Acer Healthcare Operations Limited

Highfield 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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Highfield Care Home is a 53 bed residential and nursing care service providing care, treatment and support, including end of life care and support for people living with dementia. On the day of our inspection there were 48 people living at the service of which 24 people had been assessed as having a nursing need. Saffron suite was a specific part of the service which catered for people with a diagnosis of dementia.

The systems in place for the oversight of equipment and the management of risk were not effective. Clinical equipment was out of date and some of the mattresses which were in place to reduce the likelihood of skin damage were set incorrectly. This meant that people may not receive the pressure relieving support that they needed. Skin tears were not always analysed to identify the cause and the treatment plans were not clearly documented. This placed people at risk of inconsistent care.

We found that the service was supporting a number of individual's who were at risk of falls and saw that the service had referred people appropriately to health professionals and had put specialist equipment such as alarms and crash mats in place to reduce the risk of injury. We were not assured that actions on repairs were always taken promptly and have asked that this is followed up.

Staffing levels were adequate but staff were not always effectively deployed. Checks were undertaken on staff suitability for the role prior to their employment.

Medicines were well managed and regular audits undertaken to check that people were receiving their medicines as prescribed by their GP.

Staff received training and guidance but best practice in areas such as understanding the needs of people living with dementia was not consistently implemented. The manager and staff had undertaken training in the Mental Capacity Act 2005 and understood their responsibilities.

People enjoyed the meals provided and we observed that they were well presented and appetising. The deployment of staffing however in the different parts of the service impacted on staff ability to support people with eating.

Peoples health needs were met and appropriate referrals made to health care professionals.

The environment was accessible and homely; however we have recommended that they review how they can enhance the independence and wellbeing of those individuals living in the specialist dementia unit.

People spoke positively about the support from staff. We saw caring interactions but also care which did not promote peoples dignity and was task based.

Care plans were not always accurate and did not provide staff with the guidance they needed to provide

safe and personalised care.

People were supported to follow their interests and we observed excellent practice, however we have recommended that further efforts are made to engage with people living in dementia.

Complaints were investigated but processes could be strengthened to promote transparency and openness.

People and staff told us that the manager was approachable. We saw that the manager had requested feedback about the quality of the service from relatives and people who used the service. There were systems in place to ascertain staff views and reflect on practice such as through supervisions and staff meetings.

The registered manager and provider regularly audited different aspects of the service but we found that the audits had not identified some of the issues that we had found, including a lack of consistency across the service, which meant that they were not fully effective.

You can see what actions 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?

Requires Improvement

The service was not consistently safe.

The systems in place to manage risks were not consistently well managed.

Staff were not always deployed effectively to meet people's needs.

People's medicines were well managed.

Checks were undertaken on staff to ensure that they were suitable for the role and they received training on safeguarding and abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff received training but best practice was not always implemented.

People enjoyed the meals but some people would benefit from more support.

Staff demonstrated an understanding of consent and their legal responsibilities regarding best interest decisions.

People accessed health care support when needed.

Is the service caring?

Requires Improvement

The service was not always caring

There were inconsistencies in the quality of care which people received.

Some staff were caring and compassionate but other staff were rushed and did not have time to spend with people. Care delivery was task focused, and did not always meet individual needs.

Is the service responsive?

Requires Improvement

The service was not consistently responsive

Care plans were not sufficiently detailed

People enjoyed the activities on offer but people in the dementia unit would benefit from more activities to promote their wellbeing.

There were systems in place to investigate and respond to complaints. However, records of investigation and outcomes should be maintained.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There was a lack of consistency across the service. Some part of the service worked well but other areas needed to improve.

The provider's had a range of governance systems in place but these were not yet effective in addressing some of the issues.

Highfield 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 the 20 July 2017 and it was unannounced. The inspection team consisted of an inspector, a professional advisor and an Expert–by-Experience. The professional advisor was a registered nurse and focused on clinical care within the service. An expert by experience is a person who has personal experience of care services and caring for an older person

The provider had completed a provider information return (PIR) prior to the inspection. This is a form that asks the provider to give key information about the service, what it does well and the improvements they plan to make. Prior to the inspection we reviewed the information we held about the service including notifications of incidents that the provider had sent to us since the last inspection. A notification is information about important events which the service is required to send us by law.
Prior to our inspection we spoke with stakeholders including commissioners of services. We also looked at safeguarding concerns reported to us. This is where one or more person's health, wellbeing or human rights may not have been properly protected and they may have suffered harm, abuse or neglect.

There were forty eight people living in the service and we spoke with six people who used the service, seven family members and six staff. We spoke with two nurses, a team leader, the manager and the deputy manager. We looked at three staff records, peoples care records and records relating to how the safety and quality of the service was being monitored. We observed care practice and medication administration. Following the inspection we gave feedback to the manager.

Requires Improvement

Is the service safe?

Our findings

We received variable feedback about the quality of the care in the service, with some people being very happy with the service but others less so. One relative told us "It's really good here – staff are great. I really do feel [my relative] is in a safe place, and I'm very content with everything here". Another said "It's not safe for [my relative] here – I'm on edge all the time."

The systems in place for the oversight of equipment and management of risk were not effective. There were systems in place to identify risks such as those associated with skin integrity and we saw that people who had been identified as at risk had pressure relieving equipment such as specialist mattresses and cushions in place. However, the equipment was not always set at the correct setting to promote skin integrity. We found a number of people were using mattresses which were set at the incorrect setting for their weight which meant that the mattress was not working effectively. Staff told us that people's moving and handling needs had been assessed and where people needed equipment to assist them to move, this was provided and they had individual hoist slings which were kept in their bedrooms. However, the size and type were not documented clearly in people's records and we had concerns that this could lead to an accident.

Equipment was not always being checked or maintained to ensure that it was safe to use. We looked at a range of clinical equipment, such as the suction machine, catheters and dressing packs. We found that some of the equipment was out of date. Equipment should be checked on a regular basis to ensure that it is clean, well-stocked, in date and ready to use, as the need arises and in an emergency.

The shortfalls in the oversight of equipment are a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Environmental risks were not consistently well managed, There were risk assessments in place for environmental risks which set out how often the safety systems should be checked to make sure they were still working effectively. However, we found that checks on fire safety and water temperatures had not been recently undertaken. The manager told us that the member of staff responsible for maintenance had left and they were in the process of training a replacement which meant that they were not as up to date as they should be. We spoke to the manager about our concerns about an item protruding from the paving in the garden which could be a trip hazard and asked them to review this. We saw that window restrictors were in place to stop people inadvertently falling from height and equipment such as hoists had been serviced to make sure they were working effectively.

Incident forms and body maps were completed for falls but the recording and oversight systems for skin tears were less effective and we could not always identify how people had sustained skin tears or how they were being treated. We have made a recommendation regarding this as all wounds should be assessed and documented, so that any common causes can be found and prevented. Wounds should be measured or photographed so that progress or deterioration can be recorded and staff should be provided with clear guidance as to the type of dressing that is in use.

One relative told us that their relative had fallen but, "The staff are doing all they can to help… they've put an alarm mat in [my relatives] room, and they put a mattress by the side of the bed at night so that if they fall, they lands on that, and they've given [my relative] a lower bed. "

We saw that there had been a significant number of falls since the beginning of the year. The manager told us that they were taking steps to reduce the number and type of falls, such as putting equipment into place to alert staff to movement and more regular observations. We saw that equipment such as crash mats were in place and people were being referred to the falls prevention team and if appropriate the mental health team. There had been a recent increase in the numbers of urinary tract infections and the manager said that they had been encouraging a greater intake of fluids and the kitchen staff had been increasingly creative. They said that this had started to have a positive impact and the number of falls had been reducing.

Staff completed incident forms or behavioural monitoring documentation when an incident occurred and we were told that these were reviewed by management. We could not however always see that actions had been taken promptly. We saw that a recent incident had occurred where an individual in the specialist dementia unit had left the building at night through a faulty fire door and sustained injuries to their face and leg. We saw that two similar incidents had occurred in the days leading up to the injury. The manager told us that this had been due to a faulty door catch. We noted that the door was locked but that the catch on the bottom of the door remained broken. We had concerns about the services response to and learning from incidents and asked the manager to refer this matter to the safeguarding authority for investigation.

Staffing levels were adequate but staff were not always effectively deployed. The manager told us that they used a dependency scoring tool to assess people's needs and to ensure that they had sufficient numbers of staff. Staff told us that there were enough staff but they were, "very busy". A relative told us, "Sometimes I help the staff here as they are often very busy when I come in – there are lots of residents who need lots of attention here". There were a number of staffing vacancies and we were told that they used agency staff to cover shortfalls. Our observations were that staff were not always deployed effectively. We spent some time observing in Saffron unit which supports people with a diagnosis of dementia. Staff were rushed and care was not person centred. There was one member of staff in the lounge supporting up to ten people, some of whom were eating breakfast. Other staff members were on breaks or supporting people in other parts of the service. People were calling out for assistance and there were individuals in the lounge who were at risk of falls. One individual kept trying to stand and were repeatedly told to sit down. We have recommended that staffing deployment is reviewed in Saffron unit and the manger confirmed that this would be undertaken.

People's medicines were generally well managed. We observed the nurse supporting people with their medicines. They had a caring approach and gave people the time they needed and ensured they had a drink. We observed that the nurse signed the medication administration charts after the medicines had been taken. We checked samples of medicines and Controlled Drugs (CD) and saw that they were appropriately signed for and the quantities in stock tallied. However, we noted some handwritten instructions and advised the nurse to seek clarification from one individual's GP about the prescribing instructions as they were not clear. Photographs were in place for identification purpose. Temperature checks for the room and fridge were monitored and were within an appropriate range.

There were body maps in place to guide staff on where creams and lotions should be applied and staff recorded when this was undertaken. Lotions and creams were dated on opening.

Regular audits of medication were undertaken. However we noted that staff were not always recording the times of blood sugar monitoring and it was agreed that this would be undertaken to further safeguard people.

Staff recruitment processes were in place and these helped to ensure suitable staff were employed. We looked at three staff files and found satisfactory checks were in place for staff, this included written references and checks from the disclosure and barring service to ensure they had no offences which might make them unsuitable to work in care. Interviews assessed appropriate competencies and there was evidence within the staff files that relevant checks with professional bodies were made for qualified nursing staff. The manager told us that with the change in ownership all staff had a new disclosure and barring service check and it was planned that these checks would be undertaken again at regular intervals to ensure that people were protected.

There were systems and processes in place to minimise the risk of abuse and staff had received training in protecting people from abuse. Staff we spoke with had an understanding of how to recognise allegations or incidents of abuse and understood their role in reporting any concerns to the management team

Requires Improvement

Is the service effective?

Our findings

People and their relatives generally spoke positively about the staff. One person told us, "My[relative] was Well looked after. The carers are all experienced in using the hoist and are very careful."

Staff were provided with training and support but practice was not consistently reflective of best practice. Care staff told us that that they had undertaken training such as in moving people, dementia and infection control. One member of staff told us, "I am up to date with my mandatory training, I haven't had time to do any other this year." There was a training matrix in place which set out what training staff had completed and identified those individuals who needed refresher training. We observed that staff were not always skilled in supporting people with dementia, for example we observed that when one individual tried to stand they were repeatedly told to sit down. The care plan referred to distraction therapy but this was not in evidence. We spoke to the manager about our observations and they told us that they used an external dementia trainer and would be booking additional training sessions to address the issues that we found.

Competency assessments were undertaken to check on staff understanding of what they had learnt at training. For example, staff undertaking medication administration had three observed practices before being able to administer independently. The provider was in the process of implementing a competency assessment for moving and handling.

The manager told us that newly appointed staff undertake the care certificate, which is a national initiative to ensure that newly appointed staff are properly inducted into their role. Staff told us that they had an induction but were less clear about the care certificate and how this prepared them for their role.

The manager provided us with dates of staff supervision meetings and told us that staff received annual appraisals. Staff told us that they were well supported and senior staff were accessible and provided them with guidance and direction. The manager showed us a record where they monitored checks on nursing staff registration and when nurse re-validation was due.

The manager understood their responsibilities under the Mental Capacity Act 2005, (MCA) and around protecting people's rights. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS) and the manager told us that they had assessed people's needs and made applications as required to the local authority.

Staff told us that they had undertaken training and we observed that staff asked people for consent before commencing support throughout the day. We found decisions such as Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) in place and clearly recorded.

People we spoke with told us that they enjoyed the meals, one person told us, "The meals are nice, but I do love a curry, and they don't do that here". Another person told us, "The food is nice and the staff are so friendly".

We observed lunch and saw that the food was presented well and appetising to look at. There were two separate servings in different parts of the service. In the main unit the tables were nicely laid with tablecloths and serviettes in wine glasses. The menu was on display and the meal delivery was well organised and there was lots of chatter and a nice atmosphere. We observed a member of care staff supporting an individual to eat a pureed meal, and saw this was undertaken in a well-paced and unrushed way. The member of staff gave lots of encouragement and subsequently recorded what the individual had eaten.

In the Saffron unit, dependency needs were higher and the delivery was more disjointed. Some people ate in their bedrooms and others sat at the dining table. Staff served the meals but there was not always enough staff to support people and we saw that staff struggled to provide the support people needed with eating and a number of people got up and down from the table. Staff tried to redirect people but were not always successful as other people were calling out. There was a blackboard which listed the meal to be served but it was out of date and did not reflect what was being offered. Staff asked people verbally what they wanted although did not show people plated up options to help promote their choice. Some people declined what was provided and ate little and we have recommended that further visual support is provided to assist people make choices and consideration given to finger foods for some individuals.

We saw that there were no lists in the kitchen which identified people's preferences and those requiring specialist diets, such as diabetics. Staff however were clear about who required thickener with their drinks to reduce the risk of choking.

People told us that their health needs were met and we saw that referrals were made to health professionals as appropriate. One person told us, "My [relative] sees a doctor whenever necessary - I'm very happy with my [relative] being here." The manager told us that a GP visited on a weekly basis for routine matters. There was always a nurse on duty who oversaw the nursing residents and a team leader who supported the people in the residential part of the service. People's records evidenced contacts with dentist and opticians.

People's needs were not always met by the layout of the environment. The service benefited from a bright entrance and pleasant sitting room and dining room. These areas overlooked a well-stocked and colourful garden and people had good access. However in Saffron unit the specialist unit for people with dementia was at the rear of the building and the communal sitting/ dining room was dark with poor natural light. There was a single door in the corner of the room which opened into the garden but this was not in use. The only other window was above head height which meant that people faced the centre of the room. We saw that this had been raised previously by people who completed questionnaires and the manager told us that they had tried to improve the area with wall art and rearranging the furniture.

There were doors into the garden from some people's bedrooms but these were locked and we were told that this was because people would enter the garden and access peoples bedrooms in the main part of the service. People could access the garden but only with staff support and it was not being well used on the day of our visit. We have recommended that advice is obtained from a reputable source on how they best promote the quality of life of people living in Saffron unit.

Requires Improvement

Is the service caring?

Our findings

People spoke positively of staff, one person told us, "They do look after me well here – the food is nice and the staff are so friendly." However our observations were that practice was not always consistently caring. We found examples of good practice but also example where people were not always treated in a compassionate way.

We saw kind and caring interactions such as staff speaking to people in calm and reassuring way. We heard one member of staff saying to an individual, "How are you today....Ahh I am going to put on some music….I don't want you to fall…I will get you a cup of coffee." Another member of staff assisted an individual to move and gave lots of reassurance as they went along, and told the individual "You are safe"

Other staff seemed well meaning but were rushed and under pressure. They did not have time to sit down with people or give explanations. A lot of the care was task based and focused on helping people to move, access personal care and have a drink. We observed examples of care being delivered in a brusque manner with a focus on keeping people safe and avoiding accidents. Staff did not always have time to wait for people's response before proceeding and the care provided did not always promote peoples dignity. People were told to "sit down" repeatedly, "calm down", "just a minute", or to "hang on," "Can you be patient as I need to help other people."

Staff knew people well and were able to tell us about individuals and describe what they enjoyed. People looked clean and were wearing clothes which looked comfortable and fitted them. The men were shaved. Bedrooms were personalised according to people's interests and there were pictures of importance to individuals visible. One person showed us a new cover which they had obtained for their bedroom. Another person told us, "I'm alright here – they let me do what I want. I've got my fridge and microwave, and I've changed the room around so that it suits me better – and they don't mind."

People's privacy was promoted. We saw that people were able to see visitors privately and maintain relationships with friends and family. The arrangements in place were all different and reflected individuals' wishes.

People told us that they were involved in their care and able to express their views. One person told us, "The activities coordinator, does my shopping – she lets me know what's going on." We saw that resident meetings were held and were shown minutes of meetings with people who lived in the service and relatives.

Requires Improvement

Is the service responsive?

Our findings

There were care plans in place and a one page profile which was kept in individual's rooms and provided an introduction to the persons needs enabling staff to respond promptly. However we were not clear that they were always up to date and accurate as we found anomalies between the information on the profile and that recorded in the care plan. The care plans were maintained in different locations such as the nurse's station or senior carer's office. Staff however were not always able to tell us where they were located and were not assured that they were documents that they regularly accessed or were aware of. For example we observed a member of staff removing and individuals frame to prevent them using it which was contrary to their care plan which stated, "A walking frame to be within [the persons] reach at all times."

We had concerns that the shortfalls in the documentation meant that they were not providing clear direction to staff about people's needs and how they should be met. For example, in respect of catheter care the care plan did not document the size or the arrangements and responsibilities for changing bags. There was no written evidence or record that this was being carried out and we were concerned that the lack of regular bag changes could cause infection. In respect of the support to people with diabetes, the protocols for the management and response to variations in people's blood sugar levels were not clearly documented. We recommended that the service liaise with the Diabetic Specialists and asks for a written protocol of the management of a Hypoglycaemic and Hyperglycaemic event, so that all staff follow the same guidelines to ensure effective and timely intervention.

The shortfalls we found were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The manager told us that they had undertaken some life story work with some individuals but this was not in evidence on the day of our inspection. Staff told us that there were regular handovers which updated staff on changes to people's needs and we saw handover records were maintained.

People were supported to follow interests which promoted their wellbeing. Some aspects of the activities provided had elements of outstanding practice but other areas, such as the activities in the dementia unit worked less well.

Activities were provided by an extremely enthusiastic and positive coordinator. The service had the use of a minibus and the manager told us that people are given the opportunity to go out twice a week. The manager told us that this' encourages socialisation with the community and minimises institutionalisation. People clearly enjoyed these trips, one person told us, "My [relative], recently had a trip out to Duxford in the mini bus and really enjoyed that. On the way back they went into McDonalds and the grandkids were in there!! They couldn't believe that their [relative] was actually in McDonalds – it was great".

We were shown a moving poem which an individual had written about their life in the service and were told about an initiative where local children come into the service to befriend the residents and do activities such as cake baking and painting together. On the day of our visit we observed a morning and afternoon activity

in the main part of the service. This included a singing /exercise activity which was provided by an external organisation. This was well attended and enjoyed by people, and we observed lots of singing and clapping. Some people from Saffron unit which supports people with dementia attended this activity but we have recommended that further efforts are made to engage with people in this part of the service. We observed that people in Saffron lounge looked bored and disengaged, one person for example sat with their head in their hands for long periods, others were calling out and would have benefited from further activity to promote wellbeing. The manager told us that they had a range of sensory items which they used to provide comfort and stimulation for people but these were not in use on the day of our inspection.

We received variable responses on the services response to complaints with some people telling us that the service responded well to issues but others were less positive, and did not always feel listened to. There was a complaints procedure in place and we reviewed the complaints which had been received. We saw that the manager had followed up matters and taken statements from relevant individuals however there was not always a clearly documented outcome or follow up letter to the complainant. It is recommended that following all complaints an investigation record is maintained, an outcome and a follow up letter setting out to the complainant the actions that they could take if not satisfied.

We saw that the service had also received compliments which included the following, 'The care and attention provided by the nursing team and the care staff was superb and very focused on [my relative] to meet her individual needs. [My relatives] final days – and hours – were peaceful
and the family was well supported and reassured.'

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in place who was a registered nurse, and known to people living in the service and relatives. Most people expressed confidence in the manager and the support from staff. One person told us, "The manager is very approachable, any problems and she's onto it." Another person told us, "I think the staff are very efficient here – they're trying their best."

The manager was supported by a deputy manager who worked on a supernumary basis. The manager and the deputy manager provided on call cover and had the support of the provider's quality team in an emergency outside office hours.

There was no clinical lead in post at the service and we were told that the previous clinical lead had resigned and had not yet been replaced. On the day of our inspection there was one nurse on duty who had only been working at the service for two weeks and was relatively inexperienced. The manager assured us that they had oversight over the arrangements and would be providing additional training for this member of staff and there were plans to appoint another clinical lead.

Staff were positive about the management support and the accessibility of the manager. One member of staff told us, "The manager is friendly, it is a good home." We saw that supervision and appraisals were undertaken to reflect on practice and drive improvements in the service. Staff meetings were conducted on a regular basis and we were told that they had a theme attached, such as dignity, and how this is translated into practice and peoples day to day life. The most recent meeting had focussed on the mental capacity act and we saw that this had focused on staff understanding of their responsibilities.

People were encouraged to provide feedback on their experience of the service and we saw that satisfaction surveys to ascertain people's views on the care provided were conducted annually. The results were collated and an action plan was produced to address any issues highlighted in the survey. Resident and relatives meetings were held on a regular basis to ascertain people's views and keep people up to date on any developments and changes in the service.

There were systems in place to monitor the quality and safety of the service but these were not fully effective as they had not identified some of the inconsistencies that we found at the inspection. We spoke with the manager about this and they acknowledged that their audits had not identified the clinical shortfalls. They expressed disappointment in the findings of our observations and said that this was partly due to inexperienced staff and was not reflective of day to day care across the service. However we noted that the local authority had recently audited the care at the service and also had raised issues about the support provided to people in the specialist dementia unit.

We found that some of the auditing systems that were in place were informative, for example they had monthly at risk reports which looked at a range of areas including wounds, infections and safeguarding concerns. The records demonstrated that there was management oversight however we noted that not all areas were being recorded such as skin tears, weight loss or falls. We saw that there had been a relatively

high number of falls and could not see that they had been analysed by factors such as time. The records stated 'Falls all on dementia unit….different reasons looking at possible solutions. 'The manager told us that they had been part of the prosper scheme and there were plans to train more staff to enable a greater focus on falls. The prosper scheme is run by the local authority and aims to support care homes minimise the number of hospital admissions as a result of a fall or infection.

The manager also undertook observations of practice such as at lunchtimes as well as audits on areas such as infection control, medication and care planning. It was a concern that these had not highlighted some of the inconsistencies that we found. Night visits were undertaken on an unannounced basis to check that the care was appropriate. The manager had a service improvement plan which set out areas which had been identified as requiring attention. We saw that efforts had been made to challenge practice and give reminders to staff, for example on air mattress settings and the menu not being correctly displayed. However they had clearly not yet been resolved as we found issues during the inspection. The manager told us that these areas were 'work in progress.'

The provider's quality and compliance representative visited the service on a regular basis and completed a report. We looked at these reports as part our inspection and saw that records were checked and observations undertaken. The report reviewed actions already agreed and set out areas for improvement along with dates for completion.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People who use the service were at risk of receiving inconsistent and poor care because care plans were not sufficiently detailed

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People who use the service were not protected against the risks associated with unsafe equipment