St Benedict's Healthcare Limited

St Benedicts Ferndale House

Inspection report

38 Grove Road
Gosport
Hampshire
PO12 4JL

Tel: 02392601220

Date of inspection visit:
23 May 2018
24 May 2018

Date of publication:
29 June 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 23 and 24 April 2018 and was unannounced on day one and announced on day two.

St Benedicts is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

St Benedicts is providing care and nursing for men who are living with mental health issues and or dementia. The service can accommodate 18 people there were 14 people living there when we inspected.

The service requires a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of the inspection there was no registered manager. The manager had applied for their police check and told us when they received this they would make an application to CQC to be registered. They will be referred to as 'the manager' throughout this report.

The last inspection was April 2017 when the service was rated Good overall. We brought forward this inspection as we had received significant concerns about the service.

From the information we received before the inspection, we were able to see that the home was making progress in making the necessary changes. The goal was then to maintain the changes and embed good practice into the home.

There were arrangements in place for the service to make sure that action was taken and lessons were learned when things went wrong, to improve safety across the service. However, these needed to be more robust and embedded into everyday practice.

People were safeguarded from avoidable harm. Staff adhered to safeguarding adults procedures and reported any concerns to their manager and the local authority.

People told us they felt safe. Risks were assessed to minimise them and staff were aware of people's individual risks. People received their medicines safely and they had their nutritional and health needs met. Emergency systems had been put in place to keep people, visitors and staff safe.

Staffing levels ensured that people's care and support needs were safely met and safe recruitment processes were in place.

Systems were in place to ensure the premises were kept clean and hygienic so that people were protected by the prevention and control of infection.

People's needs and choices were assessed and their care provided in line with up to date guidance and best practice. They received care from staff that had received training and support to carry out their roles.

People were assisted to make healthy choices to maintain their health and well-being.

Staff supported people to attend appointments with healthcare professionals. The service worked with other organisations to ensure that people received coordinated and person-centred care and support.

People's diverse needs were met by the adaptation, design and decoration of premises and they were involved in decisions about their environment. Staff demonstrated their understanding of the Mental Capacity Act, 2005 (MCA) and they gained people's consent before providing personal care.

Staff were caring and compassionate and people were relaxed in staff company. People were treated with dignity and respect and staff ensured their privacy was maintained. People were encouraged to make decisions about how their care was provided and staff had a good understanding of people's needs and preferences.

People were listened to, their views were acknowledged and acted upon and care and support was delivered in the way that people chose and preferred. Care plans were person centred and reflected how people's needs were to be met. Records showed that people and their relatives were involved in the assessment process and the on-going reviews of their care. They were supported to take part in activities which they wanted to do, within the service and the local community. There was a complaints procedure in place to enable people to raise complaints about the service.

The service had an open culture which encouraged communication and learning. People, relatives and staff were encouraged to provide feedback about the service and it was used to ensure continuous improvement. Staff were motivated to perform their roles and worked to empower people to be as independent as possible.

The manager had not always adhered to the requirements of their Care Quality Commission registration, of submitting notifications about key events that occurred. A programme of audits and checks were in place to monitor the quality of the service and improvements were made where required. The service had changed, according to staff, for the better and now these changes needed to be embedded into every day practice.

We found one breach of the Care Quality Commission (Registration) Regulations 2009.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were cared for by staff who knew them well.

The provider had appropriate arrangements in place to safeguard people from potential abuse.

Safe arrangements were in place to manage medicines.

The registered manager had robust recruitment systems in place.

Safe arrangements were in place to protect people from the risk of infection.

Is the service effective?

Good

The service was effective.

The provider was implementing best practice guidance in creating a good mental well being home. This would take time to embed

Staff had received relevant training and ongoing support and development.

Staff understood the requirements of the Mental Capacity Act 2005 and documentation demonstrated people's choices were respected.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect.

Staff engaged with people in a supportive and patient manner.

Care records reflected people's choices.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The provider had not always notified CQC of incidents and concerns in the home.

People were supported to participate in meaningful activities.

The provider had an effective complaints procedure.

Risks to people's welfare were assessed and managed appropriately.

Is the service well-led?

Requires Improvement

.
The service was not always well-led

A quality assurance system was in place and information from audits was used to inform a central action plan to drive improvements.

However, the system was not always effective because incidents were not always identified by staff or reviewed by the manager to show the actions taken to drive improvements.

There was new management in place and feedback from staff and people was mostly positive about the leadership of the home. Some time was needed for the team to develop and embed the changes and improvements they had planned.

The provider had policies and procedures in place for notifying the relevant organisations about safeguarding issues.

The registered manager was creating an open culture in the home which allowed people to comment about the quality of care they received.

St Benedicts Ferndale House

Detailed findings

Background to this inspection

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

The inspection was prompted by notification from adult social care services who had significant concerns about the service. We were aware of the actions being taken by other public bodies such as the police, social and health services.

This inspection took place on 23 and 24 May 2018 and was unannounced. The inspection team consisted of two inspectors.

Before the inspection we reviewed information we held about the service. We looked at notifications and previous inspection reports. A notification is information about important events which the service is required to send us by law. This information helped us to identify and address potential areas of concern. The provider was not asked to complete a Provider Information Return prior to this inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection, we spoke with two people and a health care professional. We observed care and support being delivered in communal areas of the home. We spoke with the manager and eight staff including housekeeping, care and nursing staff. We looked at the care records for five people and the medicine records for 14 people.

Good

Is the service safe?

Our findings

At our previous inspection in April 2017 we rated the provider as 'good' under the key question of 'Is the service safe?' We found at this inspection the rating remained 'good'.

Concerns raised by adult social care services included, but were not exclusive to: risk assessments not reflecting people's needs, a lack of training, lack of staff and poor moving and handling.

The people we spoke with felt safe living at the home. One person told us, "I like it here. The staff are like family. Sometimes, people argue but the staff calm it down."

The staff members we spoke with had undertaken adult safeguarding training within the last year. They understood the correct safeguarding procedures should they suspect abuse. They were aware that a referral to an agency, such as the local Adult Services Safeguarding Team should be made, in line with the provider's policy. One staff member said, "I would let the CQC know if someone wasn't being treated right. We all would, and the manager would deal with it anyway."

We asked staff about their understanding of risk management and keeping people safe whilst not restricting freedom. One staff member said, "The residents, those that can, come and go as they want within the home." However, two of the three staff we spoke with did not fully understand the rights of people with mental capacity to take risks and make potentially unwise decisions. When we fed this back to the manager they said further training would be arranged.

We noted that one person was at risk of self-harm and had attempted suicide in the past. Staff were knowledgeable about this and had put in place a number of measures to keep them safe. Such as, the removal of their call bell being replaced by regular staff monitoring at night. The person was no longer deemed at high risk.

We asked staff if they thought there were enough carers on duty to provide safe and effective care. All thought there were enough. One staff member said, "Definitely, yes. We have more staff now, so we do have the time to care for them properly". Another staff member told us, "I would say so. We get agency in if we have to but that doesn't happen much at the moment. We have the time to spend one to one with the guys." Our observations on both days of our visit confirmed this.

Staffing levels were assessed daily, or when the needs of people changed, to ensure people's safety. We were told existing staff would be contacted to cover shifts in circumstances such as sickness and annual leave. Documentation in staff files helped demonstrate that staff had the right level of skill, experience and knowledge to meet people's individual needs. The provider used a staffing dependency tool to assess and monitor staffing levels.

We spoke with a registered nurse about medicines management. We asked how medicines were acquired, stored, dispensed and disposed of. We also examined the provider's medication management policy. We

asked if staff received regular training updates and if medicine administration competency checks were undertaken. We were shown evidence of regular competency checks undertaken by staff authorised to dispense medicines. We noted staff training included updates in areas such as blood glucose. The administration of medicines followed guidance from the Royal Pharmaceutical Society. Staff did not leave the medicines trolley unlocked when unsupervised and did not sign Medicines Administration Records MARs charts until medicines were taken. Only registered nurses dispensed medicines.

We looked at the MARs for all people living at the home. We noted there were no gaps in these records. All MARs contained a front sheet with a recent photograph for identification purposes, along with relevant information, such as the person suffered from allergies or preferred to take their medicines in a particular way. Other medications were safely stored in locked cupboards. Medicines requiring refrigeration were stored in a lockable fridge which was not used for any other purpose. The temperature of the fridge was monitored daily.

We looked at how medicines given on an 'as needed' basis (PRN) were managed. PRN protocols were in place for all medicines taken this way; they outlined how, when and why they should be taken and included maximum doses over a 24 hour period. We noted where a person could be given varying numbers of tablets, for example one or two painkillers, that this was clearly recorded on MARs. People at risk of experiencing pain who could not express it verbally were frequently assessed using a formal tool. Staff were knowledgeable about how pain manifested itself for these individuals.

We noted the monitoring of therapeutic drugs was undertaken to ensure concentrations of the drug in the person were safely maintained. This was done either in the form of blood tests or in monitoring the person themselves, for example, glucose levels for those living with diabetes. We also noted there was clear guidance for staff concerning the management of people taking other types of medicines such as those used in the treatment of psychiatric disorders. These included when taking the medicines was indicated and the signs and symptoms of potential side effects.

No-one living at the home managed their medicines independently and no-one received their medicines covertly, that is without their consent or knowledge. Although one person had covert medicine authorisation in place this was only used 'in extremis', and was not being used at present.
We looked at medicines audits undertaken by the provider. They looked at the wider aspects of medicines management, such as ordering and disposal. We noted issues raised in these reports were dealt with promptly and effectively. The provider was also subject to an annual external audit, conducted by the dispensing pharmacy.

Staff files contained all of the information required under Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Application forms had been completed and recorded the applicant's employment history, the names of two employment referees and any relevant training. There was also a statement that confirmed the person did not have any criminal convictions that might make them unsuitable for the post. A Disclosure and Barring Service (DBS) check had been obtained by the provider before staff commenced work at the home. The Disclosure and Barring Service carry out checks on individuals who intend to work with vulnerable children and adults, to help employers make safer recruitment decisions.

We noted the home was clean. We did not detect any malodours during our visit. We noted the provider put preventative measures in place where necessary, for example, ensuring the adequate provision of personal protective equipment (PPE) for staff, such as gowns and gloves.

We undertook a 'walk round' of the home. We noted all areas, both communal and those used by staff, were clean and hygienic. There were three domestic staff employed, who cleaned all communal areas and people's rooms every day. We spoke with a member of the housekeeping team, who told us they had enough time to carry out these duties. They also received regular relevant training in infection control and the care of substances harmful to health (COSHH). We did find some doors open which should have been locked for example the laundry and cleaning cupboard. This was shared with the manager.

There were hand hygiene stations around the home. All hand basins contained hot running water, soap and disposable towels. Bathrooms and toilets were clean and free of litter or debris. Staff had a good understanding of infection prevention and control issues; they received regular training and updates in this area.

Arrangements were in place to protect people if there was an emergency. The registered manager had developed Personal Emergency Evacuation Plans (PEEPs) for people and these were kept in an accessible place. The emergency plans included important information about people such as their communication and mobility needs. This gave details of the safest way to support a person to evacuate the building in the event of an emergency, for example fire. The fire risk assessment and fire equipment tests were up to date and staff were trained in fire safety.

Good

Is the service effective?

Our findings

At our previous inspection in April 2017 we rated the provider as 'good' under the key question of 'Is the service effective?' We found at this inspection the rating remained 'good'.

We spoke with staff about their experiences of induction when first coming to work at the home. One staff member told us, "I wasn't new to caring when I started here but I did get an induction. I shadowed staff for two days, which was enough for me. It was fine." We noted an adapted version of the Skills for Life Care Certificate training was in place for all new staff. This familiarises staff with an identified set of standards that health and social care workers adhere to in their daily working life.

Staff had regular supervision and appraisal. Supervision and appraisal are processes which offer support, assurances and learning to help staff development. We asked staff about the managerial support they received. One staff member said, "I get supervision about every six weeks and it's good. It is open and honest." Another staff member told us, "I can say what I like. Obviously I don't wait if I have something urgent. The door is always open and I can speak to the manager." We also asked staff about the training they received. One staff member said, "I'm doing my NVQ 3 at the moment. The training is there." Another staff member told us, "I've done breakaway training and challenging behaviour management as well as the other (mandatory) stuff."

Senior staff had conducted competency checks to ensure staff were appropriately skilled to meet people's needs. For example, administering medicines and observing interactions. Records showed staff received training specific to people's needs. This included learning disabilities and behaviours that may challenge others. A training schedule demonstrated the manager monitored staff training needs and organised additional training when it was needed.

We asked staff about issues of consent and about their understanding of the Mental Capacity Act (MCA) (2005). The staff members we spoke had undertaken recent training in this area. They could tell us the implications of the Act and Deprivation of Liberty Safeguards (DoLS) for the people they were supporting. The purpose of DoLS, which is part of the Mental Capacity Act (2005), is to ensure that someone, in this case living in a residential setting, is only deprived of their liberty in a safe and appropriate way. This is done when it is in the best interests of the person, has been agreed by families and professionals and there is no other way to safely care for them.

We looked at care plans in the light of issues of consent and capacity. People had received mental capacity assessments where this was appropriate and consent had been sought from people with capacity. We noted this was done in the process of care planning and review. Where a person did not possess mental capacity, we noted up to date mental capacity assessments were in place, in addition to evidence of best interests meetings with relevant parties present.

All of the people living at the home were either subject to DoLS authorisation, or were pending approval. We noted these authorisations were decision specific; the care plans gave details about which aspects of

people's lives were subject to restrictions and what they were still able to do.

The people we spoke with were happy with the food on offer. One person said, "The cook is really good and there's plenty of food." Another person said, "I like it. The cook listens if we have a request." The staff we spoke with were knowledgeable about people's differing dietary requirements. They were aware of the importance of healthy eating, special diets and of maintaining a balanced diet. They were also aware of the balance to be struck between the need for this and people's rights to decide for themselves.

The home had been adapted to support people's needs. We saw that the communal gardens had been adapted to provide access for all independently, for example there were ramps in place for people using a wheelchair. Equipment used for moving and handling was regularly maintained and fit for purpose.

We noted people living at the home had access to a variety of external health and social care professionals in order to ensure they were adequately supported in their health and welfare. These included specialist nurses, dieticians, speech and language therapists, community physiotherapists and the Older People's Community Mental Health Team. We noted advice and support offered by these professionals were acted upon in a timely manner.

Good

Is the service caring?

Our findings

At our previous inspection in April 2017 we rated the provider as 'good' under the key question of 'Is the service caring?' We found at this inspection the rating remained 'good'.

We observed care and support given to people throughout both days of our visit. We found the care to be safe and appropriate, with adequate numbers of staff present. We observed good interaction between people and staff who consistently took care to ask permission before intervening or assisting. There was a high level of courteous engagement between staff and people.

We observed staff interacting with people throughout the day. We noted staff were respectful and kind to people living at the home. We observed many instances of genuine warmth between staff and people. On these occasions, staff took time to explain their actions in order to minimise people's anxiety.

There was a calm and inclusive atmosphere in the home. The staff we spoke with were knowledgeable about the people they were caring for and were able to explain to us people's individual needs and requirements. It was evident staff saw people as individuals. One staff member told us, "I worked in a huge care home before I came here. That was like a factory. You just didn't get any time to spend with people. This is completely different. It's just like someone's home, like a family."

We asked staff if they thought the home was a caring place. One staff member told us, "I think it is. Obviously, the people living here have problems and there can be conflict but we manage it." Another staff member said, "I would have a relative cared for here, definitely."

We also spoke with visiting health professionals during our visit. One professional told us, "I think this is my favourite place to visit. The staff are knowledgeable and always refer appropriately. It's very calm here. I've known instances where people have been admitted here smashing up their rooms and within a short time are engaging with other people ."

The service ensured that people had access to the information they need in a way they can understand it and are complying with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. A member of staff said "We have pictures of events in the house so people know what's going on."

People had access to an advocate to support their rights to have choice, control of their care and be as independent as possible. Staff had a good understanding of when people may need additional support from an advocate. An advocate is an independent person who can help people to understand their rights and choices and assist them to speak up about the service they receive.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in April 2017 we rated the provider as 'good' under the key question of 'Is the service well led?' We found at this inspection that improvements were required and there was no registered manager.

Following a safe guarding alert it had been identified that governance systems in place had not been effective. There were concerns about a lack of supervision for staff, recruitment, personalised care planning and risk assessments. There had been a lack of action to address these concerns and to ensure people were receiving a good, safe service. The lack of assessment and monitoring to mitigate the risks relating to the health and welfare of people using the service placed them at risk. We also identified the management had not notified us about significant incidents.

We found that although incidents and accidents had been recorded by staff they had not been reviewed by the manager. For example, in the records we reviewed, we saw incidents had not been reviewed between January 2018 and the date of the inspection. There was no information to assess whether the appropriate actions had been taken following the incident/accident. We checked some of these incidents against the daily records of people to check whether the appropriate actions were taken; and there was no information recorded in their daily notes to show action had been taken. We discussed the process with the manager especially in light of the recent safeguarding concerns. We confirmed we would have expected to see an investigation report into incidents and accidents. This meant the system to review and evaluate incidents may not always be effective for learning and driving continuous improvements.

Some record keeping documents still needed to be improved. For example, some fluid charts we observed had not been completed correctly and therefore people's fluid intake was not monitored accurately. This meant that people were at risk of dehydration.

The manager was aware of these instances of poor record keeping and further training was planned later in May 2018. The manager agreed to send us reports on a fortnightly basis regarding the changes they were making and to give us information on staffing levels and any issues that occur.

There has been a change in manager at the home following recent safeguarding concerns. The manager is waiting for a police check to be returned and they will then submit an application to be registered with CQC.

People and staff spoke positively about the manager. We asked staff if they thought the home was well-led. One staff member told us, "I know there have been changes with a new manager but I don't think it's affected the care at all." Another staff member said, "I think things are pretty good. The manager really listens. I told them I didn't think I could carry on doing three 12 hour shifts in a row because it's so demanding. They changed it for me." A third staff member told us, "I think it's well led, yes. The manager is always around and available to talk to".

The manager was being supported to be proactive to improve standards and they had started to conduct

audits to identify areas of improvement. These included checking the management of medicines, risk assessments, care plans, DoLS, mental capacity assessments and health and safety. The manager told us they felt supported by the provider.

The manager showed us they had begun 'intentional rounding' at the home. This is a 24-hour chart to monitor regular daily care including skin integrity, mobility and falls prevention. The senior care staff were managing this well. The manager had arranged for the senior carer to sit in on handover with the nurse to ensure a thorough handover. There was to be a 'client of the week' when the care plan and needs would be reviewed, a peer review of the care plans would take place, to share learning.

It was evident that the new manager knew what the concerns in the service were and was keen to drive improvements and make the changes needed. They were aware of the need to make improvements to the records, communication and accountability of nurses. The manager had held team meetings and clinical meetings with the nurses. We reviewed the action plan and saw the actions identified for sustained improvement included care records, physical health and mental wellbeing care plans, risk assessment and medication audits. They had also employed someone to support the new manager in meeting the concerns raised through safeguarding.

The provider involved people, their supporters and staff in assessing the quality of the service provided through surveys. The recent survey replies were still being gathered, we were therefore unable to assess how the information from surveys was used to develop and improve the service. However, we looked at the four that had been returned. Examples of replies were 'care is individualised to needs – usually'; 'St B is a wonderful home. All the team are attentive of people's care. There is lots of love so unusual in care homes today.' 'Happy to leave [name] as I know he is looked after.'

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in April 2017 we rated the provider as 'good' under the key question of 'Is the service well led?' We found at this inspection that improvements were required and there was no registered manager.

Following a safe guarding alert it had been identified that governance systems in place had not been effective. There were concerns about a lack of supervision for staff, recruitment, personalised care planning and risk assessments. There had been a lack of action to address these concerns and to ensure people were receiving a good, safe service. The lack of assessment and monitoring to mitigate the risks relating to the health and welfare of people using the service placed them at risk. We also identified the management had not notified us about significant incidents.

We found that although incidents and accidents had been recorded by staff they had not been reviewed by the manager. For example, in the records we reviewed, we saw incidents had not been reviewed between January 2018 and the date of the inspection. There was no information to assess whether the appropriate actions had been taken following the incident/accident. We checked some of these incidents against the daily records of people to check whether the appropriate actions were taken; and there was no information recorded in their daily notes to show action had been taken. We discussed the process with the manager especially in light of the recent safeguarding concerns. We confirmed we would have expected to see an investigation report into incidents and accidents. This meant the system to review and evaluate incidents may not always be effective for learning and driving continuous improvements.

Some record keeping documents still needed to be improved. For example, some fluid charts we observed had not been completed correctly and therefore people's fluid intake was not monitored accurately. This meant that the people were at risk of dehydration.

The manager was aware of these instances of poor record keeping and further training was planned later in May 2018. The manager agreed to send us reports on a fortnightly basis regarding the changes they were making and to give us information on staffing levels and any issues that occur.

There has been a change in manager at the home following recent safeguarding concerns. The manager is waiting for a police check to be returned they will then submit an application to be registered with CQC.

People and staff spoke positively about the manager. We asked staff if they thought the home was well-led. One staff member told us, "I know there have been changes with a new manager but I don't think it's affected the care at all." Another staff member said, "I think things are pretty good. The manager really listens. I told them I didn't think I could carry on doing three 12 hour shifts in a row because it's so demanding. They changed it for me." A third staff member told us, "I think it's well led, yes. The manager is always around and available to talk to".

The manager was being supported to be proactive to improve standards and they had started to conduct

audits to identify areas of improvement. These included checking the management of medicines, risk assessments, care plans, DoLS, mental capacity assessments and health and safety. The manager told us they felt supported by the provider.

The manager showed us they had begun 'intentional rounding' at the home. This is a 24-hour chart to monitor regular daily care including skin integrity and mobility and falls prevention. The senior care staff were managing this well. The manager had arranged for the senior carer to sit in on handover with the nurse to ensure a thorough handover. There was to be a 'client of the week' when the care plan and needs would be reviewed, a peer review of the care plans would take place, to share learning.

It was evident that the new manager knew what the concerns in the service were and was keen to drive improvements and make the changes needed. They were aware of the need to make improvements to the records, communication and accountability of nurses. The manager had held team meetings and clinical meetings with the nurses. We reviewed the action plan and saw the actions identified for sustained improvement included care records, physical health and mental wellbeing care plans, risk assessment and medication audits. They have also employed someone to support the new manager in meeting the concerns raised through safeguarding.

The provider involved people, their supporters and staff in assessing the quality of the service provided through surveys. The recent survey replies were still being gathered, we were therefore unable to assess how the information from surveys was used to develop and improve the service. However, we looked at the four that had been returned. Examples of replies were 'care is individualised to needs – usually'; 'St B is a wonderful home. All the team are attentive of people's care. There is lots of love so unusual in care homes today.' 'Happy to leave [name] as I know he is looked after.'

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We 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 18 Registration Regulations 2009 Notifications of other incidents The lack of notifications to CQC was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.