Agudas Israel Housing Association Limited

Beis Pinchas

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?	**Good**

Overall summary

The inspection took place on 27, 28 and 29 April 2015 and was unannounced.

Beis Pinchas is a 44 bedded care home with nursing. It provides care and accommodation for people from the Orthodox Jewish community. There were 39 people living at the home at the time of our inspection.

A new manager had been in post since December 2014 and has a pending application to register as the registered manager of the service. 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.

During our inspection we found many areas of good practice and also areas where improvements needed to be made, particularly around accurate records, risk assessments and care files. The manager was aware of most of these areas and the service was undergoing a programme of improvement.

Medicines were largely being administered safely and regularly. However we found improvements were needed for people prescribed pain relief on a when required

Summary of findings

basis, people having their medicines crushed before administration, and people on anticoagulant medicines. Staff were not always following best practice or the medicines procedure.

People were not always protected from risks to their health and wellbeing because assessments did not provide adequate guidance for staff.

Staff were inconsistent in their understanding of how to support people when they displayed behaviour which challenged the service or others. We found areas of good practice around supporting people with anxiety related to living with dementia but there were discrepancies between staff about whether lawful restraint was used, putting people at risk.

Up to date nursing registration numbers were not held in all staff files.

A thorough recruitment system meant people were supported by care staff and volunteers who were suitable for work in the caring profession.

People were safeguarded from abuse and ill treatment by staff who could recognise signs of potential abuse and know what to do when safeguarding concerns are identified.

Sufficient numbers of staff had been deployed throughout the service to meet peoples' needs.

The control and prevention of infections was well managed.

Training was provided so that staff had the necessary skills to meet peoples' need.

The provider had carried out mental capacity assessments and protected people who could not consent to a restriction on their liberty that was necessary for their safety. More information in care plans was needed to guide staff about what was in someone's best interests.

People were supported to maintain a balanced and enjoyable diet, however, the provider could not be assured people had adequate nutritional intake because records were not up to date.

The provider supported people to maintain good health because they had good access to healthcare services for ongoing support.

The provider did not always support people adequately around their end of life care because care plans did not contain enough information. The provider had recently begun work with a local hospice to improve this area.

The service promoted caring, respectful and dignified relationships between people using the service and staff.

Care staff took care to provide personalised care but the care plans did not always reflect people's full needs.

People were very well supported to maintain their hobbies and social interactions to minimise isolation.

The provider listened to concerns from stakeholders and responded by making improvements.

The atmosphere at the service was calm, open and happy. Staff morale was high and good communication was entrenched. The service was organised in a way that promoted safe care through effective quality monitoring.

We found two breaches of the regulations relating to medicine management and safe care and treatment. You can see what action we told the provider to take at the back of the full version of the report. We have made a recommendation about monitoring food and fluid intake

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?
The service was not always safe. Medicines were not always managed safely. Risks to peoples' wellbeing and safety were not managed appropriately.

Enough staff were available to support people.

Staff understood how to safeguard people from abuse.

Requires improvement

Is the service effective?
The service was not always effective. Monitoring records such as food and fluid chards were not accurately completed.

Staff were not always provided guidance about how to assess whether care was in someone's best interests.

The food was of high quality and people were supported to have access to healthcare professionals to meet their needs.

Requires improvement

Is the service caring?
The service was caring. Positive relationships were developed with people and staff.

Peoples' religious needs were catered for and staff supported people to meet them.

Peoples' privacy and dignity were maintained and they were treated with respect.

Requires improvement

Is the service responsive?
The service was responsive. People's personal preferences were taken into account however, improvements in records needed to be made to ensure they were accurate in relation to specific health care needs.

The provider had worked hard to help people maintain their interests and social integration to reduce isolation.

Requires improvement

Is the service well-led?
The service was well-led. The manager was aware of improvements that needed to be made and was undertaking ongoing monitoring to improve this.

The service had an open and transparent culture in which good practice was identified and encouraged.

Good

Beis Pinchas

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 27, 28 and 29 April and was unannounced. The inspection was conducted by three inspectors, a pharmacy inspector and a specialist professional advisor who was a nurse with expertise in dementia care. Before the inspection we reviewed the information we held about the service and statutory notifications received.

During the inspection we used a number of different methods to help us understand the experiences of people supported by the service. We spoke with six people using the service and six relatives. We also 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 three visiting healthcare professionals.

We spoke with the registered manager, the administrator, seven care workers, two nurses, two auxiliary staff members and three volunteers.

We looked at eight people's care records, eight staff files and two volunteer files, as well as records relating to the management of the service.

Requires improvement

Is the service safe?

Our findings

People living at the service reported they felt safe, "Nothing gets past me and I have never seen anything to be concerned about here. If I did I would report it to [the founder] immediately."

Despite this positive comment, we found that medicines were not always managed safely. Formal pain assessments were not being carried out to assess whether people were in pain and required their as required medicines (PRN). This was important as some people at the service found it difficult to express verbally when they were in pain. The medicines policy was not being followed for PRN medicines and these issues had not been identified in the medicines audit.

People were put at risk of receiving an incorrect dose of warfarin because this was not recorded on the medicines administration record (MAR) but rather in their anticoagulant therapy record book. On one occasion we found that it was recorded that someone had received an incorrect dose.

Tools used to crush medicines were not being washed between use which put people at risk of harm if they were allergic to certain types of medicines.

Controlled drugs were stored securely however, in the case of controlled drug patches a record was not being made of the site of application or that the old patch had been removed.

The medicine's policy was not being followed. For example, nurses told us that noone at the service was self-administering their medicines, but we saw on the MAR that one person was self-administering two creams and two inhalers. A risk assessment was not in place for this person which was a requirement under the provider's policy. Also, the minimum and maximum temperature of the medicine storage fridge was not being checked over a 24 hour period as stipulated in the policy. We found that the date of opening was not recorded for two medicines which had a limited shelf life once opened. Not recording this increases the risk of them being used beyond their expiry date.

The issues above relate to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from risks to their health and wellbeing. Risk assessments in peoples' care records addressed some of the main issues for them, such as risk of falls, moving and handling and Waterlow, however, the advice within them on minimising risks for people did not give staff sufficient guidance in all cases. For example, the goal in respect of communication for one person was "The staff member offer [the person] the best health." It did not describe the process of achieving this goal through good communication. One person had previous suicidal ideas in the past. The care plan provided staff with some good information in dealing with mental health issues and the person had been referred to the mental health team, although there was insufficient detail to protect the person if their condition worsened. There was not enough information on the signs that their mental health may be deteriorating. It did not include sufficient information on the signs that the resident may be becoming low in mood or that they may be becoming suicidal again.

Risks during a potential fire were managed adequately because staff understood how to support people in such an event. Basic personal evacuation plans provided some guidance to staff about what support individuals needed to evacuate the building during an emergency, although information about people's behaviour or communication needs were not included. Routine fire drills took place. Staff had a basic understanding about what to do in a medical emergency; however one member of staff informed us they would call the community ambulance service on Saturdays which may put people at risk of not receiving coordinated care.

The issues above relate to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Positively, we found that at least one person who could not press the ordinary nurse call bell could summon staff using a bell they just had to knock.

The recruitment process for nursing staff was not always safe because their files did not always contain their latest registration number which indicated they were registered to practice. A thorough recruitment system was in place for care staff and volunteers; The staff files we reviewed contained criminal record checks, application forms, interview records, proof of their right to work in the UK, and two references.

Requires improvement

Is the service safe?

People were safeguarded from abuse and ill treatment by staff who could recognise signs of potential abuse and know what to do when safeguarding concerns are identified. Staff we spoke with told us about different forms of abuse that could occur in such a setting and that they would report any suspected occurrences to the manager or nurse on duty. Staff were aware they should record the incident.

Staff had received safeguarding training. One staff member said, "I have never had any concerns [about the safety of people who used the service], but if I did I would have no hesitation about reporting it." We saw that safeguarding adults had been discussed at a recent staff meeting and staff were encouraged to report any signs of abuse such as unexplained bruising. Staff had confidence that the manager would respond to their concerns, however were aware that if the response was not sufficient that they could report it to the Care Quality Commission. They were unaware, however, of their duty to report to the local safeguarding team.

Although the manager was aware of her duty to report instances of suspected abuse to the local safeguarding team, the safeguarding policy was not clear on this point. The safeguarding team was not mentioned in the procedure which instead stated that the senior person should begin investigating the incident. This is incorrect as the service should report the incident and wait for further instructions from the safeguarding team.

Sufficient numbers of staff had been deployed throughout the service to meet peoples' complex needs. The rota we reviewed demonstrated that staffing numbers were adequate to support people. During the morning there were at least five members of staff in the lounge and care and nursing staff were supported by volunteers. This enabled staff to meet people's personal care and associated needs at times that suited them.

The control and prevention of infections was well managed across the service. The service was clean throughout our visit. Staff had received training and understood how to prevent infections spreading and used adequate protective clothing and waste disposal methods. Hand washing facilities were widespread within the home for religious purposes, this also aided infection control.

The sluice and macerator on the first floor were kept clean.

Requires improvement

Is the service effective?

Our findings

Training was provided to ensure staff had suitable knowledge to meet peoples' need. The staff understood the needs of the people they cared for. Some of them described the training courses they had attended and said they were "useful" and of a "good quality". One staff member told us that the provider had supported them to obtain a national vocational qualification. Staff received a thorough induction covering a wide range of mandatory topics and also included training in specialist areas such as dementia awareness as well as guidance about how to support people to follow their religion.

Records demonstrated that staff received supervision sessions every other month and underwent an annual appraisal. Staff reported they found these useful as areas for improvement were discussed and they got notes detailing what they had to do.

The Mental Capacity Act 2005 (MCA) provides the legal framework to protect and support people who do not have the capacity to make specific decisions. We noted that the provider had carried out mental capacity assessments when required under the MCA in all but one of the care files we looked at.

Care staff had completed training and had an understanding of the principles of the Act. For example, Staff understood people's right to make their own decisions whenever possible. One relative said, "Staff always ask [my relative] questions, don't tell her what to do, for example, 'would you like to' rather than, 'now it is time for …'"

The Deprivation of Liberty Safeguards (DoLS) ensure that, where a person cannot provide consent, any restriction on their liberty is in their best interests. The manager understood the legal framework and recent caselaw and had submitted DoLS applications for people who could not consent to restrictions on their liberty, such as not leaving the service without support. The relevant paper work was held in people's care files.

Care staff had a good understanding of the legal framework and were mostly aware of the people who were subject to DoLS. Staff told us they were aware that when there were concerns that someone could not consent to care they would apply for a DoLS authorisation and this would mean they could provide the necessary care but that they could not physically force them to do something. However, more guidance was need to help staff understand what was in someone's best interests in a particular situation. Positively, we found information regarding Independent Mental Capacity Adovcate (IMCA) visits in two care files meaning the service facilitated methods for people to share their views on their care and treatment.

The layout of the service was unrestrictive meaning people who were not free to leave the home when they wished were still able to move about freely if they were able. The garden was accessible and all ground floor bedrooms had patio doors. We saw people were using the garden throughout the inspection.

There was a lack of clarity about whether the provider used lawful physical restraint to keep people safe. Some members of staff said they could use this method whereas the manager said that it was not the practice of the service. The manager had identified that further improvement was needed in this area and had booked training which was due to take place the month following our inspection.

People were supported to maintain a balanced and enjoyable diet, however, the provider could not be assured people had adequate nutritional intake because records were not up to date. Some people had their food and fluid intake monitored for medical reasons. We found that the records were kept in the dining area and were not up-to-date. Staff were not always filling in the charts at the time food and drinks were given, therefore there was a risk that they would not remember accurately. One person's nutritional support records we saw did not have any entries following a dietitian's visit the previous month.

However, the provider did support people to have access to very good quality and well presented food. Staff supported people who required extra assistance at their own pace. One relative said, "[My relative] does find it difficult to chew because she gets tired. She can request to have soft/ pureed food on any given day; also sometimes she doesn't like what is on the menu and can ask for whatever she wants." We saw people helping themselves to food and fruit, that was freely available, and drinks were offered on a frequent basis.

We noted that at lunch some people were joined by friends and relatives who stayed in the supported accommodation next door. This helped to make lunch a pleasant social event; there were lots of conversations taking place.

Requires improvement

Is the service effective?

A Kosher kitchen was kept to meet people's religious needs and people's individual likes and dislikes were taken into account when staff were made aware of these. Most people told us that they thoroughly enjoyed the food. One relative said, "The food is unbelievably good; it is like a hotel… my [relative] was an amazing cook and looks forward to lunchtime." We found evidence of referrals to dietitians in peoples' care files as appropriate.

People were supported to maintain good health because they had good access to healthcare services for ongoing support. Good working partnerships had been developed with the local GP, dietitians and speech and language therapists. A GP, chiropodist and physiotherapist attended the home during our visit.

Relatives said, "I am very pleased for [my relative] is in the best place [they] could be – whatever I need they do. [My relative] has regular check-ups by the GP psychiatrist." The service supported people to attend appointments and in one case a relative told us that when a taxi did not arrive for their family member's hospital appointment, the service arranged for a staff member to take them in a wheelchair adapted car.

Care files contained records from members of the multidisciplinary team including the GP, heart failure nurse, continuing care staff, and dentist. The records showed that members of the multi-disciplinary team visited people regularly. In addition there were letters regarding hospital appointments that people had attended.

There was evidence within the care plans that people had been referred to healthcare professionals when required. For example, regular monitoring of a person's weight had showed that they had lost several kilograms without trying so they were referred to a dietitian.

We spoke with a GP who was visiting the service who indicated that the nurses called them out appropriately and had relevant information available for them.

We recommend that the provider seek guidance from a reputable source about how to monitor food and fluid intake.

Requires improvement

Is the service caring?

Our findings

The provider did not always support people adequately around their end of life care.

We found that a care plan for a person who staff told us was on end of life care did not contain information about pain management, medicines or an end of life care plan. Most people's wishes were described briefly but another plan was entirely blank. The manager was aware that this was an area that could benefit from further development and, to this end, they were being supported by a local hospice to attain Gold Standard Framework accreditation. We saw that this had been discussed with staff at a recent meeting and particular staff members had been identified to take the lead in this work.

We found caring and compassionate relationships were developed between people living at the service and with staff. A person told us, "It's wonderful. Couldn't be better – I have been in many institutions, some are like prison, some are like hospitals but this place feels like home." Another told us that staff had been very good, "I do sometimes get upset and they are there to support me." Staff are very kind, they get to know people and what they like."

Relatives were, without exception, positive about the care provided. One relative told us, "It is the nearest thing to heaven; the carers are the tops." Staff we spoke with told us about people's needs and preferences without the need to check the care plans which contained peoples' personal history.

Staff supported people to express their views. We observed staff members using hand signals alongside verbal questions and explanations. They were aware to keep eye contact and have clear speech, to be very patient and to think about what they were doing to communicate at all times. We saw posters with hand signals were available throughout the service to aid staff. In a recent staff meeting the manager had discussed the importance of working with all people who need assistance and not only those who were able to verbalise their needs. Staff sought people's consent in daily care tasks. We observed that people were offered choices of food at lunch time and there was a clear printed menu placed on each table. Staff asked people about whether they wanted to do something before they assisted them.

Staff respected people's diversity and supported people to follow their religion. Although the service was set up to serve the needs of the orthodox Jewish community, a staff member pointed out that there was considerable diversity within the community and this was confirmed by the number of different languages spoken. We were told that the service respected the traditions of each group and there were some interesting debates between people who used the service about the similarities and differences. One person said, "I was born in [a particular country], there's not many [in the service] like me, but that's OK, we all do our own thing."

People explained that they were able to pray without restrictions and there was a synagogue on site. Staff respected religious practices such as female staff did not shake hands with the male people who used the service they cared for and vice versa.

Staff were given guidance about religious practices during meetings. We noted that there had been a discussion about Pesach at a recent meeting so they could help people be involved in the festival. People felt respected as people addressed them by their preferred name, often their surname.

People's privacy was preserved. We saw that bedroom doors were closed and people could lock these for privacy. We observed one person being sensitively encouraged to go to their room so a personal care task could be carried out privately in order to maintain their dignity.

Requires improvement

Is the service responsive?

Our findings

The service was responsive to people's social and emotional well-being. For example, key members of staff were alert to the particular needs of people who had survived the holocaust and ensured they received additional support from a foundation which had been set up for this purpose. They also worked hard to anticipate potential triggers for mental distress so they could be avoided or managed, for example, during the compilation of their life stories.

We heard how one ex-soldier had been supported to receive a medal they had been awarded but never received. A small military ceremony was arranged within the home.

Care plans contained a 'personal history' of each person including personal information such as their family life. Care plans also highlighted areas of care that people could undertake themselves in order to promote independence.

We saw that choices were made available to people, for example, although a chiropodist regularly visited the service, some people were supported to receive foot care from the chiropodist they saw before they moved into the home if they wished for this to continue.

Care planning and subsequent reviews did not always provide written guidance that was tailored to the individual's needs. The assessments that took place prior to someone's admission to the service were brief and contained only limited information. The service used a commercially available care plan format. We found that there was basic information about each individual's needs and the associated risks within each care plan viewed. However, we found that the care plans would benefit from further development in order to be responsive to individual needs. For example, in one of the care files we saw that a person who could no longer speak was at risk of experiencing pain. The advice to staff was "observe body language" in order to assess this, but there was no pain assessment tool available, nor was there any information about what sort of body language might indicate pain for this person.

Staff were inconsistent in their understanding of how to support people when they displayed behaviour which challenged the service or others. We did not observe any conflicts or outbursts at the service and a calm and happy atmosphere prevailed throughout our visit. However, staff could not readily inform us of the people who may have displayed behaviour that challenged or the care they provided in these instances. They were supported by an adequate policy and one member of staff was able to discuss the issue in similar terms, namely that they would remain patient and keep the person happy in these instances. Positively, the service benefited from some generous donations, one of which was a robotic seal which interacted with people. One staff member described how 'Snowy' was used to calm people who were agitated. 'Snowy' only relaxed when they relaxed and no one wanted to upset him. This showed an awareness of how to support people who may become anxious because of matters related to their dementia.

People were not fully involved in planning their own care. We saw that care plans were reviewed monthly by staff members, but there was no evidence that people who used the service had been invited to participate in reviewing these documents. Involvement in care planning can help some people to feel more in control of their care arrangements and it can also help staff to understand an individual's priorities.

Care plans were updated following a change in the person's needs but more work was needed around wound management. Staff told us that they and the manager had developed a new care strategy for a person who had a recurring infection. One care plan demonstrated that subsequent to a person's referral to the diabetic nurse their care file had been amended accordingly.

The provider was responsive to people's religious needs. The provider ensured that there were enough volunteers and staff to meet people's religious needs during personal care such as hand washing rituals. We did not observe anyone waiting for support. Volunteers worked alongside staff to meet people's social and emotional needs. For example, a volunteer sat beside someone who was very ill to provide company and reassurance and another volunteer went with staff on a short minibus trip to a park so that the participants all received one to one support when out. This support and links with volunteers was commendable.

People were very well supported to maintain their interests and hobbies. There was no shortage of religious, intellectual, physical, artistic or social activities within the home. The activity timetable was posted on noticeboards

Requires improvement

Is the service responsive?

and approximately six different group activities were available every day of the week, including during the evening. A synagogue on site held several different services each day.

The service benefitted from access to transport so people could participate in activities outside the home as well.

People reported that there was a good choice of activities and that they often spent time in the day centre downstairs where they could be "all together". One person described an exercise class to us, "[The instructor] gets us doing all sorts. We wiggle this and we wiggle that. It is good for us to keep active." Another person told us how they did a lot of crochet.

We noted that study sessions were available to people and lively debates took place. Relatives reported that their family members enjoyed the singing group that came.

The activities manager knew the people living at the service very well and was knowledgeable about their backgrounds. They had encouraged links with local school and pupils had visited and joined in with the activities. A mother and baby session regularly occurred on site so people living at the service could interact with people of all ages.

People were very well supported to maintain social contacts and integration in the wider community which reduced isolation. A volunteer told us that they had been called in specifically as staff thought a person needed someone to sit with them as they could not leave their bedroom. Relatives and visitors reported they were made to feel welcome and the service was "like a family". Throughout our visit we noticed a large number of visitors to the service. Someone was supported to have their husband stay with them when they wanted. One person who could not easily participate in group activities due to their health condition told us that musicians and other people who visited the home to lead an activity would often come to their bedroom to ensure they were not left out.

People were supported to feedback about the service and any concerns they had. They and their relatives felt confident doing so. One relative said, "They really do listen and oblige if they can…There is not much to complain about; this is the best." They gave an example of how one of their concerns about laundry was listened to and addressed.

We saw minutes from relative and resident meetings that were held quarterly where people were asked if they had any concerns. Solutions and actions were then discussed.

Complaints were well managed. We saw that all concerns and complaints were recorded, however minor, so that they could be monitored and resolved. We saw that a member of care staff had supported a relative to make a written complaint and to hold a meeting with the manager and provider to address their concerns. This demonstrated that the staff wanted to resolve the issue and welcomed the feedback. We saw evidence that concerns were dealt with appropriately and apologies were given.

Good

Is the service well-led?

Our findings

The provider had developed an open culture at the service and staff morale seemed high. This was partly due to good communication amongst staff. Nurses and care staff kept daily notes on the care provided to each individual; these were brief but the content was relevant and to the point. They achieved the aim of informing the next shift about the well-being of the person and any significant events.

Staff were able to discuss the running of the service at monthly meetings and felt confident to raise concerns. One member of staff said, “Coming to work is a pleasure; I enjoy it here.” It was evident that the meetings were meaningful and effective and promoted best practice and provided a forum to update staff about recent legal developments in the health and social care field. Staff felt supported by the manager who was accessible and they felt listened to. Regular supervisions were held and were ongoing. Staff reported they were a useful way for them to improve.

Staff felt accountable to the people who used the service, their families and the wider community and were keen to make the point that this encouraged good practice within the home and ensured poor practice was quickly spotted and reported. A member of staff told us, “We are in the spotlight.” Each person had a named nurse and a keyworker; their names were displayed in each bedroom.

The manager had applied for registration through the CQC in December 2014, and was currently undergoing the process of becoming the registered manager. The deputy manager was currently solely working in a clinical capacity as a nurse rather than taking on management functions. The service was organised in a way that promoted safe care through effective quality monitoring. The manager had implemented a monitoring system since her arrival in post and was working through a schedule of audits of a wide range of areas.

The manager was aware that documentation was an area that required improvement and had begun to address the issue. We viewed a recent care plan audit she had undertaken which was very detailed and included guidance for staff on how to improve their knowledge of how to draft documents. We saw evidence that the guidance in the audit was discussed with the staff member in question in a face to face meeting. This meant that the manager had the skills to drive forward the improvements that were required in this area.

All audits, but that for medicines, identified areas for more work and were used to drive forward improvements. For example, a recent infection control audit identified the need for new equipment which was then ordered. Spot checks of staff were completed and support provided where improvements were needed. The service operated a system whereby staff members had to register each visit they made to an individual’s bedroom by using a fob. This enabled management to monitor the care provided. For example, if a person complained that staff were slow to answer their call bell this could easily be investigated. Feedback surveys had recently been completed and action plans drafted to address the failings they identified.

Accidents and incidents were monitored on an annual basis, however, more frequent review would assist in honing in on particular times or locations were accidents were more frequent so timely action could be taken to eliminate risks.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider did not ensure the proper and safe management of medicines. Regulation 12(2)(g)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider did not assess all risks to the safety of service users and did not do all that was reasonably practicable to mitigate all risks. Regulation 12(2)(a) and (b)**