but that they would support them if one was required.

Good

Is the service responsive?

Our findings

Before people moved into the service a pre-assessment of their needs was completed by one of the more senior staff. It was agreed with the registered manager that the service was able to meet the person's needs and then the person would move in. We were told that people were encouraged to visit first if that was possible before a final decision was made. From the people's identified needs, care plans were put in place with corresponding risk assessments if any were needed. Care plans were regularly reviewed and updated to ensure that they were suitable to support people's assessed needs and relevant people were involved when reviews took place, including the person, their relatives and healthcare professionals.

Behaviour charts were in place where people had been identified as requiring additional support with behaviour that challenged the service. The charts detailed dates, times, what the behaviour was, what was said and what the person looked like (happy/sad etc.). This information was used to help identify any trigger points and try to minimise any episodes of challenging behaviour displayed. Staff told us how they used this information to help them recognise any signs of potential challenging behaviour.

Fluid charts had not always been completed to show the levels of intake by individuals. We saw examples were this would have been useful to support staff in the monitoring of individuals who were at risk of dehydration. We saw examples and staff confirmed that they now completed this information.

Where people required regular turning in their beds due to their immobility, we confirmed that staff had completed the task and recorded the information in the person's care records. We noted that the provider had only started to use body maps. Body Maps are diagrams designed for the recording of any observable body injury that may appear on a person. They are particularly important to record, for example, ongoing skin damage or where allegations of safeguarding concerns are made and it can be particularly useful to body map a person who is transferring services to ensure the new service has accurate and up to date information. One person who had a pressure sore had a body map in place, was using a special mattress to support their body and was having their dressings changed every three days as per the instructions from the GP.

One person told us they had been to the local theatre to watch a show and another told us they had been out and had afternoon tea. During the inspection we observed some activities taking place, for example ball exercises with people in one of the lounges and also an entertainer visited the service and performed magic tricks. People appeared to enjoy both. Some residents told us they were not bothered about activities but a small number said they got a little bored sometimes. There was a list of activities displayed that were available at particular times at the service, for example, crafts, bingo, dominoes and afternoon teas. We noted there was a computer available for people to use with the assistance of staff and the registered manager confirmed this. A hairdresser visited the service every week to undertake any grooming requirements people might have had. One person told us, "I love having my hair done, it makes you feel ever so much better."

A member of the clergy visited the service regularly to support people's religious needs and we were told that if anyone wanted a particular religious denomination to visit the service, then staff would arrange this. A staff member told us that a number of people had been taken to churches in the local area either by their family member or by one of the staff if they wanted to.

We spoke to the registered manager about other activities that could be made available to the people at the service, particularly those with dementia related conditions. They said they would look into this and we discussed dementia related websites, for example Stirling University, where they could gain best practice ideas.

People told us they felt that care was tailored around their individual needs. For example, having a bath when they wanted or choosing what they wanted to eat. We arrived on the first day of inspection early, and were able to confirm that people got up when they wanted. One person told us, "I get up when I want and I go to bed when I want, I eat what I like and that's good enough for me."

People knew how to make a complaint if the need ever arose and told us they would if they needed to. There had been one formal complaint made and this had been dealt with effectively by the registered manager.

Good

Is the service well-led?

Our findings

At the time of the inspection there was a registered manager employed at the service. The registered manager was the son of the original provider and had lived and been part of the service ever since it had opened in the 1960's. He was clearly passionate on being able to provide a good, quality and caring service to the mostly local people that now lived there.

We were told that the registered manager was often seen walking around the service, chatting to people and ensuring everyone and everything was fine. One person said, "He is nice and checks I am happy all the time." One relative said, "There is always an open door, we can speak with them anytime."

There were clear lines of accountability and responsibility. The registered manager was supported by a team of nurses and care staff. The provider employed an administrator who used to be a registered nurse and who now helped support the registered manager and maintain the training.

Staff appeared happy in their work, and told us their job was to care for people and to make them as comfortable as possible. One staff member said, "Friendly and helpful staff, and nice residents". Another said, "I have made friends for life even with those staff that have left Close House."

Staff meetings took place regularly and staff told us they felt supported to do a good job and had the opportunity to bring any issues or concerns to their line manager. Staff told us they enjoyed free meals at the service, which they said was a bonus to their working conditions.

We arrived at 6.30am and sat in on the early morning handover from night staff to day staff. Daily staff handovers provided staff on each shift with a clear picture of each person at the service and encouraged two way communications between care staff and nurses. This helped ensure everyone who worked with people who lived at the service were aware of the current needs of each individual. Relatives told us they felt the staff team communicated well and provided care in a consistent manner to their family members.

Yearly surveys had been completed to gather the views of people and their relatives. We noted that this year's survey was due to be completed in November 2015. The registered manager told us that any issues that arose would be dealt with immediately. He said that people and their relatives normally came to him immediately with any issues and he dealt with them straight away. People told us that they felt fully involved in the service and relatives that we spoke with confirmed the same. They said they met with staff and were able to discuss any issues or raise any concerns they had at any time.

A number of audits and quality assurance checks were completed by the registered manager and staff and where any issues were identified, actions were taken and followed up to completion. The pharmacy who supplied the service had also completed their own medication audit in February 2015 to review procedures and at that time all of the requirements had been achieved. We discussed the current medicines audit at the service, as the shortfalls we had identified in safe management of medicines had not been highlighted by the medicines audit. The registered manager told us they had recently commenced using the current audit tool. After discussion they agreed that the previous audit arrangements had been more robust and would look to change back.

Infection control monitoring took place and actions were noted as being complete which included, bins having been replaced and a protective mask was now available. The service also had two infection control link nurses who took the lead in ensuring good practice was promoted to all staff.

The provider used an electrical system to record and monitor people's care records and this was backed up every day to ensure information could not be lost.

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 Staff did not always have effective systems in place to manage people's medicines. The service lacked information and protocols for 'as required' medicine. Medicine risk assessments were not always in place and topical medicines were not robustly monitored. Regulation 12 (g)