Richmond Villages Operations Limited

Richmond Village Aston On Trent Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection of Richmond Village Aston On Trent Care Home took place on 15 August 2018 and it was unannounced. Richmond Village Aston On Trent Care Home is a 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. The home was part of a retirement village which included access to spa and leisure facilities, a restaurant, and gardens. Within the home care was provided across two floors and there were communal rooms on each floor. There was a room for craft and other activities as well as leisure areas; for example, one room was created in the image of a pub.

Richmond Village Aston On Trent Care Home is a care home for 61 older people which was registered with CQC in September 2017. There was a planned approach to people coming to live at the home and at the time of our inspection 19 people were living there. This was their first inspection.

There was a registered manager in post. 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.

The audits and systems implemented to monitor the service and improve it were not always effective in doing so. Medicines were not always well managed to reduce the risks associated with them and to ensure people received them as prescribed. The checks that were in place to manage them were not always completed or actioned. Tools for monitoring staffing levels were not always effectively analysed and we found that there were not always enough staff deployed to meet people's needs promptly. When safeguarding concerns were raised or things went wrong there was not always sufficient learning from them to reduce the risk of them happening again.

When staff were rushed or task focussed they did not always take the time to speak with people or reassure them. They did not always promote and respect people's privacy. At other times we observed kind and respectful relationships with staff.

People's capacity to consent to restrictions which were put in place to keep them safe was not always assessed. Legal safeguards to authorise these were not always applied for. Therefore, people were not always supported to have maximum choice and control of their lives in the least restrictive way possible.

People were encouraged to pursue interests and hobbies and regular activities were planned. Visitors were welcomed at any time. There were regular meetings with people and their relatives and the feedback was used to improve the home.

People were supported to maintain good health and this was done through partnership with other

professionals and organisations. There were also facilities on the village site for people to use such as gym and chiropody. Mealtimes were not rushed and people were given a choice of meal. We saw that food and drink was regularly provided and records were maintained for people who were nutritionally at risk. Care plans were regularly reviewed to correspond with changing support needs and they were personalised and accessible.

Staff received regular supervision and training to enable them to do their job well. Safe recruitment procedures were followed to ensure they were suitable to support people. There were systems in the home to keep it clean and free from infection.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 consistently safe.

Medicines were not always well managed to ensure that people received them as required. Learning from when things went wrong and safeguard concerns was not always implemented. Other risks were assessed and mitigated. There were not always sufficient staff to ensure that people were supported promptly. Safe recruitment procedures had been followed when employing new staff. Infection control procedures were embedded.

Is the service effective?

Requires Improvement

The service was not consistently effective.

When people did not have capacity to do make their own decisions, assessments were not always completed to ensure decisions were made in the person's best interest Staff received training and support to enable them to work with people effectively. People were supported to maintain a balanced diet and to access healthcare when required. This was done through close collaboration with other professionals. The environment was designed to meet people's needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's dignity and privacy were not always upheld. Staff did not always spend time with people to reassure them when they were distressed. There were some caring, respectful relationships with the people they supported. Relatives and friends were welcomed to visit freely.

Is the service responsive?

Good

The service was responsive.

People were encouraged to participate in hobbies and interests. Care was reviewed to meet people's changing needs and new plans were devised. Complaints were investigated and responded to in line with their procedure.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The systems in place to monitor and improve the quality of the service were not always effective in doing so. People knew the registered manager well and reported that they were approachable. The staff team felt well supported and understood their responsibilities.

Richmond Village Aston On Trent 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 August 2018 and was unannounced. It was completed by two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. An additional inspector attended for a short time to complete a 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 used information the provider sent us in the Provider Information Return (PIR) to plan the 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 also used information we held about the home which included notifications that they sent us.

We used a range of different methods to help us understand people's experiences. We spoke with five people who lived at the home about their experience of the care and support they received. People who lived at the home had variable verbal communication and some people were living with dementia. Therefore, we observed the interaction between people and the staff who supported them in communal areas throughout the inspection visit. We also spoke with three visiting relatives to gain their feedback.

We spoke with the registered manager, the deputy manager, two nurses, the activities co-ordinator and four care staff. We reviewed care plans for four people to check they were accurate and up to date. We also looked at medicines administration records for seven people. We reviewed systems the provider had in

place to ensure the quality of the service was continuously monitored and reviewed to drive improvement. These included audits and quality checks for infection control, medicines management, accidents and incidents, and health and safety checks.

Requires Improvement

Is the service safe?

Our findings

Medicines were not always managed to minimise the risk they posed to people nor to ensure that people received them as prescribed. One person we spoke with told us that their main concern was running out of their medicines. They said, "They haven't had the foresight to count up the pills and see how many are left and when I ran out they said they couldn't do anything about it because the pharmacy was closed. This had happened twice." We found that medicines were not always stored and recorded in line with national guidance. We checked medicines administration records (MAR) and found that some of them had gaps in them because staff had not signed to say that people had received their medicines. When we tried to compare the amount of medicine in storage with the amount recorded to see if people had received them we found that the recording of stock on the MAR were not always accurate or up to date. Therefore, we were unable to ascertain whether they had received them. For example, one person had 18 medicines recorded as administered from a stock of 20. When we check this, we found there were 4 remaining which meant the person had either missed 2 or the records were not accurate. We found errors in every person's medicines that we reviewed and we therefore could not be assured that people received the medicines they required.

Medicines were not always managed in line with national guidance. One person received their medicines covertly, or without their knowledge (usually given in food or drink). The National Institute for Health and Care Excellence (NICE) quality statement is, 'Adults who live in care homes and have been assessed as lacking capacity are only administered medicine covertly if a management plan is agreed after a best interests meeting.' When we spoke with the registered manager about this they told us that the person rarely had their medicine covertly and it was decreasing. They told us that if they had them covertly that would be recorded on the MAR. We checked the person's MAR and saw that it was not recorded. When we spoke with staff they told us that they always gave the person their medicine covertly. Therefore, the staff were not following the procedure to record the administration of the person's medicine to be able to review it in line with their care plan.

The recording on the MAR were not always completed in line with national guidance. We found that where some prescriptions were handwritten the entry had not been signed by a second responsible person in line with 'Standards for medicines management' from the nursing and midwifery council (NMC). When people required medicines 'as required', or PRN, there should be guidance for staff to know when they should take them. We found that these were not always in place and those in place were not detailed enough to support staff; for example, 'to reduce agitation and restlessness' does not describe how this would look for an individual. In addition, some MAR lacked important information such as how it would interact with another medicine the person was taking. Also, one record did not have a photograph of the person which is recommended to ensure that the medicine is given to the correct person. This demonstrated to us that the systems which should be in place to manage the risks associated with medicines were not consistently in place.

People were not always protected from harm when their behaviour posed risks to themselves and others. We were aware of one incident between two people which had been referred to the local authority safeguarding team to protect them both. We saw these people were in a room together without staff

present. When we asked one member of staff what arrangements had been put in place to protect them both after the previous incident, they were not aware of any occurrence. We checked their care plans and found that the people should be regularly supervised. Therefore, although plans had been put in place for the individual's, these were not shared and understood by the staff supporting them.

Lessons were not always learnt from when things went wrong to reduce the risk of it happening again. When we looked at records of accidents and incidents we saw that in June 2018 two people who were living with dementia discussed using the code of the door to the floor. On this occasion the code was changed. However, there were two further incidents when people had managed to leave the floor through this locked door. One person had been assessed as requiring one to one staff support to keep them safe and the other needed to be under constant supervision of staff. On the day of our inspection visit we saw that visitors were given the code for the door and used it in front of people, including some children who were visiting. When we spoke with staff they were not aware of how often the code was changed. The registered manager told us that it was not routinely changed or reviewed. This demonstrated to us that actions had not been implemented after the previous incidents to reduce the risk of it happening again.

Systems and recording which had been put in place to manage risk were not always completed fully or in line with guidance. Records of one's persons behaviour were not completed fully to be able to understand what the behaviour was or what may have contributed to it. Another person had monitoring systems in place to review the amount of fluids they drank and that the fluids were thickened to reduce the risk of choking. There was professional guidance for them to have three scoops of thickener in fluids. In the records we reviewed it was sometimes recorded as two scoops and sometimes four which was not in line with the guidance and put the person at increased risk of choking.

This evidence represents a breach in Regulation 12 of the Health and Safety Care Act 2008 (Regulated Activities) Regulations 2014.

The systems in place to protect people from abuse were not always effective because the learning from safeguarding concerns was not always shared with staff to protect people from further incidents. In addition, actions were not always considered to protect people from repetition of accidents or incidents. Staff had received training in safeguarding and understood how to identify signs and report in line with procedures. One member of staff said, "I understand what the signs are and would have no hesitation in reporting any concerns."

There were not always enough staff deployed in all areas of the home to meet people's needs. On one floor in the afternoon we observed that people were waiting for care. There were alarms alerting staff that people required assistance and these were frequent and some lasted for more than five minutes. We spoke with one member of staff to ask where other staff were and they answered, "I don't know, I am also looking for staff to assist someone with personal care". We observed that two people who could not independently mobilise were in a communal area for over twenty minutes without any staff support. One of the people told us that they didn't have a call bell to hand to ask for assistance. Another person we spoke with said that they had to wait sometimes and that at other times delays were caused by staff not being organised. For example, the staff sometimes needed to leave the room to get protective gloves and this delayed their personal care and left them uncomfortable.
We reviewed the alarm system for the past week and found that 10% of the alarm calls were answered after 8 minutes. This was out of tolerance for the provider's procedure. When we looked at other systems we saw that people and their relatives had also raised concerns about staffing levels and staff retention. We spoke with the registered manager who told us that recruiting and training staff was a primary focus for the home. On the other floor and at other times of the day there were enough staff and we saw that they had time to sit

with people and provide them with support in a timely manner. We completed a Short Observational Framework for Inspection (SOFI) on this floor for half an hour and this evidenced that people had positive interaction with staff during that period.

Other risks to people's safety were effectively managed to protect them from harm. We saw that staff were confident in moving people using equipment, that they did not rush people and took time to explain their actions. Some people were at risk of skin damage and were using equipment such as cushions and specialised mattresses to reduce the risk. We reviewed records which demonstrated that staff had clear guidance in managing these risks and that they were regularly reviewed.
The home was clean and odour free and there were infection control checks in place. People we spoke with reported that they were happy with the cleaning of their rooms. One person said, "The housekeeping is excellent; the bed is always clean. They're hell bent on doing it properly." We spoke with domestic staff who told us that they well supported and had enough time to do their job well. We saw staff used protective equipment such as gloves and aprons, which helped to control the risk of infections spreading. This demonstrated to us that systems to manage infection were embedded throughout the home.

The provider followed safe recruitment procedures to ensure that staff were safe to work with people. They completed Disclosure and Barring Service (DBS) checks on staff before they supported people living at the home. The DBS helps employers make safer recruitment decisions by checking whether they have previous convictions. One member of staff told us, "They took three references before I started work and my DBS came back when I was an induction before I was supporting people."

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides the 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 capacity to take particular decisions, any made on their behalf must be in their best interests and least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA, and whether any conditions are authorisations to deprive a person of their liberty were being met.

People told us that staff always explained care to them and asked them for permission. We saw and heard this throughout the inspection. However, when people did not have capacity to make their own decisions there were not always assessments in place to evidence this or how decisions had been made in their best interest. For example, when one person had restrictions placed upon then such as bed rails, there was no assessment to demonstrate how these were in their best interest or the least restrictive option for them. Although some people did have DoLS authorisations in place they had not been applied for everyone who required them. The conditions on the DoLS that were in place were met and one relative we spoke with told us how they had been included in discussing them.

Care and support was planned and delivered in line with current legislation and best practice guidance. Staff understood people's assessments about their needs and were given guidance to assist them to meet them. For example, one person had diabetes and their blood sugar and medicines were monitored and managed in line with NICE guidance. NICE stands for the National Institute for Health and Care Excellence and their guidelines are evidence-based recommendations, for health and care in England.

People's healthcare needs were met to ensure their wellbeing. People and their relatives told us they had access to a range of health services and that the GP visited weekly. One relative said, "They are good at letting me know any changes to my relative's health. For example, they told me that the GP has asked them to review my relative's sleeping in case their medicines need changing". The nursing staff at the home told us how they worked closely with other professionals to ensure that people's health needs were met. For example, we saw that when one person had lost weight a referral had been made to the speech and language therapist in relation to their eating. This demonstrated to us that the staff team worked effectively across organisations to ensure that people's needs were met.

People were supported to have enough to eat and drink. One person told us, "There is plenty of choice of food and lots of drinks and snacks available." Another person said, "The food is good, and they mash it for me to help me eat it." We did have some mixed feedback about the quality of the food and we spoke with the registered manager about this. They told us they had also received mixed feedback and were working to make changes. One of the changes that had been made was to align the menus in the care home with the food offered in the restaurant. The chef was also going to attend weekly meetings to listen to what people

would prefer.

People had a choice of meals and desserts offered to them. Some people were shown two different meals to assist them to make their choices. When people required support to eat, we saw that it was given patiently and with respect. Some staff ate their meal alongside people who lived at the home. One relative told us, "I really like it when staff sit with them; it seems to encourage my relative to eat". Staff were knowledgeable about specialist diets that people required and food was prepared to assessed needs. We saw that there was close monitoring of whether people were losing or gaining weight and that records of people's nutritional intake were recorded when they were at risk.

There was a restaurant in the village and we saw that some people in the care home ate their meal there. One person ate with their visiting family and other people were supported by staff to go to the restaurant. People we spoke with told us that they enjoyed the additional facilities that the village gave them. One person said, "I like to use the library, the hairdressers and the chiropody". There were gardens for people to enjoy including a sensory garden for people living with dementia. This had a well-defined free flowing path which met the best practice guidance from The Dementia Centre at Sterling University. Within the care home there was signage to assist people to orientate. There were communal rooms and objects to stimulate memory. This showed us that the environment was planned to meet people's needs and to create a comfortable home.

People were supported by staff who were skilled and knowledgeable. One person we spoke with said, "The staff are very good. They check up on me when they know I am not feeling well." A relative said, "The carers are attentive and there's skilled nursing staff available." Staff confirmed that they received regular training and supervision to do their job well. One member of staff said, "I have done lots of training including national qualifications." There was a planned induction for new staff. One member of staff told us that they felt very well supported in starting their job. They said, "I did a week of training which covered moving people safely, food safety, and dementia. I then did four shadow shifts and spent time with the team leader to make sure I knew all about the people before I worked on my own." The registered manager told us that all staff in the village complex completed the same induction training, including those who worked in hospitality and the leisure facilities. They said, "It means that they understand people's needs so that people receive joined up care."

Requires Improvement

Is the service caring?

Our findings

People did not always have their dignity and privacy respected and upheld. We observed interaction from staff which did not offer people comfort when they were distressed. One person talked to a member of staff about their discomfort and the member of staff did not respond or offer any reassurance. They then escorted the person to a communal area and left them there without explanation. The person asked us where the staff had gone and told us they had promised to help them. We intervened and asked another member of staff to assist them. We saw that when staff were busy they had less time to speak with people. We spoke with another member of staff in a communal area and they talked about people in the room. For example, they said, "[Name] has dementia, but they're not too bad and you can talk to them." This did not respect their privacy or treat them with respect. We also saw that staff did not always notice when people were not covered or dressed to protect their privacy.

At other times we observed staff have caring and kind interaction with people. One relative said, "The staff always talk to [Name] and they appear to like the sound of their voices because they smile. The staff hold their hand and are very attentive." Another relative told us, "I like the staff; they give good, loving care. They understand my relative's moods and seem to be able to anticipate what they want even though verbal communication is now difficult." Most staff knew people well and could assist them to become less distressed when needed. For example, when one person was anxious and restless a member of staff asked them to complete a task. The person did this and was much calmer and more engaged. The staff member told us what the person's previous occupation was and that occupying them in this way helped them to concentrate. People were well presented and relatives told us they were pleased that about this as it was important to people.

People told us that they made choices about their care. One person told us how they liked to stay in their room and often chose to remain in nightwear. Another person told us that they chose when to go to sleep and get up. When people were less able to make verbal choices, we saw that staff used objects of reference to help them to make decisions, pointing at things and waiting to see how people responded. This showed us that the staff understood the importance of people being included in deciding on the support they received.

Relatives and friends were welcome to visit freely and we saw friendly interaction with staff when they did. There were private areas they could spend time with relatives if they chose to. There were also rooms that families could stay in when they visited. One relative told us, "When family who don't live nearby have visited they have stayed in the retreat; it is a really helpful facility to have."

Good

Is the service responsive?

Our findings

People were given the opportunity to pursue their interests and hobbies and they were encouraged to engage in a diverse number of activities on offer. There was a dedicated member of staff who planned activities based on people's previous interests and experiences. One person told us they had enjoyed making mosaics, baking, well-dressing and origami. A relative said that they were pleased there was the opportunity for their relative to join film night and the village choir which met regularly. One person we spoke with was using the leisure facilities. They told us, "I used the gym before I came here and I am doing the same exercises now. The gym instructor here was very good at helping me."

People were supported by staff who knew them very well and understood their preferences and interests. One relative we spoke with said, "When I first came here I needed staff to move me with a hoist. I can walk again now though and they understand I like to do things myself. The staff help me with personal care but not much else; I like to be independent." Staff we spoke with were aware of people's needs and talked to us confidently about their care and support. One member of staff said, "We have meetings at the beginning of each shift where we discuss any changes in people's care needs." We observed a handover meeting between the nursing staff and found that they discussed each person in detail.

Care plans provided staff with detailed information on how to meet people's needs in a personalised manner. We saw that they were regularly reviewed and amended when required. They included information about people's wishes for the end of their life, including decision's around whether people wanted active resuscitation. We spoke with one relative about end of life support and they explained that they had discussions with the person and staff about their wishes. There were medicines in place to manage pain for the individual. They were not yet used but were in place in case the person deteriorated suddenly. The relative told us they were welcomed to visit at any time and that they felt the staff were good at understanding their needs at this point in their relative's life.

Staff understood people's diverse needs and ensured they were met and that people did not suffer any discrimination in line with their protected characteristics. They assessed any needs when people moved into the home. We saw care plans contained information which helped staff to support people; for example, how people preferred to communicate. In the PIR the provider told us, 'We currently offer information in varying formats, for example the use of pictorial aids for some people with cognitive impairment, and large font printed on a yellow background for people with visual impairment.' We saw some information in the home was displayed on posters, including some with pictures and symbols. This demonstrated to us that the provider complied with the Accessible Information Standard (AIS) which was introduced to make sure that people with a disability or sensory loss are given information in a way they can understand.

There was a complaints procedure in place that people and their relatives felt confident to use when needed. One person told us, "I have raised concerns and I was happy with the response I received. The registered manager often catches up with me to check I am happy now." We reviewed records and saw that when the provider did receive complaints, they were responded to in line with their procedure.

Requires Improvement

Is the service well-led?

Our findings

The quality audits and checks which were completed were not always effective in improving the service. When we looked at medicines, one member of staff showed us a check that should be completed daily to ensure that medicines have been administered, signed for and that the stock was correct. We saw that this had not been completed for over one week and therefore the staff had not found the errors in stock and recording which we had at this inspection. A medicines audit had been completed the previous month by a senior member of staff in the organisation. Some of the action points had been met; for example, room and fridge temperatures were now being completed. However, other areas identified had not been addressed, because we found that PRN protocols were still not detailed enough and the front page of the MAR were not always fully completed. Other audits were also not accurate; for example, a health and safety audit completed on 20 July 2018 recorded that staff did not require support after an incident of violence or aggression, because none had occurred. However, we found that there had been an incident of physical harm to a member of staff on 10 July 2018.

At this inspection we were told that the system used to monitor call bell usage assisted the registered manager to monitor staff interaction with people and to use as evidence to plan staffing levels. We asked to see this for the week before the inspection and found 10% of all calls took longer than 8 minutes to answer. We also noted there were 5 calls which took over 20 minutes to answer. We asked the registered manager about this and they said it was likely to be a fault with staff not switching the alarm off. However, in the provider's guidance it said, 'Any outliers above 8 minutes should be identified on a weekly basis by checking the system data and discussing and documenting this at the weekly clinical risk meeting. Outliers may need to be investigated to understand the reason for this and actions put in place to avoid non-compliance'. The registered manager sent us the call monitoring report after the inspection visit as requested. However, no analysis or action plan had been completed to investigate the 'outliers' on the report at this time.

There was a registered manager in post. 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. People and relatives knew and said that they were approachable. We saw them interact with people who lived at the home throughout the day and when we spoke with them they were knowledgeable about people's support needs. The home had been registered with CQC in September 2017 but the registered manager explained to us that they had not started taking people to live there until January 2018. They had a phased plan in place for new people coming to the home; however, the registered manager said that it had caused some difficulties in recruiting new staff to meet the plan. This led to some staffing issues including those staff who were in post working additional hours to cover vacancies. The provider had now agreed to recruit in advance of the next stage of the plan in recognition of these difficulties. When we completed the inspection visit there were new staff being recruited and were undergoing their training.

Staff felt that they were well supported and able to develop in their role. One member of staff told us, "I have a very good relationship with the registered manager who I can ask anything if I am not sure." They had

regular team meetings and we saw that they had discussed recruitment and staffing levels. At the last meeting staff reported an improvement in staffing levels and shorter working days.

The provider gained feedback from people who used the service and held regular meetings with them. There was a meeting on the day of inspection although not many people attended. The registered manager told us that they would speak with people individually instead. There were links with other agencies and professionals to ensure that people's needs were met effectively and that people remained part of their community. There was a memory café held on the day of our inspection and some people were supported to attend alongside people who had come to the village for that meeting. The provider had employed a member of staff to make links in the local community and we saw that several groups were now using the facilities for meeting; including the local women's institute and the British Legion. This demonstrated to us that the provider was committed to ensuring that people had opportunities to be supported by other organisations and to remain members of their community.

The registered manager understood the responsibilities of their registration and ensured that we (CQC) received notifications about important events so that we could check that appropriate action had been taken. In the PIR the provider told us, 'The Registered Manager maintains regular contact with the CCG (clinical commissioning group) Quality Improvement Manager, who runs a Registered Manager Support group. The Registered Manager subscribes to 'Skills for Care' updates, and is part of the Skills for Care Registered Manager Support Group.' This demonstrated to us that the provider supported the registered manager to form relationships with other professionals for support and development in their role.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not always receive safe care and treatment.