Caring Homes Healthcare Group Limited

Denham Manor

Inspection report

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Ratings

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

Overall summary

This inspection took place on the 10 and 11 November 2014. At the last inspection on11 May 2014, we asked the provider to take action to make improvements to the management of people's care and welfare, supporting staff and how they assessed and monitored the quality of service provision, and this action has been completed.

Denham manor is registered to provide care to 53 people who live with dementia or who are older people. On the day of our inspection there were 31 people living in the home. The home was undergoing refurbishment of people's bedrooms and bathrooms.

The home had a registered manager in place. 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.

Systems were in place to record the care provided. These included charts to record when people were moved to prevent pressure sores, consumed food and drink and had general care and attendance. Some people's charts had not been completed. The forms were used to monitor the care given, without this information monitoring was not possible.

Extensive refurbishment of the home was underway; the registered manager had considered the risks to everyone entering the building. They had systems in place to protect people from harm whilst the refurbishments were taking place. Although people told us they felt safe living in the home we found some areas presented hazards to people. The provider had failed to restrict access to these areas. This placed people at risk of harm.

People told us the food they received in the home was good. However we observed a lack of staff available to support people with their food at lunchtime. This meant some people became upset and frustrated. We have made a recommendation about the management of staff at mealtimes.

We saw there were sufficient numbers of staff available at other times of the day and night to support people. Systems and checks were in place to ensure staff were safe to work with the people in the home. Staff were supported to carry out their role through induction training, supervision and appraisals. We observed staff and their interactions with people. They were caring and attentive, people responded well to this. Not all staff felt supported by the registered manager which made them reluctant to raise concerns or complaints.

Medicines were stored and administered safely. People's health was monitored and when required staff acted quickly to refer them to other professionals to maintain their health.

The home was following the Mental Capacity Act (MCA) and making sure that the human rights of people who lacked mental capacity to take particular decisions were protected.

Care plans recorded people's assessments of their needs, and how care was to be delivered to them. Risks associated with their care had been identified and documented. People told us they were happy with the way their care was delivered and staff took notice of their preferences.

The provider displayed a copy of the complaints procedure in the home, and people received a copy. Discussions took place in meetings to remind people how to make complaints or raise concerns. Where complaints had been made, the registered manager or the provider had responded appropriately. People were given the opportunity to feedback their views of the service through meetings, questionnaires and discussions with staff. The provider acted upon this information to improve the service.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the home were not safe. The provider had not ensured records had been completed, so the care people received could be monitored.

Access to some areas of the home that presented a risk to people, had not been restricted.

There was not always sufficient numbers of staff available to support people with their meals. People told us they felt safe living in the home. Staff had received training in how to safeguard people from abuse, and knew how to report concerns.

Is the service effective?

Good

The service was effective. Staff received training and support to enable them to carry out their role.

Where a person lacked capacity to make decisions we saw that the Mental Capacity Act (MCA) 2005 best interest decisions had been made. The Deprivation of Liberty Safeguards (DoLS) were understood by staff and appropriately implemented to ensure that people who could not make decisions for themselves were protected.

People were supported to maintain good health and had access to appropriate services which ensured they received on going healthcare support.

Is the service caring?

Good

The service was caring. We observed staff carrying out positive and sensitive interactions with people. They were friendly and knew how to support people and preserve their dignity when carrying out care.

The service provided effective end of life care.

Is the service responsive?

Requires Improvement

The service was not responsive.

An activity organiser had been employed to ensure people's social needs were met. They organised group and individual activity sessions which were in line with people's hobbies and interests.

People's individual needs had been assessed and care planned to meet these needs. However what people told us about the way their care was provided was not always the same as what was recorded in the care plans.

People were reminded of how to make complaints. Where complaints had been made they had been responded to in line with the provider's complaints policy and procedure.

Summary of findings

Is the service well-led?

The service was not well led. People and their relatives had the opportunity to raise comments on the way care was delivered. The provider took people's comments on board and made changes to improve the way care was delivered.

There were mixed views from staff about how the service was managed. Some staff felt comfortable approaching the registered manager for advice, others did not.

Audits had been undertaken to check the standards of care were meeting the required standard. Where improvements or changes were required these had been completed.

Requires Improvement 

Denham Manor

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 unannounced inspection took place on 10 and 11 November 2014. The inspection team included a specialist advisor who was a registered nurse, a pharmacist inspector and two inspectors.

The home had previously been inspected on 11and 12 May 2014 when it was found not to be meeting the requirements of the law in some of the areas inspected.

Before the inspection, 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 previous inspection reports and other, information we held about the home including notifications. Notifications are changes or events that occur at the service which the provider has a legal duty to inform us about.

We observed how care was provided to people, how they reacted and interacted with staff and their environment. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with five people who lived in the home and five relatives. We reviewed three staff recruitment files, four staff supervision and appraisal records and five staff training files. We examined seven people's care files and care recording charts, and examined ten people's records related to the medicines they received. We read a range of records about how the service was managed including policies and procedures and audits.

We spoke to 13 staff including the registered manager and operations director, chef, site maintenance manager, activities co coordinator, nursing staff and care staff. We spoke with the local GP and received written feedback from a health worker who visited the home to advise on skin care.

Requires Improvement

Is the service safe?

Our findings

At our inspection in May 2014, we found the provider was not complying with Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.This was because call bells were not always accessible to people and staff did not always respond in a timely way to ensure people's safety. During this inspection, we found the provider had made some changes. Care plans recorded whether people had the ability to use the call bell system to summon assistance. People's feedback about the staff response time to call bells was mixed. One person told us they had to wait a long time, whilst another told us they were answered quickly. People were able to summon assistance through the use of the call bell or by calling for staff. Records showed on average staff responded to calls within three minutes.

Charts were completed to record different aspects of the care provided to individuals. For example, turning charts were in place for some people who were at risk of developing pressure sores. A turning chart recorded how and when the pressure on a person's body had been relieved by being assisted to reposition. However, we found not everyone's turning charts were up to date. One person, who was at risk of developing pressure sores, had three pressure sores at the time of the inspection. Although the nurse on duty had a treatment plan for the wounds, and we observed good care of the sores, the turning charts had not been completed accurately. One person's chart to record repositioning had not been completed for 23 hours and on another occasion there were no recordings to show the person had been repositioned overnight for three consecutive nights. We discussed our concerns with the registered manager, who planned to discuss the concerns with staff. We saw staff completing turning charts for the previous night. They told us this was because they and their colleagues on night duty had forgotten to complete them at the time the person was repositioned.

One person's care plan stated the person was at risk of developing pressure sores and should be repositioned every two hours. The person did not have any pressure sores and could ask staff to reposition them when uncomfortable. The turning chart had last been completed four days prior to the inspection. The records were insufficiently completed to demonstrate the staff members had complied with the requirements of the care plan. This meant the forms could not be used to monitor the care being provided to the person.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person's health needs were not being met. The person was assessed as high risk for developing pressure sores. The person had limited mobility and told us they spent most of the day sitting in a chair. Their care plan did not recommend pressure relieving equipment for the chair. Records showed the person had a pressure sore. When we discussed this with the manager and regional manager they reviewed the sore and told us it was not a pressure sore but a rash. When a person in the home had a skin problem it was recorded in the person's tissue viability book. Records related to this person's rash were not stored in their tissue viability book but in their care notes kept separately in their room. We were told by the staff and registered manager the home had run out of tissue viability books and had ordered some more. Monitoring of the body area had not taken place according to the records. We mentioned this to the registered manager who told us they would speak immediately to the staff about the concerns.

Some people were prescribed medicines to be taken 'when required'. There were procedures for staff to follow when giving these medicines and nurses could describe how they were used, but they did not contain enough specific information about the person's needs to ensure that the medicines would be given consistently when they were needed. For example, one person was administered a medicine to help them when they became anxious. There were no details recorded of how the person presented with anxiety or if other methods were used to assist the person to relax.

During this inspection we found three areas of the home presented hazards to people. The areas were unlocked and accessible. A disused sluice room had a bolt on the outside to prevent entry, however this was unlocked. The light in the sluice room did not work. Signs on the door leading to the attic stated it should be kept locked. It was unlocked. We brought our concerns to the attention of staff; however a later check showed they were still unlocked. A disused

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Is the service safe?

toilet room was being used to store equipment. There was no sign on the toilet door to indicate it was now used as a storage room and the door was left open. The provider had failed to manage the risk to people in this area of the home.

Extensive redecoration work had been started at the home. The manager had undertaken risk assessments related to the work to ensure the associated risks to people, staff and visitors were minimised. Environmental risk assessments were in place, for example, fire risk assessments and Legionella risk assessments. These had been reviewed and action plans were in place and monitored.

The provider had assessed the number of staff required to support people based on the needs of the people living in the home. Staff rota's verified these levels were maintained. Bank and agency staff were used to fill staff absences. A number of other staff were also employed such as domestic staff, chef, maintenance and administration staff.

During lunchtime in the dining room we observed one staff member supporting one person with food and at the same time another person with a drink. The second person was calling out and was frustrated by the wait. The staff member told us they would support the second person after the first person had finished their meal. We observed they waited one hour for their meal to be served to them.

One relative told us the numbers of staff caring for people in the home had increased recently. Two people told us the staff were often rushed, this impacted on the amount of time they had to interact with people. One person told us they did not wish to "put pressure" on staff by requesting support. Throughout the inspection there appeared to be sufficient numbers of staff to meet people's needs apart from at lunchtime.

People and their relatives told us they felt safe living in the home. All staff were either trained or had training planned in how to safeguard adults from abuse. Staff understood how to report concerns of abuse. Information on how to raise safeguarding concerns was displayed throughout the home for staff, relatives or people to refer to in the event of any concerns arising. Safeguarding was discussed in both staff meetings and during recruitment interviews. The provider was aware of their legal responsibility to share safeguarding information with us and the local authority, and had procedures in place to do so.

Documentation related to staff recruitment showed staff had been recruited safely. References and checks had been carried out on candidates alongside an interview to establish if they were suitable and safe to work with people.

Medicines were stored securely and disposed of appropriately. We saw nurses spent time with people to encourage them to take their medicines and made a timely and accurate record when they were taken. Codes were used to show if medicines were not given for any reason. Some people had medicines that required the person to have regular tests to ensure that the dose given was correct. These tests were completed regularly and the doses adjusted as instructed.

Part of the medication administration record (MAR) for one person who had recently been admitted was unclear showing two different dosing regimes, although nurses we spoke with were able to describe how they would administer the medicines. The care plan for this person was being developed, however at the time of the inspection it did not have enough detail to inform nursing staff as to the management of this person's medicines. This was corrected during the inspection.

The home had a homely remedies policy that had been agreed with the GPs and records were made of any homely remedies used. Allergies were clearly recorded and photographs used to identify people.

We recommend that the service consider good practice guidance on supporting and assisting people at mealtimes.

Good

Is the service effective?

Our findings

Following our inspection in May 2014, we asked the provider to make improvements to ensure staff received the support necessary for their role. During this inspection we found improvements had been made. A relative told us there has been a definite improvement in the quality of moving and handling skills of staff. Records showed new staff received an induction, regular supervision and appraisals. Training deemed as mandatory by the provider had been completed by most staff; however, building work had interfered with access to the computers, which had delayed some on line training for new staff. Additional training was available to staff in areas such as diabetes and understanding dementia. Nurses had received training in medicines management and those that had recently started were working through an e-learning package. Information about medicines was available and we saw one nurse reassuring a person after checking information that they had asked about. We observed a nurse giving an impromptu training session to two other staff to improve their knowledge and skills.

At our previous inspection in May 2014 we observed some people had problems in communicating with some staff. This was because some staff were from diverse ethnic backgrounds and in the majority of cases English was not their first language. Following the last inspection the provider sent us an improvement action plan. They informed us new staff were being assessed on their understanding of written and spoken English their as part of the recruitment process.

During this inspection one relative told us communication remained a problem due to staff not having a good understanding of English. One person who lived in the home told us they had difficulty understanding staff due to their spoken English. One staff member acknowledged their English needed improving and was attending lessons. We did not observe any negative impact on the care people received by staff whose first language was not English.

The home was following the Mental Capacity Act (MCA) and making sure that the human rights of people who lacked mental capacity to take particular decisions were protected. The MCA 2005 and Deprivation of Liberty Safeguards (DoLS) set out what must be done to make sure the human rights of people who may lack mental capacity to make decisions are protected. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. Where an individual required restrictions being placed on their liberty a deprivation of liberty safeguard (DoLS) was in place. An application for a DoLS had been made for one person and subsequently authorised and the provider was complying with the conditions applied to the authorisation. The PIR informed us 22 people in the home had either a DoLS or an application for DoLS in place. The majority of the applications had been made because access in and out of the home was restricted.

Mental capacity assessments had been completed to establish if people were able to make decisions and consent to the care they were receiving. People's family or representatives were consulted in relation to the care of people who lacked capacity. All staff had received training in MCA and DoLS and showed and awareness of how it applied to their role.

During lunchtime some people commented on how nice their lunch was. Their comments included "I don't like vegetables but they know I love fruit and they give me this". "Food is pretty good here, I can say if I don't like something and they will get me something else". "There are two choices at each meal and if you don't like them they do you something else". A relative said "I have seen the food and it looks good, my relative has made positive comments and they are helped to eat if needed".

People were offered choices and alternatives to the meals on offer. People were positioned appropriately so they could eat comfortably and safely themselves or positioned to allow comfortable assistance from a staff member. Food was prepared to meet people's individual needs, such as blended or soft foods. They were nutritionally balanced and looked appealing. The chef had a record of people's food and drink preferences. Where people had requested an alternative to the menu this had been recorded. Each person had their nutritional needs assessed through the use of Malnutrition Universal Screening Tool and their risk of dehydration was also assessed. This information about people's dietary requirements meant adaptations to people's meals could be made to ensure they received sufficient food and fluids.

Each person's health needs had been recorded in their care plan. One person confirmed staff responded quickly if they were unwell and they saw the doctor when required.

Good

Is the service effective?

Another person told us “The nurses are good”. All healthcare concerns were raised with the nursing staff who referred people to healthcare professionals where appropriate. For example, a dietitian. An external healthcare worker told us they had received appropriate referrals from the home for advice. The GP regularly visited the home to see people who may have been unwell or to discuss preventative measures with regards to people’s health care. They were impressed by the quality of care provided. They told us staff were prompt at raising concerns and the nursing staff were knowledgeable. Dr’s appointments and information related to people’s health needs were recorded in the GP handover book and communication book. This enabled all staff to be aware of any changes in people’s health care needs.

Good

Is the service caring?

Our findings

People told us they felt cared for by the staff in the home. One person said the staff were caring, another person said "The care is very good".

We observed staff caring for people in a kind and inclusive way. For example, when a member of staff was supporting a person with their food they spoke with them and included them in the conversation, even though they were unable to respond. We observed a nurse administering medicines to a person, the nurse allowed them to take them in their own time without trying to rush them.

We saw staff were caring towards the people they supported. For example; staff spent time with a person who was distressed, they supported them in a caring way. Staff were chatting and encouraging people with their eating and drinking. We saw a staff member was very patient and relaxed with a person who they were assisting, they were frequently smiling together. We heard staff speaking kindly and respectfully to people.

One person told us staff respected their privacy, by allowing them to spend time on their own. Another told us how their care needs had changed and the care they now needed was personal. They described to us how staff preserved their dignity when carrying out their care. A staff member told us how they protected people's dignity and privacy by ensuring people did not come into the bedroom when they were carrying out personal care. We observed and a relative confirmed, staff did not allow relatives to enter the room when personal care was being carried out; this was in line with the person's wishes. When discussing with staff how they cared for people, we found they were well informed about preserving people's privacy and dignity and treating people with respect.

Staff received training in how to communicate with people who had dementia. Staff learnt how to read body language and how to speak to people clearly. We observed how this was put into practice. For example, staff gave people time to process information and respond. Pictorial menus were available to people and pictures were used to assist people with communication. People's rooms were personalised with their own belongings, which helped them feel comfortable and at home.

One staff member told us about how they cared for a person coming into the home. They said "I introduced myself and explained my role and asked how I could help them. I made sure they had everything around them to make them comfortable". When asked about giving people choices and respecting their choices they said "If someone says they don't want something, then I don't do it". They told us they had to be accommodating in their approach, they said "If the person says they are not ready you come back to them and work around it – you have to be flexible". Another staff member described part of their role as "Supporting residents to enjoy their lives … and to engage with them to prevent loneliness". Our observations of the staff and through discussion with them we saw and heard how each person was treated as an individual with individual needs.

Care plans recorded people's needs along with their preferences and choices. A relative told us a person was getting the care they needed in the way they wanted it providing. They described the care as "absolutely excellent." They told us of their experience of the staff in the home and described them as "Really friendly. They are very caring, very pleasant and friendly. They all have a laugh and joke with us. We feel they are like part of our family."

Some nursing staff had attended end of life training. This enabled them to facilitate people's wishes and to know how to provide the specialist care that people may require at the end of their

life. Additional training for more staff was planned. The GP was complimentary about how staff cared for people at the end of their life and how people were able to die with dignity.

Requires Improvement

Is the service responsive?

Our findings

During the previous inspection in May 2014 we asked the provider to make improvements to the activities provided to people. This was to ensure people's social needs were met. During this inspection we found improvements had been made. An activity organiser had been employed. People told us they were happy with the activities on offer. Bible study was also available to meet some people's spiritual needs. The activity organiser gave people information about activities on a printed sheet which they brought to their rooms. During the afternoon there was a group activity in the lounge which included some physical and coordination activity. We observed people participating with the activity, they were smiling and laughing and engaging with the staff. Where people were not able or did not want to participate in group activities one to one sessions were available. One person said "The activities worker comes and plays trivial pursuits with me; I like general knowledge so sometimes we do quizzes".

People or their relatives told us they were involved in their assessment of need and how their care was planned. One person said "The manager did the assessment with me that was good." A relative told us "We always ask staff how they (the person) are and they seem to know all about them, which is nice". One staff member told us "We check care plans and risk assessments or people tell you what they want… I respect people's wishes".

Care plans documented people's choices about how they wished their care to be provided, for example, what time they preferred to go to bed and how often they wished to shower. However, there were differences between what two people told us and what was recorded in their care plans. For example, one person said they would like to have a shower more often than they did. Their care plan stated the person should have a shower once a week. The daily records showed the person had not had a shower in the 10 days prior to the inspection; instead they had been washed in bed. Another person told us it was no longer safe for them to have a shower, but the care plan stated they should be asked each day if they wished to have one. The care plan had not been updated.

Other people told us how their choices had been respected and they had been listened to. A person said "I told them I don't want a shower every day and I want to see the hairdresser and this happens". A relative told us "They do give choices and ask people for their decisions. I have observed staff saying 'What do you want to do? For example sitting up in bed, getting dressed."

Care was provided to people in an individualised way. We observed three staff throughout the day caring for one person in their room. They were kind, considerate and included the person in their care. When we questioned each of them about how they cared for the person, they were able to describe what the person needed, liked and how they kept the person safe. For example, they could competently demonstrate how to check the air mattress was working correctly.

People were encouraged to make choices. At lunchtime people were given appropriate choices, these included if they wanted a napkin to protect their clothes, the use of a straw with their drink and where they would like to sit. In doing so people's independence was maintained.

Most care plans were regularly reviewed to ensure they were still appropriate to each person's needs. Where changes to their health had occurred this was recorded in the GP handover book, and discussed with the nurses. This ensured people's health needs were responded to quickly and appropriately. We saw people had been referred to outside professionals such as tissue viability nurse and the palliative care team. Where instruction about a person's care was given, this was documented in their care plan.

One person told us "if I had a complaint I would tell my family, I have never seen anyone in authority" they were unaware of who the manager was. Another person said "I can raise concerns when I talk with staff". Two relatives told us they knew how to complain, one said they felt empowered to make a complaint and the registered manager would treat it seriously and with respect. Staff gave conflicting views about how confident they were about raising concerns or complaints with the registered manager and senior staff. Whilst some felt able to speak to them about any concerns others did not feel encouraged to do so, as they did not always feel listened to.

A copy of the complaints procedure was displayed in the foyer. Discussions had taken place in a residents meeting around how people could make a complaint. Documentation showed the provider had responded to two complaints in line with their policy and procedure. The registered manager told us they had learnt lessons from

Requires Improvement

Is the service responsive?

complaints and taken action to prevent a reoccurrence. For example, following a complaint they now ensure people moving into the home have clear information related to the cost of care. We saw records to verify this had happened.

Requires Improvement

Is the service well-led?

Our findings

Generally people spoke positively about the service. A relative told us they were in the home each day and they were "more than happy with the care" they had seen provided.

There were mixed responses from staff regarding the management of the home. We received negative feedback from three staff members regarding the registered manager. They told us the registered manager was difficult to approach and did not always respond in a supportive way when concerns were raised. As a result they did not feel staff were encouraged to raise concerns openly or whistle blow. However, we saw posters around the home giving details of a confidential external organisation available to staff to raise any concerns. Systems were in place to carry out investigations following complaints or concerns raised. Where these had been undertaken, the outcome was used as an opportunity to improve the service. We read documentation to verify this.

Some people and staff told us they did not see the registered manager often, and this made communication difficult. However, three staff said the registered manager was approachable and confident as a manager. One staff member told us they could go to the registered manager with any concerns at any time.

People and their relatives had the opportunity to feedback their thoughts on how the service was managed through meetings with the registered manager. Minutes of the meetings showed people were able to comment on the service they were receiving and improvements had been made. For example, where people didn't want to join large group activities, smaller groups or individual activities were offered.

People and their relatives had completed surveys about the quality of the service. The last survey completed in 2014 showed people were happy with the service. Questions asked for people's views on how their care was delivered, the environment, social aspects of life, meals, complaints, health choice and security. 100% of respondents felt safe within the home and felt they could see visitors in private. However, only 19% of people were aware of the provider's complaints procedure. Records from a residents meeting showed this had been discussed with people to ensure they were made more aware of how to complain. An action plan had been drawn up from the results of both surveys which detailed the improvements to be made.

The provider is required by law to inform us of certain incidents that occur at the home that effect people who receive care. Examples of these include safeguarding concerns and the death of a person. The provider had informed us within the given timescales of incidents that had occurred.

There were a range of audits regularly undertaken. These were in place to assist the provider to monitor the quality of service people received, manage any risks and assure the health, safety and welfare of people who used the service. The registered manager completed clinical governance audits. These recorded for example, instance of weight loss, accidents and infections.

Environmental audits had also been completed for example, legionella, testing of gas equipment and the maintenance of fire equipment. Where areas required improvement an action plan had been drawn up and we saw the actions had been completed.

All audits were regularly reviewed and monitored by the senior management and discussed with the registered manager. The operations director told us the provider was considering changing the audits to ensure they were relevant to the key lines of enquiries (KLOE) used by the Care Quality Commission when inspecting adult social care services. They hoped this would help the provider to understand if the service was safe, effective, caring responsive and well-led.

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 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	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records People who use services and others were not protected against the risks associated with unsafe or inappropriate care arising from a lack of proper information about them by means of inaccurate records and documentation of care. Regulation 20 (1) (a). This corresponds to regulation 17 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.