Aronel Cottage Care Home Ltd

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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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Aronel Cottage is a residential care home providing personal and nursing care to up to 38 people. The service provides support to people who have care and health needs including impaired mobility, frailty of age, diabetes and people living with Parkinson's disease. At the time of our inspection there were 38 people using the service. Accommodation was in one adapted building over two floors which were accessed by a lift.

People's experience of using this service and what we found
Aspects of leadership and governance of the service were not effective in identifying some service shortfalls. There was not an adequate process for assessing and monitoring the quality of the services provided and that records were accurate and complete.

People and their relatives told us current visiting arrangements were restrictive. We received feedback that the provider did not always follow government guidelines for visiting in care homes. We made a recommendation about visits to the care home and sign posted the provider to current government guidelines for visiting in care homes.

People were not always protected from avoidable harm because the provider did not have effective procedures in place to make sure people were safe. Incidents were not always responded to or reported to the appropriate authority. Action was not always taken to mitigate the risk of harm to people.

Processes were not in place to ensure support plans and risk assessments contain detailed and person-centred information to accurately reflect the needs of people. Risks to people's health and wellbeing were not consistently managed. We have made a recommendation about staff knowledge and understanding of dysphagia and modified diets.

Staffing levels were enough to meet people's individual needs. Positive and caring relationships had been developed between staff and people. People were treated with kindness and compassion and staff were friendly and respectful. Feedback from people and their relatives told us they were happy with the service. Comments included 'Nothing is too much trouble' and 'There appears to be enough staff, I don't hear call bells constantly ringing and the staff seem to be calm and competent'

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update

The last rating for this service was good (Published 6 June 2018).

Why we inspected
We received concerns about the failure to notify CQC of incidents that affect the health, safety and welfare of people who use the service. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Aronel Cottage on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to protecting people from abuse and harm, safe care and treatment and overall governance and management of the service, at this inspection.

We have made recommendations about visiting in care homes and improving staff skills in dysphagia.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 always safe.

Details are in our safe findings below

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Aronel Cottage Care Home Limited

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was undertaken by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Aronel Cottage is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Aronel Cottage is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
Due to technical problems, the provider was not able to complete a Provider Information Return. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all this information to plan our inspection.

During the inspection
We spoke with eight people who used the service and six relatives about their experience of the care provided. We spoke to the registered manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with seven members of staff including two registered nurses, two care staff, one ancillary staff and the chef.

We reviewed a range of records. This included fourteen people's care records and medicine records. We looked at three staff files in relation to recruitment and induction. We reviewed accident, incident and falls records. A variety of records relating to the management of the service, policies and procedures were reviewed.

After the inspection
We continued to review information and sought clarification to validate evidence found. We looked at additional information requested including medicine records, assessments and information about people on modified diets. We sought feedback from health and social care professionals about the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Using medicines safely

- Systems in place to identify, assess and monitor risk were not always effective. Risk management plans were not in place to mitigate known risks including those associated with health conditions such as diabetes, respiratory conditions and catheter induced infections. Support plans did not provide enough guidance to enable staff to support people in a safe and consistent way.
- For example, a person received prescribed medicines for angina. Nurses knew the person had angina however the person's care plan did not reflect they had this health condition. Guidance was not available to staff to recognise the signs of the persons health deteriorating or the action to take. Another person was receiving clinical wound management for a pressure ulcer which had significantly deteriorated whilst they had been in hospital. The persons care plan had not been updated since their hospital discharge and recorded a small ungraded ulcer wound. This meant people could not be assured of receiving appropriate and consistent support from staff who were not familiar with their needs including new or agency staff.
- There was an absence of robust falls prevention and management. Information from falls risk assessments had not been used to develop falls management plans or mitigate the risk of falls. Care plans did not reflect measures taken to mitigate a risk of a further occurrence. Where there was evidence of multiple falls consideration had not been given to seeking advice from healthcare professionals such as the falls prevention team (FPT). The FPT can provide assessments, advice and exercises for older people who are at risk of falling.
- There was a lack of effective oversight and monitoring of head injuries. NHS guidance advises that head injuries are observed closely for a period of 24 hours to monitor whether a person's symptoms change or get worse. Where people had received a fall that resulted in an injury to their head or face consideration had not been given to a period of enhanced monitoring. There was a failure to consider the risk of increased internal bleeding associated with blood thinning medicines taken by two people. Registered nurses told us they relied on the staff to report any changes in a person's condition. The provider did not have a policy for head injuries and guidance was not available for staff. This meant we could not be assured care staff would recognise the signs of a person's health deteriorating or seek advice from the registered nurse on duty or medical professionals in a timely way.
- Medicine care plans did not provide enough information to ensure people's medicines were administered safely. Protocols were not in place for administering 'as and when required' (PRN) medicines. PRN protocols explain how people should receive their medicines to ensure they are only taken when needed and as prescribed. Where the prescriber had given specific instructions, such as to avoid grapefruit whilst taking certain medicines, this information was not transferred on people's care plans. There was an absence of information in care plans to guide staff about how people preferred to receive their medicines and how they could maintain their independence. This meant people could not be assured of receiving their medicines in

line with their personal preferences and the prescriber's instructions.

The provider had failed to ensure care and treatment was provided in a safe way or that risks to people had been mitigated. There was a failure to ensure the proper and safe management of medicines. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Medicines were administered by trained nurses. Medicines were stored and disposed of safely. Medicine administration records (MAR's) were accurate with no gaps in recording. We observed medicines were administered in line with good practice guidance.
● People told us they received appropriate support with their medicines. One person said, "I used to forget to take them, there's no chance of that now", and other said "I feel lucky to have a nurse to give me my tablets, it gives me piece of mind".
● People were asked if they needed PRN medicines such as pain relief before it was dispensed. People received their medicines on time, this included time specific medicines for people with Parkinson's disease.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● Systems and processes were not robust to protect people from the risk of abuse. Staff were unclear of their individual responsibilities to prevent, identify and report abuse when providing care and treatment. There was a failure to consider accidents and injuries in line with local authority safeguarding guidance. This included two occasions in the past six months where people had received a serious injury or had been exposed to preventable harm. We have written more about this in the well-led section of this report. We made the local authority aware of our concerns regarding the failure to consider and report incidents and accidents in line with the local authorities safeguarding guidance.
● The providers processes for recording accidents and incidents did not ensure people were protected from harm or that lessons were learnt. We reviewed accident and incident records for the last 12 months. There was an inconsistent approach to recording injuries with an unknown origin such as bruises or small skin tears. Information was not used to investigate or mitigate the cause of the injuries and there were no processes for learning lessons to drive service improvements or keep people safe.

The provider's processes did not ensure the right level of scrutiny and oversight to ensure people were protected from abuse and improper treatment. This was a breach of regulation 13 (safeguarding people from abuse and improper treatment)) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the provider reviewed accidents and incidents from the last six months in line with the local authorities safeguarding guidance and made retrospective notifications to the local authority and CQC where required.

● People told us they felt safe with the level of care and support the received. A person told us "As much as I would prefer to be in my own home, it is much safer for me here and that gives my daughter piece of mind". Feedback from relatives was consistent: they felt their loved ones were looked after and kept safe.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
People were able to receive visitors to the care home. Visitors accessed the service through a side entrance and used a designated visiting area which the provider had adapted to support safe visiting during the global pandemic. We received consistent feedback from relatives and people regarding arrangements not being flexible and time restricted. This was due to the providers booking system which only enabled visits to be booked in 30 minute slots and only one person was able to have a visitor at a time. Relatives told us they found this very restrictive especially when they were travelling long distances to spend time with a loved one.

Prior to the inspection we had received feedback about restricted visiting that was not in line with government guidelines and the difficulty in obtaining essential care giver status. Government guidelines are, 'Every care home resident should be able to choose an essential care giver to benefit from companionship and additional care and support provided by someone with whom they have a personal relationship'. We spoke to the provider about this and action had been taken to address and resolve this concern.

The provider told us their current visiting arrangements were in place to keep people safe, maintain infection control and ensure staff were available to facilitate visits and undertake lateral flow device (LFD) checks and testing. We directed the provider to current government guidelines on visiting which state there are no nationally set restrictions in place on visiting in care homes. Providers are expected to, 'Facilitate visits wherever possible and to do so in a risk-managed way'.

We recommend the provider review their visiting arrangements in line with current government guidelines on visiting in care homes.

Staffing and recruitment
● Safe recruitment processes protected people from the recruitment of unsuitable staff. Appropriate recruitment checks were undertaken to ensure staff were safe to work with people. This included undertaking appropriate checks with the Disclosure and Baring Service (DBS) and obtaining suitable references. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● There were enough staff to meet people's needs. People and their relatives consistently told us there were enough staff and our observations confirmed this. People received support from a core team of staff who knew them well. This ensured people received continuity of care from a familiar team.
● People felt staff had enough time to adequately provide their support. Feedback included, "Staff are very kind and always on hand" and "There is usually plenty of staff around". People told us call bells were responded to promptly and we observed this.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet

● We were not assured staff understood the different levels of food textures and drink thickness as set out in the International Dysphasia Diet Standard Initiative (IDDSI) for people with swallowing difficulties. People who had difficulty swallowing or were at risk of choking had been assessed by the speech and language therapy team (SaLT). The information recorded in people's care records was not consistent with the guidance from the SaLT assessments. For example, four people's care records reflected a liquidised diet although none of the SaLT assessments advised this. We did not find any negative impact on people who were receiving modified diets however we made the registered manager aware of our findings.

We recommend the provider seeks guidance from a reputable source to improve staff's knowledge and understanding of dysphagia and IDDSI.

● Assessments were undertaken to determine people's risk of malnutrition and dehydration. Where required people had food supplements and enriched food added to their diets to enhance their dietary intake and reduce their risk of weight loss and malnutrition.

● Specialist diets were catered for. This included meals for people who had diabetes and where people had allergies or specific preferences and dislikes. People told us the meals were plentiful and of good quality. One person said, "there is no chance of us going hungry". Another person described the food as "piping hot and delicious". We observed people's mealtime experiences and saw people were given menu choices and where to sit. People who required support to eat and drink received this in line with their needs.

Staff support: induction, training, skills and experience

● Staff did not receive 1-1 supervision in line with the provider's policy. Staff told us they couldn't recall the last time they had supervision and records confirmed this. This meant that the provider had not ensured a robust process for assessing staff learning, areas for development or if further additional training or support was required. The provider told us staff supervision had be impacted by the additional pressures of working during the global pandemic. Following the inspection, the provider gave assurances staff supervision and personal development processes had been implemented in line with the providers policy.

● During the inspection we observed some staff practice that did not provide assurances as to the effectiveness of staff learning. For example, some staff lacked an understanding of the underlying principles of the Mental Capacity Act (MCA) and safeguarding. We observed practice by one staff that placed a person at risk of falls due to the incorrect use of equipment. We reported this to the registered nurse who was aware of this practice and said they would ensure that it was stopped with immediate effect. We observed other

staff following safe moving and positioning techniques to support people to stand, transfer and use the hoist safely.
● Staff received training and an organisational induction. This included information about people, their support needs, organizational policies and training in mandatory topics. The service used the Care Certificate as an induction tool for new staff who had not worked in care before. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.
● People felt staff were competent to give them the care they needed. People told us they felt reassured by having registered nurses on duty 24 hours a day. Relatives said staff looked after their loved ones well. One relative told us "I've seen two carers help (name) into the chair and it's done nicely" Another relative said "when I speak to (name) he says he's very happy with the carers and looked after well'.

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Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People's needs were assessed before they started to receive support from the service, to ensure their needs could be met. The information gathered included people's preferences, backgrounds and personal histories. People and relatives told us they had been involved in the planning of their care and discussed their needs with staff prior to using the service. Protected characteristics under the Equality Act (2010), such as disability, ethnicity and religion were considered in the assessment process. This ensured people's diverse needs were considered and promoted within their care.
● People's physical and health needs were assessed. People were provided with equipment to enable them to be treated equally with others and maintain their independence. For example, when people had physical disabilities, they had access to hoists, wheelchairs and walking aids to support them to move and position. People's risk of developing pressure ulcers was assessed and pressure relieving equipment was provided. Nurses had clinical oversight of people's skin integrity and records evidenced effective support in this area.
● People told us they had access to external healthcare professionals to help maintain their health and to seek medical assistance if they were unwell. A person said, "If I need to see a doctor they are called very quickly". Feedback from relatives informed us of good and prompt access to health care. This had helped ensure that people's needs were effectively assessed and met.

Adapting service, design, decoration to meet people's needs
● The service was suitable to meet people's needs; adaptations had been made to meet the needs of people using wheelchairs and walking aids. There was an absence of signage and decoration to enhance orientation or communication. The service was currently being redecorated; we made the registered manager aware of our observations so they could be considered as part of this process.
● People's preferences were used to enhance their bedrooms which were personalised and contained personal effects such as pictures, photos, equipment and items to support their hobbies and interests.

● People spent time in their bedrooms and in the communal lounge, which was bright, light and spacious. Some people sat with groups of friends; others told us they enjoyed looking out into the garden. People told us that they enjoyed the outside space and it was accessible to people who used wheelchairs. One person said, "I really like the garden it so pretty at the moment with all the spring flowers". Another person told us they were going to suggest to the provider that a bird bath was purchased for the patio area as it would be nice to watch the birds from the lounge.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (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 MCA 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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and they were.
● The registered manager spoke of the need for presuming that people had capacity to make decisions and to ensure that people were supported in the least restrictive way.
● MCA assessments and best interests' decisions were completed. DoLS authorisations had been applied for and approved for the appropriate people; there was a process to check DoLS authorisations to ensure they remained valid and conditions were being met.
● People told us that staff checked with them before providing care. One person told us, "Staff ask me if it's okay before doing anything." Another person said, "They always knock on my door first and always ask if I want any help".

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care ; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- There was a lack of effective oversight and monitoring of the service. The registered manager did not work in the service on a regular basis and the registered nurse on duty oversaw the day to day management. Nurses told us the registered manager called in every few days and was available by telephone if required. Feedback received from people and visitors informed us the registered manager was not visible in the service. At the time of the inspection one of the registered nurses was applying to CQC to become a registered manager for the service.
- There were concerns that the provider had not taken ownership or fulfilled their obligations and responsibilities. The systems for assessing, monitoring and improving safety and quality of the service were not always effective and had not identified the shortfalls found during the inspection. Processes were not in place to ensure the service was operating in line with the providers own policies, compliance, best practice guidance or legislation. The provider was unable to demonstrate processes for quality audits or checking of records. There was a failure to identify inaccuracies within care plans or that information was not enough to support people appropriately or mitigate risks. The provider had failed to maintain an accurate, complete and contemporaneous record in respect of people's care and treatment.
- There was a failure to monitor or supervise staff to ensure that people were receiving a safe and effective service and that system and processes were being adhered to. For example, there was a lack of supervision and oversight by the provider of people left in charge in the absence of a registered manager. The failure to provide staff with supervision and regular competency checks meant the provider had failed to identify gaps in staff knowledge and where care practice was not in line with best practice guidance.
- Processes were not in place to monitor or audit medicine practices. This meant the provider had failed to identify that some medicine practices were not in line with National Institute for Health and Care Excellence (NICE) guidance for managing medicine in care homes. This included reconciliation of medicine stocks and person centred approaches to PRN medicines.
- Management skills, knowledge and oversight did not foster a culture that protected people from avoidable harm. During the inspection the registered manager, nominated individual and registered nurse were not familiar with the requirements of local authority safeguarding guidance. This had led to a failure to consider and report safeguarding concerns. Evidence presented failed to demonstrate outcomes from reviewing incidents and accidents had been used to keep people safe, drive improvements and mitigate risk.
- The provider had not always ensured the premises were safe for people to use and free of potential

hazards. For example, we observed cleaning materials that had the potential to cause harm to people if ingested, stored in non-lockable cupboards in the hall next to the lounge and people's bedrooms. The provider had placed people at risk of harm by failing to ensure safe control of hazardous materials as set out in the COSHH Regulations 2002.

The provider had failed to establish systems and processes to assess and improve the quality and safety of the service provided or to assess and monitor risks. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff demonstrated a commitment to providing people with good care and improving the quality of their lives. It was very clear from discussions they knew people very well, this included their past lives, interests and needs. We observed warm and positive interactions between staff and people living in the service.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● Services that provide health and social care to people are required to inform CQC, of important events that happen in the service. The provider had not always informed CQC of significant events. For example, a person had sustained a significant injury whilst being supported by staff which resulted in a hospital admission. Another person had become entrapped within their bed rails and was found with red marks on their legs and abdomen. These incidents had not been considered in line with local authority safeguarding guidance and there was a failure to notify CQC which is a regulatory requirement. This meant we could not be assured the provider had taken appropriate action at the time or implemented measures to mitigate the risk of a further occurrence. Following the inspection, the provider reviewed accidents and incident records from the last twelve months and sent to CQC retrospective notifications where required.

● Relatives told us they had been assured of their loved one's well-being during the COVID-19 pandemic and felt included and informed. Relatives said they were kept informed of any changes or medical appointments by letter and phone calls. Records showed that when incidents had happened, families had been communicated with in a timely way.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● During the global COVID-19 pandemic there had been a reduction in professionals visiting the service. Provision had been made to enable telephone consultations to take place instead of face to face meetings. Where practicably possible and where there was a need, healthcare professionals had visited the service.

● The registered manager and nurses worked professionally with external agencies such as the local authority and GP practice. The registered manager was involved in local leadership and care networks.

● People told us they did not have the opportunity for residents' meetings and shared any concerns, ideas or good news stories directly with staff. During the global pandemic the provider said they had not sought formal feedback from third parties, and this was something they planned to do. We reviewed written feedback from visitors to the service and this was positive. Feedback reflected staff "dedication and kindness" and comments such as "I will never be able to thank you enough" and "thank you for all your care and support, I would highly recommend your lovely home".

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment •Risk management processes were not in place to mitigate known risks. •Support plans did not provide enough guidance to enable staff to support people in a safe and consistent way. •There was an absence of robust falls prevention and management. •There was a lack of effective oversight and monitoring of head injuries. •Medicine care plans did not provide enough information to ensure people's medicines were administered safely. •Protocols were not in place for administering 'as and when required' (PRN) medicines

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment •There was a failure to consider accidents and injuries in line with local authority safeguarding guidance. •Staff were unclear of their individual responsibilities to prevent, identify and report abuse when providing care and treatment. •The providers processes for recording accidents and incidents did not ensure people were protected from harm or that lessons were learnt. •There was an inconsistent approach to recording injuries with an unknown origin •Information was not used to investigate or mitigate the cause of injuries.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance •There was a lack of effective on site management by the registered manager. •There was a lack of provider oversight and monitoring of the service. •Systems and processes were not in place for quality monitoring or audit. •There was a failure to consider and report safeguarding concerns. •The provider had not always ensured the premises were safe for people to use and free of potential hazards