Sunrise Operations Beaconsfield Limited

Sunrise of Beaconsfield Limited

Inspection report

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Ratings

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

Overall summary

Sunrise Beaconsfield provides accommodation and care for older people including those living with dementia. The service is registered with the Care Quality Commission (CQC) to accommodate up to 95 people; however we were informed the service would usually have an upper limit of 93 people. At the time of our inspection there were 90 people living at the home.

Sunrise Beaconsfield has a registered manager in place. 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.

Summary of findings

This unannounced inspection took place on the 6 November 2014. At our last inspection of Sunrise Beaconsfield in February 2014 we found the home met all the regulations assessed.

We received some very positive feedback about the service and observed some very good care and support. However, we found in some cases people's dignity was not fully protected and they were not always treated with appropriate respect whilst care and support were being provided.

We received conflicting assessments about how adequate staffing levels were. When we talked with people, observed support being provided over lunch and monitored call bell response times, we found people experienced delays in the provision of their care and support.

Those relatives we spoke with during our visit were satisfied with the standards of care they observed. Those relatives who contacted us before and after our visit were less positive about staffing although they all thought the staff tried to provide good care and support.

Risk was managed well and people were protected from avoidable harm. There was an effective system of care planning in place and records were kept up to date and accurate.

Staff recruitment was safe and effective.

Staff told us they felt supported through training and supervision. Staff meetings had not been as frequent as intended in the recent past but we were told this was being addressed. Staff said they could approach the registered manager informally at any time and were supportive of them and senior staff.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were not consistently provided with prompt care and support when they needed it. They experienced delays, for example, during meal times and when using the call bell to request attention.

People were supported by staff who had been subject to a robust recruitment process.

People were protected from the risk of injury or harm by a robust process of risk assessment to identify, manage or eliminate risk to their health, safety and welfare.

Is the service effective?

Good

The service was effective.

People received care from staff who were appropriately supported through training, supervision and appraisal.

People received the support they needed to access healthcare services either in the community or in the service in order to maintain their health and well-being.

People's changing care needs were identified through a process of regular reviews. This ensured the appropriate adjustments could be made to their care and support so that their needs were effectively met.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff did not always treat people with respect or protect their privacy and dignity.

People were positive about the standard of care they received.

People were supported by an effective system of care planning, review and recording. They and people responsible for them were involved in decisions about the planning and delivery of their care.

Is the service responsive?

Good

The service was responsive.

People were asked how they wanted to be supported. People who were responsible for them were also involved in decisions about the planning and delivery of their care.

People were able to make comments, compliments and complaints about the service formally or informally.

Summary of findings

People were supported to take part in activities in the home and community to meet their need for social activity, stimulation and entertainment.

Is the service well-led?

Good

People were positive about the leadership of the registered manager and told us they were "approachable."

Staff said they were well-supported and had the opportunity to discuss any issues with their line manager or the registered manager formally or informally.

There were systems in place to monitor the quality of service provided.

Sunrise of Beaconsfield Limited

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 6 November 2014 and was unannounced.

The inspection team included two inspectors, a dementia care specialist advisor 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. In this case older people's services.

Before the inspection, the provider completed and returned a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed the information in the PIR together with any other information we had about the home. We contacted health and social care professionals with knowledge of the service. This included a GP, NHS community psychiatric nurse, podiatrist and chiropodist.

During the visit we spoke with 15 people living at the home, one relative and 13 care and support staff. We also spoke with the registered manager. Two relatives contacted CQC to provide their assessment of the service after our visit and one before.

We observed people's interaction with staff in lounges and dining areas and with their permission in their rooms. We looked at eight care plans, medicines records, three recent staff recruitment files and records of staff training and supervision undertaken by staff. We also looked at quality monitoring processes and reports undertaken by the provider.

Requires Improvement

Is the service safe?

Our findings

People's experience and views about staffing levels varied significantly. Before the inspection concerns were raised about staffing levels, particularly at night. During the inspection we looked at staff rotas for the period July 2014 to November 2014 and discussed staffing levels with the registered manager, senior staff and people who received care. Following the inspection we also received feedback on staffing from healthcare professionals who regularly visited the home. Some of this was positive about staffing and some less positive. Whilst the reminiscence unit for people who live with dementia was felt by one to be adequately staffed they said; "There are never enough staff on duty on the independent living unit as the people are seen as independent when they are not."

The registered manager said staffing levels were determined according to the dependency and care needs of people who required care and support. This was assessed before admission and a calculation done to establish care hours required to meet those needs. It was acknowledged that there had been pressures on staffing during the period July to October 2014. A senior member of staff said staffing levels had been impacted by staff leaving and staff sickness. They noted that they had now recruited to all vacancies and were currently only recruiting for bank staff. "We have a brilliant team now." We saw staff team minutes confirmed that staff numbers had been down but the service had now recruited fully to vacancies. However, we were also told by one member of staff the service was still recruiting for additional night staff.

Rotas showed staffing levels had improved and those for October and November which indicated all shifts had been appropriately staffed, with sickness absence covered by existing staff. We found staff shifts had been extended to cover sickness or short notice absence of staff in order to maintain agreed staffing levels. There was also flexibility within the staff team to support people and meet their needs. Administration staff were trained to support people with moving and handling if required to in exceptional circumstances. On one unit during our visit a lead carer was off sick and a senior manager had provided cover for them.

During the inspection we found conflicting evidence in respect of call bell response times. We were told by staff that they did not think call bells were monitored, however the registered manager confirmed call bells should ideally be answered within four minutes. During the inspection we monitored two call bell responses at over ten minutes. However, two people we spoke with told us they found response times reasonable; "I know they are busy and I make allowances for that" one person said. On the reminiscence unit we were told some people had difficulty using call bells. To identify if people were out of bed at night and where they had been assessed at being at risk of falling, pressure mats were in use to alert staff to their movements.

People's experience of staff support at lunch varied. One person told us; "They sit you down quite early and you have to wait a long time as they have a lot to serve, there is not enough staff." Another person said; "What is slow is being served, we have rather a long wait….twenty minutes or so." We noticed one table had only one member of staff helping four people who required assistance with their meals. During the time we observed, the member of staff had to leave the table to help other people at a second table, leaving no-one supporting the first table. The registered manager confirmed there should have been two members of staff supporting the people at that table. Other people who we talked with told us they did not have any particular concerns about mealtime staffing and noted it was; "Generally a very pleasant experience."

Rotas provided for additional staff to be available during the busiest times of the day; between 7am to 11 am and 4.30 pm to 9.30pm. Staff we spoke with told us there were now routinely enough staff to meet people's needs. One said; "Even if we were one short we still delivered the same care, but now that new staff have joined I really notice the difference and it is fine by me."

People were positive about their personal safety and security. People said they were able to lock their rooms to keep their personal possessions secure. No concerns were expressed about the safety of the premises and we did not see any unsafe or inappropriate storage of equipment which might, for example, have been a trip hazard.

Potential risks to people's safety were identified within their care plans. For example, from falls or damage to the person's skin from pressure. There were control measures put in place to eliminate or manage risks where that was possible. For example, falls risk assessments identified the number of staff and equipment required to move the person safely and pressure relieving equipment was put in place to protect vulnerable skin areas.

Requires Improvement

Is the service safe?

Staff confirmed they had read people's risk assessments. Where there were specific concerns staff told us these were discussed at handover between shifts. One member of staff said they would alert a senior manager about changes in risks to people and noted; "They are very good, they act on information." We saw daily log notes used at handover included updates on the risks for one person following and accident. A member of staff said; "We are informed about any action to be taken, for example if people require food and fluid monitoring".

People were protected from the risk of infection. Staff had received training in infection control. They followed good practice, for example we saw they wore appropriate protective clothing when providing care. There were infection control policies and procedures in place and being followed. This helped protect people from the risks associated with acquired infections.

People were protected from abuse. Staff confirmed they had received safeguarding adults training and this was confirmed from training records. Staff were able to talk with knowledge about what might constitute abuse and what they should do if they saw or suspected it. "If I see something I have a duty to report this to the manager". Staff were aware of the whistle-blowing policy. This protects staff from being victimised if they raise concerns about a service. There were safeguarding information and contact details available in the home for staff and others to refer to. However, this was not very prominently displayed and we did not see an easily accessible flow chart with contact details to inform staff or others where to report safeguarding concerns. Staff told us they would bring any safeguarding concern to the attention of the manager or senior staff to deal with. There had been safeguarding referrals made by the provider since the previous inspection which showed they had taken appropriate action to safeguard people within the home.

People received their medicines safely. We checked people's medicine records on all units within the service. These were accurate. We looked at arrangements for the storage and disposal of medicines and found they were safe. Controlled drugs records were accurate and signed by two people as required. There were appropriate risk assessments for use where people had the capacity to self-medicate safely. The expiry dates for medicines were checked and temperatures of medicines storage were recorded to ensure they were within recommended limits. We confirmed medicines audits were undertaken regularly to monitor and support good practice and ensure people's safety.

People were protected from unsafe equipment. Regular maintenance schedules were in place for equipment to ensure it remained safe to use. We looked at service records for fire extinguishers and found they had been regularly serviced in line with the manufacturer's recommendations to ensure they remained operationally effective in the event of fire. People received safe and appropriate assistance to move within the service or access baths or showers, for example. Staff were provided with training in the safe use of hoists and other equipment used in the care of people.

There were effective staff recruitment processes in place to safeguard people from the employment of unsuitable staff to provide their care. We looked at the recruitment files for three recently recruited staff. We found appropriate checks had been undertaken before they commenced work.

We found people were protected from potential emergency situations because plans for their safety and the continuation of their care and support were in place. We were told each person had a personal evacuation plan and that the building had fire doors and evacuation chairs for use where these were required.

Good

Is the service effective?

Our findings

People's health and care needs were met. One person commented "I am well-looked after." They were also positive about the standard of the care staff. One relative said staff were; "Unfailingly calm and cheerful." A healthcare professional noted about the reminiscence unit; "Residents are cared for very well, staff are very good, showing patience and tolerance with the residents." They were less positive about outcomes for people who received care in the independent living part of the home when they had patterns of behaviour which sometimes challenged the service.

People's care needs were assessed. Care plans included evidence of pre-admission assessments to identify individuals' care needs. This enabled, for example, any specific equipment required to be put in place before the person moved in and ensured their needs could be met from the outset. The initial assessment process also included a nutritional assessment which identified any risk factors such as a history of weight loss or swallowing difficulties as well as establishing any dietary requirements. This could include people who were diabetic or who needed their food thickened to assist them to swallow food safely.

People's changing care needs were identified through a process of regular reviews. There was a 'wellness' check for everyone once a month. Where they identified any changes in people's health needs staff notified the wellness team within the service who acted upon them. This meant where new or changed needs were found, care plans could be adjusted to ensure they were met. This might include, for example, what a healthcare professional referred to as 'behavioural challenges' which had not been identified at the initial assessment.

Staff said training they received enabled them to meet people's changing needs. "I learn so much every day whilst I am out on the floor as people's needs change". The same person confirmed that people's changing health and social care needs were monitored and identified at staff handover and through the lead or key care staff. Another member of staff said; "Every day I learn a new thing, for example, I see the changes in behaviour for people with dementia. I have had dementia training and I use this information to help me support them." One staff member told us; "Wellness is a massive support to the care role and health concerns are dealt with by them." Another member of staff told us about a person who had a fall and was admitted to hospital. They said; "When they came out I noticed they were not eating like they used to, so I informed wellness and the lead care staff and monitoring was put in place and action taken."

People received support from a range of specialist health and social care professionals. Care plans included details of the involvement in people's care of GPs, district or community nurses and community mental health nurses for example.

People received care from appropriately trained care staff. Staff confirmed they received regular training to help them meet people's care needs. New staff had been given appropriate induction training which reflected 'Skills for Care' common induction standards. This meant they knew what was expected of them and were given the knowledge, skills and support they needed to carry out their specific role. For example, domestic staff confirmed they had received infection control training and training about the use and storage of chemical cleaning materials which could be hazardous to people's health. One member of staff talked about the e-learning they had undertaken. This was the usual form of training with additional practical training sessions for manual handling and fire safety.

We checked staff training records and found the majority were completed and up to date. Training records included periodic updates where this was judged as necessary by the provider; for example moving and handling and safeguarding along with others. The training monitoring system we saw identified where training was due to expire and when training had expired or had not been completed.

People received support from staff who felt well-supported. A programme of staff supervision and appraisal was in place. We saw records to support this and staff confirmed there was a mixture of formal and informal supervision, together with an annual appraisal. Staff said they had the support they needed and also felt able to approach senior staff and the manager at any time if they had a problem or needed advice on a specific matter.

People confirmed choices were available for all meals. People told us the food was quite good and was nutritious and well-presented. We observed lunch in one part of the service. We saw food looked well-presented and nutritious. There was a choice for people, although in the lunch we observed we did not see how those people who could not

Good

Is the service effective?

easily read the menu or understand the choices available were helped to exercise choice. One person said; "We have a choice to a certain extent and if you do not like what is on offer you get cheese on toast."

People were able to eat at their own pace. Staff were aware who needed assistance and this was given discreetly although there were delays when care staff were helping others as the planned number of staff were not in place at the time we observed the meal.

Although drinks were available during mealtimes, we were told by one healthcare professional that in their experience not everyone had drinks readily available in their rooms. We noticed that on the day of the inspection there was no water readily available for people sitting in the lounge, although staff offered drinks during the course of the day.

People appeared calm and relaxed during our visit. We saw evidence in the reminiscence unit of how memories were reinforced, for example by the physical layout and furnishing of the area to reflect appropriate eras like the 1940s. This included pictures, furniture and items like a cot to reflect different stages of life. We saw it was possible for people to personalise their own living space in an individual way to reflect their, life, interests and those people and events which were significant for them.

The staff we spoke with had a good understanding of the implications for them and the service of the Mental Capacity Act (2005) (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). The MCA provides the legal framework to assess people's capacity to make specific decisions at a given time. When people are assessed as not having the capacity to make a decision themselves a decision is taken by relevant professionals and people who know the person concerned. This decision must be in the 'best interest' of the person and must be recorded.

The Care Quality Commission (CQC) monitors the operation of the DoLS as they apply to care services. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after them safely.

We reviewed DoLS applications and documentation, including that from the supervisory body. This was comprehensive. We were told applications had been made as directed by the supervisory body. (In this case the Local Authority). For example, in the reminiscence unit where people living with dementia lived, 21 people had been the subject of a DoLS application. We were told that in approximately 12 cases assessments had been completed and authorisations given for periods of either 6 or 12 months. Other people were awaiting an assessment and we saw evidence that applications had been made to the local authority. In a sample of individual files we saw examples of mental capacity and best interest assessments.

In the PIR the provider stated 22 people who currently received care had made an advance decision to refuse treatment (DNAR) at the end of their life. Thirty seven people were stated as having given another person valid and active lasting powers of attorney with authority to take decisions about the service provided to them. Care plan documentation included details of these and any DoLS in place.

Requires Improvement

Is the service caring?

Our findings

People's dignity was not always fully protected and staff did not consistently have regard for people's dignity. During one afternoon activity session, when people were making Christmas cards, we observed a member of staff approach a person sitting in a group. They remained standing, gave no explanation of care to be given and only said the person's first name. They then held a metal dessert spoon containing tablets in front of the person's mouth. The person opened their mouth to take the medicines, without any drink being offered. The member of staff walked away with no comment, whilst the person who had taken the medicines grimaced.

In another part of the service we were able to see as we passed a person's room, that they were being assisted to use the toilet. We were able to see them being assisted back into their bedroom in their underwear without the outer door to their room, the toilet or bedroom door being closed.

We also saw one occasion when care staff entered a person's room without knocking or announcing themselves whilst the person was in bed. They opened the curtains and then spoke to the person. They turned on the light without asking the person if they wanted the light on and without closing the outer door. They were then joined by another carer who again did not knock or ask before entering the person's room.

At 11.30 am during our visit we saw care staff weighing two people on a mobile weighing chair in the reception area. In one case the person was talking to a friend and another the person had their coat on ready to go out with a visitor.

During a lunch observation, whilst we saw some positive staff interactions we also saw some poor ones where people's names were not used, prompts or encouragement were not offered and with staff standing to provide assistance rather than sitting alongside the person concerned, at their level.

These were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014

In their PIR the provider said dignity was respected and promoted through their principles of service, including privacy and dignity for people. Staff told us they were aware of these principles and that their induction and ongoing training included the importance of maintaining people's privacy and dignity whilst care was provided and always treating them with respect. One said; "I always keep doors closed and ensure people are covered by a towel – I would not like to be dressing when my door is open." Another member of care staff told us "I wait outside a toilet, if a woman does not want a male carer this is respected. I keep doors closed for personal care".

There were also very positive interactions between care staff and people. For example we saw a member of care staff help a person who was struggling to use a drinks machine. We saw care staff helping people mobilise around the service respectfully, attentively and with patience. We saw staff and people having relaxed conversations, which they appeared to enjoy. We observed care staff spoke with people in a warm, friendly but respectful manner. We heard one member of care staff praising people for their singing and dancing.

People were very positive about the standard of care they received. One relative said their informed research had caused them to choose Sunrise Beaconsfield for their relative and they had; "No adverse comments, the service was; "caring and effective." One person said of the care staff; "They are all very nice and very obliging", another said; "All staff are very good to see what we need."

People who received care and support, together with people responsible for them said they were involved with care planning. Care plans included varying levels of evidence of this, however people and their relatives told us they felt as formally involved as they wanted or needed to be. They indicated they were far more likely to achieve what they wanted through routine informal conversations rather than formal reviews, although they confirmed these did take place.

The activity staff looked at people's care plans to identify their specific interests, including any religious beliefs or observance. They said; "I know who likes to do what and who doesn't". They were aware, for example of a person who followed a particular religion although they did not require any assistance to achieve this. There was a multi-faith service available and a Roman catholic service which was open to all. They described some activities associated with key national saint's days. Although staff

Requires Improvement

Is the service caring?

told us they did not think there was any specific equality and diversity training, they referred to a code of practice which included a statement on 'embracing diversity and non-discrimination."

The registered manager confirmed advocacy services were available if people required them. In most cases however, people either self-advocated or their relatives did on their behalf.

Good

Is the service responsive?

Our findings

People's health and social care needs were assessed before they moved in. This ensured the service could provide the support they required. Care plans were in place to document people's needs in respect of, for example, their mobility, dietary needs, medical history and daily routines.

Care plans we reviewed were detailed and current, with risk assessments based upon individual needs. Care plans had been kept under review to make sure they reflected people's current circumstances. This helped ensure staff provided appropriate support to people if their needs changed. Reviews were usually six monthly unless circumstances required an earlier review. "Wellness" reviews were carried out monthly by the wellbeing co-ordinator, these included weight and blood pressure. The daily notes we saw within care plans were relevant and included sufficient detail.

We received generally positive feedback from healthcare professionals about the way the home responded to changes in people's health and well-being. They said staff contacted them if they were worried about people's healthcare needs.

The catering staff confirmed people's specific dietary requirements were always met, with appropriate alternative meals available where required. Care staff told us they always offered people choice; "I give people choice about what they want to eat, if they want to go out, bath or shower and lunch time. If someone doesn't want lunch, they can have a sandwich later."

The service supported people to take part in social activities. Each person had an individual service plan and an individualised activities programme. People have access to the internet and Skype. We saw a programme of activities and spoke with a member of the activities staff. They confirmed they support people with individual needs. For example, one person liked swimming and they went with a carer each week. During our visit there was an organised outing taking place, a church service, an artist and a quiz. People told us there were activities arranged for them most mornings during the week. We observed care staff reading the newspaper with people and discussing the news. We also observed craft card –making sessions and we were told there were craft and music sessions held which people said they enjoyed.

People had access to and involvement with the local community. The service had the use of a mini-bus which enabled people to enjoy outings and visits to places of interest. People told us; "For me there is a lot of entertainment", "I go out on all the trips" and "I feel included with all the activities." In the PIR the provider listed some of the event within the local community which the service was either involved with or initiated. These included dementia friends training, GP educational events, advice on wills and trusts and local choirs, school concerts amongst others.

People were aware of there being a complaints policy. However, none of those we spoke with had made a formal complaint and felt it unlikely they would ever need to. They said they could raise any concerns they had informally with staff or the registered manager and were confident it would be sorted out. They confirmed there was a regular residents' support forum where issues could be raised and questions asked. In the PIR, the provider recorded six written complaint being received in the previous 12 months, which was resolved within 28 days in line with the complaints policy. Over the same period the provider recorded eight written compliments.

Good

Is the service well-led?

Our findings

People said they had confidence in the current management. Whilst they were aware of meetings held periodically to discuss the service, they preferred and were more likely to discuss any concerns or seek any information informally with the registered manager, senior staff or care staff.

Relatives told us they were free to discuss their relative's care and provide feedback to care staff or the registered manager. Some of the relatives who contacted CQC had specific issues with the service, principally about staffing levels. They confirmed the local management were approachable even where they remained concerned about staffing and some elements of their relative's care.

The registered manager had for a period, been providing management support to another Sunrise home which was between registered managers. Relatives in particular welcomed the fact they were now able to concentrate fully on Sunrise Beaconsfield. People were positive about the leadership of the registered manager and told us they were "approachable."

Staff said they were well-supported and had the opportunity to discuss any issues with their line manager or the registered manager formally or informally. One member of staff said the home was "An open and caring environment", they said; "I feel the manager is available and I can raise concerns and I am listened to". Another member of staff said; "I have had fantastic support from the manager." One staff member spoke very positively about their quarterly one to one supervision sessions which they said were helpful and included; "Goals for the future."

In the PIR the service confirmed there was an annual staff survey to obtain feedback more formally from staff. We found that formal meetings for staff had not been held as regularly as was intended due to changes in staff. This was being addressed and we were told these would be held monthly in future. Those minutes we did see included discussion on staffing and recruitment and the need to report changes in people's care needs. As a result of comments made the eating arrangements for people who required support with meals had been moved so as to be included with those who did not.

Staff were able to identify the values of the organisation. "To preserve dignity, encourage independence, show respect and nurture spirit." They told us these were discussed at their appraisal meetings. In the PIR and in conversations with staff we were given details of staff awards processes; for example 'Heart and Soul' awards which rewarded and recognised good practice.

There were systems in place, for example, to monitor and record the administration of medicines and maintenance of equipment, including call bells and fire alarms. This helped ensure any safety or maintenance issues could be promptly identified and addressed. We discussed maintenance with a senior member of the maintenance team. They confirmed there was a system of monitoring in place for premises and equipment and confirmed any reasonable request for new equipment had always been agreed.

The PIR had been completed appropriately and returned promptly. This showed the provider was aware of and met their responsibility to report and respond to information requests in line with their requirements of their registration with CQC.

The PIR gave details of how the service worked closely with community health and social care services. Through their regional and national structure, the service took part in national and local initiatives from time to time and sought ways to; "Further enhance service delivery and quality of care" on the basis of best practice and research, for example pain relief in dementia. Staff confirmed they had very positive relationships with community health and social care staff who provided support to people within the service.

There was a system in place for the reporting and recording of incidents and accidents. The CQC had been appropriately informed of any reportable incidents as required under the Health and Social Care Act 2008.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services Which corresponds to Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2014 Dignity and Respect. The registered person must, so far as reasonably practicable, make suitable arrangements to ensure the dignity, privacy and independence of service users. People's dignity was compromised during the provision of care and support. Regulation 17(1)(a) The registered person must treat service users with consideration and respect. People were not consistently treated with consideration and respect in the way their care and support were provided. Regulation 17(2)(a)