Parkview Care Homes Limited

Asher Nursing Home

Inspection report

33 Wilbury Gardens
Hove
East Sussex,
BN3 6HQ
Tel: 01273 823310
Website: www.macleodpinsentcarehomes.co.uk

Date of inspection visit: 10 & 11 December 2015
Date of publication: 10/02/2016

Ratings

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

Overall summary

We inspected Asher Nursing Home on the 10 and 11 December 2015. Asher Nursing Home is a mental health nursing home providing care and support for people living with enduring and complex mental health needs. The home can accommodate up to 17 people. On both days of the inspection, 15 people were living at the home. The age range of people varied between 35 – 86 years. Predominately people required support with their mental health; support was also needed in relation to diabetes, pressure care and physical disability.

At our last two inspections in June and July 2015, breaches of legal requirements were found and we took enforcement action against the provider. We issued warning notices in relation to person centred care, safe care and treatment and good governance. Requirement actions were served in relation to need for consent, safeguarding service users from abuse and improper treatment and nutritional needs. The provider wrote to us to say what they would do to meet legal requirements of the Health and Social Care Act 2008 (Regulated Activities)

Summary of findings

2014. After our last inspection in July 2015, Asher Nursing Home was placed into special measures. This inspection found that there was enough improvement to take the provider out of special measures.

We undertook this unannounced comprehensive inspection to check that they had followed their action plan and to confirm that they now met legal requirements. We found improvements had been made with some areas. However there remain some areas that are yet to be fully addressed and some new concerns relating to the management of medicines.

Accommodation was provided over three floors with a lift and stairs connecting all floors. Located in Hove, the home provides access to the city centre and seafront. There is good access to public transport. During the course of the inspection, people were seen coming and going, going out to see friends, shopping, meeting family, having family visit or going out in local taxi's.

A registered manager was not in post. A manager was in post, who was not yet registered with the Care Quality Commission. 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 and associated Regulations about how the service is run.

People received their medicines on time and medicines were stored in line with legal requirements. However, new concerns were identified in relation to the management of as required' (PRN) medicines which placed people at risk of them not receiving their medicines in accordance with the prescribed guidance.

An activity timetable was now in place but further work was required to ensure people received meaningful activities and the risk of social isolation was minimised. One person told us, "All I do is drink tea and smoke. That isn't an existence; I might as well be dead. There are no activities here." We have therefore identified this as an area of practice that requires improvement.

Care plans and risk assessments had been reviewed and updated to provide robust guidance for staff to follow. Care plans also now included information on the person's life history and were written from the perspective of the person. However, care plans continued to lack guidance on how to support people to meet their individual goals, what their aspirations were or how to build on their strengths. It was not always clear what the person's goal was and if staff were engaging with the person to promote their independence and support them to move on.

Slight improvements to the home's quality assurance framework had been made; however, the provider lacked oversight of incidents and accidents. Incidents and accidents were not monitored for any emerging trends, themes or patterns. We have identified this as an area of practice that requires improvement.

People and staff commented that the variety and quality of food had improved. One staff member told us, "The variety of food is better, more vegetables and people are trying to eat more vitamins." Although improvements to the quality of food had been made, the management team and staff lacked oversight of people's weight. Various recording systems made it hard for management to strategic oversight of people's weights and monitor for any weight loss or weight gain. Guidance documented in people's nutritional care plans were not consistently embedded into practice. We have identified this as an area of practice that needs improvement.

Further work was required to ensure people's nursing care needs were effectively met. Staff recognised that Asher Nursing Home was a nursing home and therefore they should be providing nursing care, however, staff lacked an understanding of basic nursing care, such as ensuring the setting of people's air flow mattresses were correct. We have identified this as an area of practice that needs improvement.

Mental capacity assessments were now completed in line with legal requirements. Consideration had been given to whether people were deprived of their liberty under the Deprivation of Liberty Safeguards (DoLS). Where restrictive practice was taking place, clear documentation was in place.

Staff spoke highly of the changes made since the last two inspections and of the new manager. One staff member told us, "There's improvement to staff morale and the new manager appears to be very good. She took time to speak with staff one to one to see whether we felt supported and what could be done which was great."

Summary of findings

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

Asher Nursing Home was not consistently safe. Improvements had been made from the last inspection, and based on the evidence seen we have now revised the rating for this key question to 'Requires Improvement'.

Not all stock levels of medicines were being safely managed. Risk assessments were in place which provided staff with the guidance they needed to help mitigate risks. However, some risk assessments required updating.

The temperature of hot water was now safely managed. The management of self-neglect was being addressed.

Recruitment systems were in place to ensure staff were suitable to work with people.

Is the service effective?

Requires improvement

Asher Nursing Home was not consistently effective. Improvements had been made from the last inspection, and based on the evidence seen we have now revised the rating for this key question to 'Requires Improvement'.

The provider lacked clear oversight of people's weight. Recording was not clear and often contradictory. Guidance documented in people's nutritional care plans was not yet embedded into practice and on-going improvement were required to ensure people's nursing care needs are effectively met.

The requirements of the Mental Capacity Act (MCA) 2005 was now being met. People had been assessed under the Deprivation of Liberty Safeguards (DoLS) and where restrictive practice was taking place, clear documentation was in place.

Is the service caring?

Requires improvement

Asher Nursing Home was not consistently caring. The ethos of goal setting and rehabilitation was not fully embedded into practice. Further work was required to support people to build on their strengths and promote goal setting whilst living with an enduring mental health need.

The staff embedded an ethos whereby personal space was respected and staff always gained consent before entering someone's bedroom. The balance between safety and autonomy was also respected.

Mechanisms were also in place to involve people in the running of the home.

Is the service responsive?

Requires improvement

Asher Nursing Home was not consistently responsive. Further work was required to ensure activities were meaningful and stimulation was provided for people.

Summary of findings

Care plans had been reviewed and updated to reflect people's life history. Staff felt team work and communication within the home had improved.

People's concerns and complaints were investigated, responded to promptly and action taken.

Is the service well-led?

Asher Nursing Home was not consistently well-led. The provider lacked oversight of incidents and accidents. Incidents and accidents were not monitored for emerging trends, themes or patterns.

Staff spoke highly of the new manager and the changes made since the last two inspections. Staff felt that morale had improved along with team-work.

The provider recognised that on-going work was required to make the necessary improvements.

Requires improvement

Asher Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We visited the home on the 10 and 11 December 2015. This was an unannounced inspection. The inspection team consisted of three inspectors.

During the inspection, we spoke with seven people who lived at the home, four care staff, two registered nurses, two chefs, deputy manager, manager and the regional manager via email after the inspection. Before our inspection we reviewed the information we held about the home. We considered information which had been shared with us by the local authority and looked at safeguarding concerns that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also contacted the local authority to obtain their views about the care provided in the home.

Before the inspection, the provider completed a Provider Information Return (PIR). A PIR 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 used the PIR to help us focus on specific areas of practice during the inspection. We also used the provider's action plan to help inform and aid our inspection.

We looked at areas of the building, including people's bedrooms, the kitchen, bathrooms, and communal areas. Due to the mental health needs of people, we also spent time observing care practice in the communal dining room/lounge and sitting interacting with people. During the inspection we reviewed the records of the home. These included staff training records and policies and procedures. We looked at ten care plans and risk assessments along with other relevant documentation to support our findings. We also 'pathway tracked' people living at Asher Nursing Home. This is when we looked at people's care documentation in depth and obtained their views on how they found living at Asher Nursing Home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Requires improvement

Is the service safe?

Our findings

At our last inspection in June 2015, the provider was in breach of Regulations 12 and 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because risk assessments were poor and lacked sufficient guidance on how to safely and effectively manage people's physical and verbal aggression. Clear management plans were not in place when people had a history of sexualised behaviour towards staff. Hot water within the home was exceeding the recommended temperature and was placing people at risk of accidental scalding. Management plans were not in place to manage the risk of people self-neglecting.

Due to the concerns found at the last inspection, people were at significant risk of not receiving safe care and the delivery of care was inadequate. An action plan had been submitted by the provider detailing how they would be meeting the legal requirements by October 2015. At this inspection, improvements in some areas had been made; however there are still areas of practice that require improvement.

At our last inspection in June 2015, we raised concerns regarding PRN (as required medicines) protocols; this was because guidance was not in place on the steps to take before administering the PRN medicine. We asked the provider to make improvements in this area. Some people were prescribed anti-psychotic PRN medicines. PRN medicines can be prescribed for people with mental health needs to manage levels of anxiety, behaviour that challenges or periods of anxiousness. PRN medicine should only be offered when symptoms are exhibited. Clear guidance and risk assessments must be available on when PRN medicine should be administered and the steps to take before administering it. PRN protocols were now in place. For example, the PRN protocol for one person included offering a milky drink, having a chat, then if this failed to give them a sleeping tablet. Individual Medicine Administration Records (MAR charts) indicated that most people were not regularly administered their PRN medicine. However, we found one person had been given their PRN medicine every night for the last month, instead of only when it is required. The purpose of the PRN medicine was to help with their agitation. The MAR chart did not consistently record why the PRN medicine was administered every night. Daily notes and handover documentation failed to record that if the person had been agitated and required their PRN medicine. We asked a member of the management team why the person was requiring their PRN medicine so frequently. Management were also unaware that the person was being administered this medicine has it had not been handed over from night staff. We brought this to the attention of the management as there was a risk that the person was receiving their PRN medicine inappropriately.

Some people were known to return to the home under the influence of alcohol. There care plan clearly identified that if the person was to return to the home under the influence, for their medicines to be withheld. The care plan for one person who was diabetic and often returned under the influence noted for staff not to assume they were under the influence as they may be experiencing high or low blood sugars instead. Documentation confirmed that when people were returning under the influence, their medicines continued to be administered. The daily notes for one person on the 4 December 2015 recorded, '(Person) came back looking wet from the rain. They seemed intoxicated. They were polite in mood. Had their meds and went to bed." The daily notes for another person on the 9 December 2015 recorded, 'Last night (person went out at around 22.00pm coming back at 00.00am seemingly intoxicated, they were rude to staff, using inappropriate language. They went to their room to sleep for a few hours before returning downstairs for a smoke. They accused me of calling them a scumbag; I don't know why they thought this. They were acting somewhat paranoid.' The MAR chart for this person on the 9 December 2015 documented that at 22.00pm they were administered their PRN anti-psychotic medicine. However, the daily note made no reference to the person presenting as agitated before they went out or administering the medicine when they returned under the influence.

Medicines were stored safely. There was one dedicated locked clinical room which was appropriately equipped so that medicines could be kept safely. Medicine fridges were maintained and kept at a recommended temperature. Extreme temperatures (hot and cold) or excessive moisture causes deterioration of medicines. Documentation confirmed the temperatures of the fridge and clinical room was checked on a daily basis and were consistently within the recommended limits. Most medicines were dispensed from the pharmacy in a blister pack (medicines stored in a weekly pack). However, some medicines were dispensed directly from original boxes. The provider had implemented

Is the service safe?

a balance check sheet to record the running stock level balance of such medicines). However, this was not consistently completed or accurate. For example, staff had recorded they had 85 tablets in stock of a person's pain relief tablet, but we counted 90 tablets. Another person's stock balance sheet for their anxiety PRN medicine stated there was 47 in stock, but we counted 46 tablets,. Another person was prescribed a strong pain relief as PRN, we counted they had 68 tablets in stock; however, this was not recorded on their MAR chart or the balance check sheet. Therefore there was no oversight or awareness of how much should be in stock and what was actually in stock. Robust stock monitoring is required to ensure that all medicines are accounted for, reduce potential for misappropriation and to ensure and medicines do not run out.

Due to poor management of PRN medicines and inaccurate records of stock levels, we have identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) 2014.

Risk assessments and risk management is an integral part of good quality mental health care. Risk management involves developing flexible strategies aimed at preventing any negative event from occurring or, if this is not possible, minimising the harm caused. All risk assessments had been updated and reviewed to provide guidance for staff members to follow. Where people had a history of sexualised behaviour towards staff and members of the public, clear management plans were now in place, For example, one person had to be monitored during certain hours of the day and were to remain in the home or garden during those hours due to incidences in the past. Guidance was also in place that if the person made inappropriate sexual remarks, staff were to inform them that those remarks would not be tolerated and to inform the person that they have the option to contact the police. Staff members demonstrated firm awareness of the measures required as part of the risk assessment. One staff member told us, "There are certain times according to the care plan they are not allowed outside on their own. We just need to maintain where they are during those times."

On a daily basis, staff members recorded how people presented (daily notes). One person's daily notes documented that their behaviour in recent weeks had escalated with inappropriate sexual behaviour and comments towards staff and had also disclosed they were in love with a member of staff. Documentation also noted they had made sexual comments about other people living at the home. The person also spoke openly to the inspection team about their love for a staff member. Their risk assessment and care plan identified they had exhibited inappropriate sexual behaviour. The management plan included for female staff to assist with personal care or two male staff. However, guidance was not available on what staff should do in the instance their behaviour was inappropriate to ensure all staff were responding consistently. There was also no management plan on how to safely manage the disclosure of their feelings towards. We have therefore identified this as an area of practice that needs improvement in order to provider more consistent guidelines

Clear guidance was now in place for when people exhibited physical and verbal aggression. Each care plan included a 'managing challenging behaviour' risk assessment which included step by step guidance on how to de-escalate challenging behaviour. For example, one care plan included guidance on how to safely intervene if staff noticed the person enter into a crisis. Guidance included Where the risk of violence was identified, guidance was in place for staff to follow which included, 'Take a position just outside my personal reach (out of arm's reach) on the non-dominant side, keep me in visual range and if other residents are in the vicinity, ask them to leave the room to decrease the distractions and protect my dignity.' Robust guidance was therefore in place to ensure all staff were consistently following the same agreed strategy.

At the last inspection in June 2015, the risks associated with self-neglect had not adequately been addressed. Self-neglect was a challenging area of practice, as staff had to balance the rights of the person against their right to self-determination. A failure to engage with people who are not looking after themselves, whether they have mental capacity or not, can have serious implications for the health and well-being of the person concerned. In April 2015, self-neglect was identified as a safeguarding concern. The last inspection found care plans and risk assessments failed to identify when a person's self-neglecting would have met the threshold for safeguarding and there was little evidence of consultation with other professionals. Improvements to the management of self-neglect had been made. Under the Care Act 2014, safeguarding concerns had been raised for those who self-neglected their personal care needs. Input from healthcare

professionals had been sourced and multi-professional meetings had been held. Clear guidance was now in place for the management of self-neglect. For example, one person had a history of self-neglecting, guidance now included for staff to inform the person that if they refused personal care, they would not be allowed to use the home's mini-bus and would be unable to visit their relatives. This agreement had been in partnership with the person, staff and healthcare professionals.

Staff members and the management team told us that most people living at Asher were at risk of self-neglecting. A member of the management team told us, "Apart from one person, everyone else, wouldn't shower or change their clothes, without us prompting them." A staff member told us, "We try and encourage people to change and wash their clothes." Although, it was clearly recognised by staff and the management team that people were at risk of self-neglecting without prompting from staff, daily notes made reference to people refusing assistant with personal care. For example, one person on the 30 November 2015 and 2 December 2015 refused personal care. However, documentation then failed to record if staff offered assistance again or if there refusal was taken at face value. Staff members told us they would offer assistance again and try and encourage the person to have a bath or shower. However, documentation did not reflect this to help ensure a consistent approach. We have identified this as an area of practice that needs improvement.

Safe water temperatures within care homes should not exceed 43c. Temperatures above 43c can place people at risk of scalding themselves. At the last inspection in June 2015, we found on occasions water temperatures had exceeded the safe temperature range, documentation failed to reflect what action had been taken to ensure peoples safety. Improvements had been made to the management of hot water temperatures. Water temperatures were consistently within appropriate temperature range.

Staffing levels consisted of one registered mental health nurse, three care assistants in the morning, two in the afternoon and two at night, along with the deputy manager and manager during the week. Weekends consisted of two care assistants throughout the day and night and one registered mental health nurse. Staff members felt staffing levels were sufficient but they could be stretched at times. One staff member told us, "Staffing at weekends has been reduced but some people need more support. Staffing is stretched and with mental health things can change very quickly." We asked the manager how staffing levels were calculated. The manager told us, "I feel the current staffing levels are sufficient. I don't think a dependency tool for mental health is appropriate. If more staff were needed, I would put more staff on the rota." The regional manager told us, "Staffing levels are determined not only by dependency and residency levels but also competency of staff. It was determined that with the lower residency levels and the needs of the residents in the home at the time, that it was safe to reduce staffing levels at weekends as the home is much quieter during these times. If a crisis happens at the weekend, our sister home (home next door) has enough staff on duty to offer assistance and there is always a senior member of staff and or a manager available to attend the home if needed."

During our inspection, our observations found that people were not placed at risk due to insufficient staffing. However, it was clear as identified by staff that people's needs and presentation could change rapidly. For example, one person became increasingly agitated regarding their lack of cigarettes. They then started verbally abusing staff. Staff reacted promptly, however, the incident involved three members of staff engaging with the person and de-escalating the situation. The incident demonstrated how staff clearly understood how to de-escalate the situation. However, we queried what would have happened if this incident occurred at the weekend, when only one registered mental health nurse and two care staff would be available. We also queried at weekends, if someone wanted to go out and needed staff support that would only leave one staff member and the registered mental health nurse. If the nurse was assisting with medicines, that would only leave one staff member to 14 people. Although management told us that staffing levels were determined by the needs of people, documentation was not in place to demonstrate how the needs of people were assessed and contributed to the assessment of staffing levels. We have therefore identified this as an area of practice that needs improvement.

Staff recruitment records showed appropriate checks were undertaken before staff began work. Disclosure and Barring Service checks (DBS) had been requested and were present in all records. Staff confirmed these checks had been applied for and obtained prior to commencing their employment with the service. Staff files contained evidence

Requires improvement

Is the service safe?

to show where necessary; staff belonged to the relevant professional body. Documentation confirmed that all nurses employed by Asher Nursing Home, bank nurses as well all had registration with the nursing midwifery council (NMC) which were up to date.

Requires improvement

Is the service effective?

Our findings

At our last inspection in June 2015, the provider was in breach of Regulations 11 and 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because mental capacity assessments were not completed and consideration had not been given as to whether people were deprived of their liberty under the Deprivation of Liberty Safeguards (DoLS). Following our inspection in June 2015, we received information of concern relating to poor management of people's nutritional and healthcare needs. We therefore undertook a focused inspection in July 2015, where the provider was found to be in breach of Regulation 12 and 14. This was because the management of people's diabetes was poor and people's nutritional needs were not adequately managed.

Due to the concerns found at the last two inspections, people were at significant risk of not receiving effective care and the delivery of care was inadequate. An action plan had been submitted by the provider detailing how they would be meeting the legal requirements by October 2015. At this inspection, improvements in some areas had been made; however there are still areas of practice that needs improvement.

People and staff commented that they had noticed improvements to the quality of food. One person told us, "The food is good, really nice." Another person told us, "I really like the food, it's very good." One staff member told us, "We've improved the food, it's very good now and the residents are happier." Another staff member told us, "The variety of food is better, more vegetables and people are trying to eat more vitamins." On the first day of the inspection, the home had a food delivery; the deputy manager showed us that they now ordered fresh fruit, vegetables and now ensure all meals are made from fresh ingredients, reducing the number of ready meals used. We also checked the fridge and found plenty of fresh ingredients available.

At the last inspection in July 2015, we found that where people were losing weight, robust action was not always taken. Consideration had not been given to fortified diets or sourcing specialist cutlery. Where people required a soft diet, robust guidance was not always in place. Improvements had been made but areas for improvement remain.

Staff and management lacked clear strategic oversight of people's weights. People's individual weights were recorded in various places, for example on the home's electronic system and on various pieces of paper. However, the weight records did not match. For example, one piece of documentation from December 2015 recorded that one person had lost 12kg since September 2015. Due to that amount of weight loss, we asked staff for the person's other weight records to demonstrate how it was assessed that they had lost 12kg. The person's monthly weights since September 2015 could not be located. A staff member told us, "The person usually refuses to be weighed every month, so I'm not sure where this staff member has got this calculation from." Subsequent to the inspection, the regional manager informed us that they had explored this and confirmed the person had not lost 12kg. Another person's weight records noted that in October 2015 they weighed 113.2kg. In November 2015 their weight was recorded as 121.5kg, a gain of 8kg. A significant amount of weight to gain in a month. However, documentation on another sheet of paper in December 2015, noted the person weighed 114.3kg in December 2015. Therefore, documentation reflected this person had gained 8kg one month, and then lost 7kg the next month. We found this to be a consistent theme across the documentation, weight records varied on the different documentation they were recorded on. We therefore queried how the management team and staff had clear oversight of people's weight and were able to take action when people had lost weight. The manager agreed that the current system was not fit for purpose and failed to provide oversight. We have therefore identified this as an area of practice that needs to improvement.

From the documentation and talking to staff, we did not identify any concerns that people were losing weight. The management team confirmed that where necessary people had been referred to the dietician and Speech and Language Therapist (SALT). People now had an individual nutrition care plan which included guidance on how to effectively manage their nutritional needs. For example, one person's nutrition care plan identified they sustained a very high empty calorie intake diet due to the large amount of sugar they digested. Input from the dietician included, three main meals daily with snacks in between and to try and lose five to ten percent of their body weight. To meet the dietician's recommendation, the care plan included guidance such as 'non-nutritive sweetener to be used

instead of sugar. Healthy snacks to be offered and encouragement of adapted cutlery.' Another person's nutrition care plan identified they may only eat certain foods such as jacket potato and chips with a choc ice for dessert. The care plan included guidance on how staff could effectively support the person to remain at a stable weight and also put more weight on. This included fat, cream and extra protein to be added to their meals and for the person to weighed weekly.

We found however, what was recorded in the person's care plan was not consistently embedded into practice. For example, we asked the chef if they fortified any of the food for people, which they replied no. However, one person's care plan identified for fat, cream and extra protein to be added to their meal. Another person's care plan identified they could only eat with one hand and required specialised cutlery which they did not always engage with. The chef on the first day of the inspection also advised us that this person required a soft diet. We spent time sitting with this person at lunchtime. They spoke highly of the food but they were struggling to cut up the lasagne and chips. They ate a couple of the chips whole and then left the rest of the chips. A staff member did ask if they required any assistance, but instead of offering to cut up their food, they pulled back the pasta (lasagne sheet) on the person's plate, so the person could easily eat the mince. Documentation confirmed this person had not lost weight recently but our observations at lunchtime demonstrated that staff failed to engage with this person to cut their food up, so they could eat independently with their adapted cutlery. On both days of the inspection, we also received contradictory information from the chefs. On the first day of the inspection, the chef told us that three people required a soft diet. Whereas on the second day of the inspection, another chef told us that only one person required a soft diet (as it was their preference as they had no teeth). We therefore raised concerns regarding the contradiction between the two chefs and whether therefore people were receiving the necessary diet.

At the last inspections in June and July 2015 we raised concerns regarding the management of diabetes. This was because guidance was not in place on how to manage people's diabetes safely and people's blood sugars not being checked. Documentation confirmed that the management team had sourced input from people's individual GPs about when people's blood sugars should be checked. One person's care plan included guidance that their blood sugar should only be checked if they presented as unwell. Where required, people also had diabetes care plans and risk assessments. Care plans considered how the person's diet interacted with the diabetes along with their mental health needs. For example, one person's care plan identified that the person was over-weight which impacted upon their diabetes. It was also identified that due to the person's mental health, their delusions may affect them from understanding their diabetes and not agreeing with meal choices. Guidance was in place which included for the person to eat a well-balanced diet along with eating more fresh vegetables and to offer low fat options such as boiled potatoes instead of chips and boiled egg rather than fried egg. Although nutritional and diabetes risk assessments were in place for the effective management of diabetes, the guidance recorded in the risk assessments was not consistently embedded into practice. For example, on the first day of the inspection, the person was sitting with a large plate of lasagne and chips rather than boiled potatoes. Documentation failed to reflect whether the person preferred chips that day instead of boiled potatoes. The chef was also unable to advise whether the person chose chips instead of boiled potatoes.

Our observations and from talking to staff it was clear that actions had been taken to address the concerns from the last inspection regarding diabetes. One staff member told us, "For those who are diabetic, we are quite careful with food. We try and encourage sweeteners." However, the good practice identified in care plans regarding people's nutritional needs and diabetes was not yet consistently embedded into practice. We therefore identified this as an area of practice that needs improvement.

Asher Nursing Home is registered to provide nursing care to people and at the last inspection in July 2015, concerns were raised that people's healthcare needs were overlooked. Following the inspection, the provider informed CQC, that a registered nurse had been recruited to work 18 hours a week to focus on the general nursing care needs of people. On the day of this inspection, we were informed that this nurse had not yet been recruited. The action plan submitted by the provider also identified that staff would receive training on nutrition and well-being, weight monitoring, identifying those at risk of malnutrition, those with diabetes and other health related issues. The action plan identified staff would receive this training in October 2015. We asked staff if they had received any training since July 2015, staff commented they were

unable to recall any training. One staff member told us, "Not that I can remember, I had moving and handling but that was before July." Training schedules confirmed that only a handful of staff had received training in nutrition and well-being. The manager told us that additional staff will be sent on the course and that 'swallowing awareness' training had been booked for early 2016. However, it was not consistently clear what action had been taken to ensure people's nursing care needs were being met, assessed and recognised.

Staff members demonstrated a firm awareness that the service was a nursing home. One staff member told us, "We are supposed to be a nursing home but are we meeting those nursing needs." One staff member told us how the little things were not always recognised, such as the glasses of juice on the tables. They told us that these were too heavy for the older 'residents' to pick up but if it hadn't have been for their observation, would this have been noticed, despite the home being a nursing home. We were informed that two people had a profiling bed in place. A member of the management team told us, "The previous manager sourced the profiling beds as preventive measure to reduce the risk of skin breaking down. The two people that have the profiling beds have reduced mobility." We checked one profiling bed and found it included an air flow mattress. For people sleeping on an air flow mattress, it is important that the setting of the air mattress matches the person's weight. Otherwise, it may increase the risk of a person sustaining skin breakdown. Staff however, were unaware that the mattress was an air flow mattress and therefore were unaware of the importance of ensuring the mattress was on the right setting. As staff were unaware of the importance of ensuring the mattress was on the right setting, there was no clear guidance in the person's care plan. A skin integrity risk assessment was in place which identified that the person experienced urinary incontinence and severe arthritis which heightened their risk of skin breakdown. However, the risk assessment failed to identify that the incorrect setting on the air flow mattress could heighten the risk of skin breakdown.

We were informed that no one was experiencing any skin breakdown; however, the provider and staff had failed to recognise how a piece of equipment could place a person at risk and therefore failed to act upon the nursing care needs of some people. We have therefore identified this as an area of practice that needs improvement.

At the last inspection in June 2015, the requirements of the Mental Capacity Act 2005 (MCA) were not being met and consideration had not been given as to whether people were deprived of their liberty under the Deprivation of Liberty Safeguards (DoLS). Improvements had been made and the provider is now meeting the requirements of Regulations 11 and 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The Mental Capacity Act (MCA) 2005 was designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. The philosophy of the legislation is to maximise people's ability to make their own decisions and place them at the heart of the decision making. Mental capacity assessments were now completed which considered specific decisions and were completed in line with legal requirements. People, where appropriate, were also assessed in line with the Deprivation of Liberty Safeguards (DoLS) as set out in the Mental Capacity Act 2005 (MCA). DoLS is for people who lack the capacity to make decisions for themselves and provides protection for people ensuring their safety and human rights are protected. The manager told us, "We made applications, but some came back just as restrictive practice and identified that the person's liberty was not restricted." Where restrictive practice was taking place, such as withholding of cigarettes or money, best interest checklists were in place which considered the 'proposed intervention, what is the benefit/justification for the intervention, potential risks and if least restrictive options had been considered.' For example, one best interest checklist considered whether and explored the restrictive practice of withholding someone's cigarettes. The checklist identified that to reduce risk of fire in the home and to reduce the risk of behaviours that challenge when the person exhausts their supply of tobacco, the benefit would be to withhold their cigarettes. The potential risks were the person may become distressed or agitated in they were unable to get a cigarette when they wanted one. The mental capacity assessment identified that the person lacked capacity to make this decision; therefore it was agreed in their best interest for this restrictive practice to take place.

Staff members demonstrated a strong awareness of restrictive practice and could tell us whose cigarettes or money was withheld. One staff member told us, "We keep two people's cigarettes as this has been agreed in their best interest. One person would smoke one after the after then

Requires improvement

Is the service effective?

harass others for cigarettes. We now give them one an hour." Another staff member told us how restrictive practice was utilised for withholding of cigarettes, money and occasionally personal care.

Requires improvement

Is the service caring?

Our findings

At our last inspection in June 2015, the provider was in breach of Regulations 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because people were not involved in the formation of their care plan and goal setting was not utilised to support people to move on.

Due to the concerns found at the last inspection, people were at risk of receiving care that was not caring and we asked the provider to make improvements. An action plan had been submitted by the provider detailing how they would be meeting the legal requirements by October 2015. At this inspection, improvements in some areas had been made; however there are still areas of practice that require improvement.

At the last inspection in June 2015, people were not actively involved in contributing towards their care plans. People were also unaware they even had a care plan. At this inspection, we found improvements had been made with on-going areas for improvement. Care plans had been reviewed and the majority of the care plans were now written from the perspective of the person. One person's personal care plan was written from the perspective of how they wished things to be done. For example, 'Staff to support me to take a shower each day. Staff to encourage me to choose my toiletries, grooming items and clothing prior to going into the shower room. My delusions often delay me in starting my personal care and staff should keep me on track by repeating and explaining what needs to be done and why.' Care plans also now included key information about the person, such as, 'what do people like and admire about me?' 'How best to support me?' and what 'Is important to me.' For example, one person commented that what most people liked and admired about them was there good sense of humour, that they were caring, honest and assertive. Staff spoke highly of the changes to the care plans. One staff member told us, "The nurses and managers used to write the care plans but we as carers are now getting more involved which is a good change."

People were not consistently aware of their care plan. One person told us, "I think I have a care plan." Another person told us, "I'm not too sure; I think I've heard of it." Although people were not consistently aware of their care plans, documentation demonstrated that staff had spent time getting to know people, ascertaining key information and utilising this information to aid the formation of the care plan.

Goal setting in mental health is an effective way to increase motivation and enable people to create the changes they desire. It also helps actively involve people and enable them to express their own views and goals. At the last inspection in June 2015, we found people's individual goals were not always pertinent to them or set by them. Documentation also failed to reflect if the person had met their goal or if further work was needed in order for them to achieve the goal. It was not clear the progress the person was making. Some improvement had been made but not sufficient improvement to meet the breach of regulation. Care plans still lack guidance on what people's individual goals were and what people were working towards. The management team told us that they had identified some people who they felt could move on from Asher Nursing Home. One person was going to the care home next door to learn to cook independently. Another person had also started recently going next door to participate in the cooking sessions. The manager also told us of one person who they felt could move onto other accommodation such as sheltered accommodation or back to their own home. The management team also identified that due to the age and complexity of some people's mental health needs, they would be unable to move on from Asher.

Guidance produced by Social Care Institute for Excellence documents that, 'Recovery' and well-being approaches to mental health issues developed by younger adult service users and working-age mental health services are equally applicable to older people. 'Recovery' does not imply 'cure', but builds on the personal strengths and resilience of an individual 'to recover optimum quality of life and have satisfaction with life in disconnected circumstances'. Many people living at Asher Nursing Home had been living there for many years and were now reaching their 60s, 70s and 80s. Although it was identified that some people would be unable to move on from Asher Nursing Home, care plans continued to lack information or guidance of any goals they wanted to achieve whilst living at Asher Nursing Home, such as manage their own laundry, make their own bed or self-administer their medicines. There was also a lack of guidance of how staff built and developed people's personal strengths or supported people to achieve goals whilst living with an enduring mental health illness. From

Is the service caring?

talking with staff and the management team, it was clear that they wished to have a greater focus on rehabilitation and working with people to support them to move on. A few care plans had been updated and included a move on/ discharge care plan. For example, one person's move on care plan identified they had expressed a wish to eventually live back in their own home. To help achieve this goal, the actions included, '(Person) to make their own bed and tidy their room. To work on their own laundry. Referral made to START (organisation to help people move on) and to begin cooking independently'.

From talking to staff and the management team, it was clear they were working towards a model of care which focused on goal setting, rehabilitation and supporting people to move on. However, this was not yet fully embedded into practice. From talking to staff and looking at documentation, it was not consistently clear how people were involved in making decisions about their care, what their goals and aspirations were and how they were actively involved and empowered to contribute to their care plan and goal setting. Further work was therefore required to ensure people's individual goals and aspirations were understood, detailed in their care plan and staff actively supported them with achieving those goals. This is therefore a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Asher Nursing Home adopted an ethos whereby people's bedrooms were their own personal space. Many people living at the service had previously been homeless, spent months in hospital or not had their own space. Staff recognised the importance of empowering people to treat their bedrooms as their own and respected people's personal boundaries and space. Throughout the inspection, we observed staff knocking on people's doors and gaining consent before entering. Although staff recognised that importance of personal space, staff also balanced this with people's safety. Staff told us that since the new manager had been in post, additional safety checks had been implemented to ensure the safety of people and also minimise any smoking related incidences. Staff recognised that balancing autonomy with safety was important but recognised it was important to achieve a balance. Therefore people were checked upon hourly. Staff commented that some people still continued to smoke in their bedrooms, so checking upon them hourly also reduced this risk and encouraged them to come into the communal lounge and smoke outside.

Mechanisms were in place to involve people in the running of the home. 'Resident' meetings were held as a forum to involve people and provide people with the opportunity to express ideas, raise concerns and provide feedback. Minutes from the last meeting in November 2015 documented that smoking in rooms was discussed, food along with Christmas and activities. Suggestions for the menu were noted such as pizza night, Chinese or Indian and bangers and mash. Activity ideas included entertainers, rock climbing, dart board, London lights and Royal pavilion.

Staff members confirmed visiting was not restricted; people were welcome at any time. Staff confirmed they encouraged people to maintain relationships with those who were important to them and worked in partnership with friends and relatives to promote the wellbeing of people.

We spent time with people in the communal lounge and people told us of their experiences and how they found living at Asher Nursing Home. One person told us, "I like living here." Another person told us, "I like having my own room." Staff spoke highly of the people they supported and it was clear staff had spent considerable time getting to know people, their likes, dislikes and personality traits. Staff could clearly tell us about people's individual needs in detail. For example, staff told us how one person could bully another person and therefore this had been raised and identified as a factor which made the other person very vulnerable. From talking to staff, it was clear they were passionate, knowledgeable and kind. When talking to people, staff used their preferred name, maintained eye contact and used a gentle tone.

People's privacy and dignity was upheld. Staff members understood the importance of respecting people's privacy and dignity and were able to describe how they maintained people's privacy and dignity by knocking on door and waiting to be invited in. Staff told us that when they supported people with personal care, they made sure the doors were closed and curtains drawn. People were called by their preferred name and observations demonstrated that staff interacted with people in a manner which upheld their dignity.

Requires improvement

Is the service responsive?

Our findings

At the last inspection in April 2015, the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was a significant lack of meaningful activities and the delivery of care was not person centred.

Due to the concerns found at the last inspection, people were at risk of not receiving responsive care. We asked the provider to make improvements. An action plan had been submitted by the provider detailing how they would be meeting the legal requirements by October 2015. At this inspection, improvements in some areas had been made; however there are still areas of practice that require improvement.

At the last inspection in June 2015, we raised concerns regarding the lack of meaningful activities for people living with mental health and the impact this had on people. At this inspection, we found an activity timetable was in place which detailed what was happening every day. For example, activities included coffee at the local café, pamper sessions, arts and crafts, massage with masseur, computer games, board games, bingo and coffee mornings. On the first day of the inspection, a coffee morning took place. With permission, we joined people for this event. Six people gathered for the coffee morning and together they discussed Christmas and what they would be doing. In the afternoon we observed a game of dominoes and noughts and crosses between a staff member and two people. During the inspection, we spent time with people in the communal lounge. We identified that there was significant periods of time when there was inactivity and pro-longed periods where the only stimulation was the television or music playing in the background.

The management team and staff identified that engaging people can be hard. A member of the management team told us, “Often we organise things but people then don’t want to go.” On the first day of the inspection, we were informed of one person who had declined to go shopping. They then spent the day watching television in the communal lounge or smoking. Staff members were in the process of introducing therapeutic activities care plans for people. These care plans identified how best to engage with someone and promote meaningful activities. For example, one therapeutic activity care plan identified that the person rarely engaged with activities, preferring their own company, and spending most of the day in their room. Actions identified included for the person to be offered activities that might interest them. ‘Keyworker to discuss with the person a realistic programme of achievable activities.’ We found people had a weekly activity timetable, however, this timetable often recorded ‘appointments’ and ‘visiting family’ for everybody as the activity for the day. Daily activities were therefore not personal to the individual.

Lack of meaningful activities can increase the risk of social isolation and further the risk of mental health needs deteriorating. During the inspection, many people spent time in their room alone or time in-between the smoking area and communal lounge. During the inspection, we heard one person say to a staff member, “All you do is work and all we do is nothing.” One person told us, “All I do is drink tea and smoke. That isn’t an existence; I might as well be dead. There are no activities here.” From our observations it was clear that people spent a significant amount of their time either smoking or sitting in the communal lounge drinking tea. There were lots of interactions between people regarding the exchange and selling of cigarettes but there was very little stimulation for people to take them away from smoking. The activities we observed, such as the coffee morning and the staff member playing a game with two people, provided interaction, structure. However, the rest of the day, people were left with little stimulation.

Engagement with meaningful activities can help make people feel valued, help people develop new skills and promote their identity. For people with mental health needs, engagement with activities can provide structure and promote well-being. For people living at Asher Nursing Home, activities were not consistently based on their assessed needs or personalised to them to help promote their wellbeing. This is therefore a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At the last inspection in June 2015, care plans were not personalised to the individual Care plans had now been reviewed and included the life history of the person and provided a much clearer sense of the who the person was. Staff members spoke highly of the new care plans and the level of detail the care plans provided. Care plans now included a social history page which provided an overview of the person and their life before moving into Asher

Requires improvement

Is the service responsive?

Nursing Home. For example, one person used to be a model, while another person was a civil engineer. Although care plans had been reviewed and updated to include people's life history, information was still not available on how the person perceived their mental health, if there was any medication or treatment they would not want in the event of their mental health deteriorating. Information such as preferences is vital in recognising how people can remain in control of their life and regain a meaningful life despite living with a mental need. We have therefore identified this as an area of practice that needs improving.

Guidance produced by MIND noted that 'communication and engaging with people with mental health needs was an essential component of all therapeutic interventions.' Different systems were utilised to share information. Handovers took place between each shift. This enabled new staff coming onto shift to be aware of any concerns, if people had any appointments or people were feeling unwell. Since the last inspection in June 2015, staff spoke highly of the changes in communication. One staff member told us, "Team work and communication has improved. In terms of recording, we record a lot more now as before there was no evidence of what we were doing." A communication book was utilised to share important messages alongside a diary to record when people had appointments such as GP or optician. In people's individual care plans there was also a diary of when people last saw the GP, dentist, optician, care coordinator psychiatrist. This provided a visual overview of when people were having regular access to healthcare professionals.

There was information about how to make complaints in the form of a complaints procedure which was also contained in the service user guide. The complaints policy was also displayed in the entrance of the home. The policy contained the contact details of relevant outside agencies and the timeframe of when complaints would be responded to. Since the last inspection in June 2015, the provider had received four complaints. Information was available on the nature of the complaint, action taken and the outcome.

Requires improvement

Is the service well-led?

Our findings

At the last inspection in April 2015, the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because incidents and accidents were not monitored for emerging trends, themes or patterns. Feedback from people and their relatives was not acted upon and systems were not in place to monitor or analyse the quality of the service provided.

The concerns identified at the last inspection found Asher Nursing Home was not well-led. We asked the provider to make improvements. An action plan had been submitted by the provider detailing how they would be meeting the legal requirements by October 2015. At this inspection, although improvements had been made there remains some continuous concern.

Documentation was in place for the recording of incidents and accidents. At the last inspection in June 2015, the provider had no oversight of incidents and accidents. They were not monitored for any emerging trends, themes or patterns or how learning was derived from incidents and accidents. We found at this inspection, the provider was still not monitoring incidents and accidents for emerging trends, themes or patterns and there was a lack of oversight to help prevent further incidents and accidents. Documentation also failed to consistently reflect what action was taken following an incident and accident to reduce the risk of any further incidences/accidents from occurring. There was no investigation into what may have caused the person's behaviour which resulted in the incident occurring. For example, one incident noted that a person ran out of the home in a distressed state, they ran out onto the main road and as a car slowed down, they grabbed the window on the car and refused to let go. The incident form reflected that staff managed to get the person back inside when the person disclosed they thought a member of staff had poisoned them and that was why they were experiencing pain. Following this incident, there was no follow up of the incident to reflect what action was taken to explore the reasons for the person behaviour what further action may be required to prevent any future incidences. Staff members we spoke with confirmed action was taken but acknowledged the recording was poor.

We were only shown incidents and accidents up until September 2015. We were told that further incidences had occurred since September 2015 but the documentation had not been completed. The manager told us that most incidents and accidents were now being recorded on the home's electronic system; however, we were unable to find any recent incidents/accidents recorded on the system. We asked staff where they would be expected to record any incidents and accidents and what they would classify as an incident and accident. Staff told us that any altercations between people and staff would be seen as an incident. On the first day of the inspection, we observed an altercation between two people and a staff member. One person involved was becoming very agitated and verbally abused the staff member. The second day of the inspection, we checked what had been recorded There was no documentation making reference to the incident. Therefore the management team had no record of this incident or mechanism in place to monitor how many altercations were taking place. Documentation from the communication book in November 2015 also makes reference to the absence of an incident form when a person was found to be kicking their door. We therefore questioned how the management team had strategic oversight of incidents and accidents.

Under the Care Act 2014, Providers and managers are required to have systems and mechanisms in place to enable them to identify patterns or cumulative incidents. Mechanisms were not in place for the monitoring and auditing of incidents and accidents. The manager told us, "This is something we plan to start doing in the New Year." However, in the interim it was not clear what oversight was in place.

Since the last inspection in June 2015, the provider had implemented a quality assurance framework based around the Care Quality Commission's five key questions, is the service safe, effective, caring, responsive and well-led. The audit considered each key line of enquiry and then the additional prompts under the key lines of enquiry. For each key line, the audit considered whether they were meeting it, what they did well and what the service could do better. For example, under well-led, the audit had identified that staff meetings, handovers, supervisions, appraisals and surveys demonstrated how people and staff were actively involved in developing the service. What could the service do better to involve people and staff, the audit identified that they could have more meetings. However, where the

Is the service well-led?

audit identified what improvements could be made, it failed to provide an action plan or a date for completion. Therefore it was not clear how the provider was continually monitoring and improving the service.

Due to the above concerns in relation to lack of strategic oversight of incidents and accidents and the provider's quality assurance framework not being consistently robust, we have identified a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At the last inspection in June 2015, feedback from people had not been acted upon. For example, following any satisfaction surveys, where the provider had received negative feedback, no action was taken. Improvements had been made to the management of satisfaction surveys and responding to any feedback received. Subsequent to the inspection, the regional manager told us how all satisfaction surveys were now being managed through an external agency. The regional manager told us, "These are completed by people and family and sent directly to them. We don't actually see the feedback until it is posted on our website and we'll receive an email letting us know when feedback is being posted. It gives us the opportunity to respond directly with any issues." Following any feedback, results were then analysed and an overview was then displayed informing people of the results. For example, a recent food satisfaction survey found that most people had noticed an improvement to the quality of food. The survey also found that everyone was happy with the choices on the menu.

A new manager was in post but they were not yet registered with the CQC. They had been in post for two months and advised they would be submitting their application to become a registered manager shortly. The management structure consisted of the manager, deputy manager and a regional manager. Staff spoke positively of the management structure and felt there was always someone from the management team available to talk to. Since the last inspection in June 2015, it has been debated what the ethos and purpose of Asher Nursing Home is. It has been debated with the provider whether the ethos of the home is to provide a home for life whereby people's mental and health care nursing needs can be met or whether its aim is to support people to regain their independence and move on to a more independence lifestyle. Since the inspection, the provider and management team have spent time considering the ethos and philosophy of the home and what ethos they wish to adopt. The manager told us, "I see a lot of potential here and I really want to focus on recovery work and rehabilitation with people. The long term plans may be considering having different floors of the home for different purposes. One floor could be the rehabilitation/ rehab floor, while one could be for the older people here with nursing care needs." The manager also added, "We are now working more closely with the care home next door (same provider) to share ideas, learn from one another and work more collaboratively."

Due to the complex care needs of many people living at Asher, for years, people have been smoking in the home and smoking was only banned from inside the home last year. The impact of smoking in the home has therefore left the interior and décor of the home looking tired, stained and dirty in appearance. On the days of the inspection, only one cleaner was working. Staff told us how the levels of hygiene in the home had improved recently as there had been two cleaners, but with one cleaner leaving, the deterioration could be noticed. From our observations, it was clear the environment was not mutually inclusive to mental health and supporting people with recovery work or rehabilitation. However, this was clearly recognised by the provider and an action plan had been devised which detailed what refurbishment was required to promote a more calming, stable and therapeutic environment. An action plan was in place which included what work was required. This included the implementation of a new kitchen, new chairs for the communal lounge, re-decoration of all rooms and new flooring. The action plan was detailed but lacked clear dates of when all the work should be completed.

Staff spoke positively of the changes since the last inspection in June 2015. One staff member told us, "A lot has changed, I appreciate the new manager, and she's very professional." Another staff member told us, "There's improvement to staff morale and the new manager appears to be very good. She took time to speak with staff one to one to see whether we felt supported and what could be done which was great." A third staff member told us, "We are working towards making improvements. This is hard work due to the previous culture. It takes time to change which is what everyone is working towards." The

Requires improvement

Is the service well-led?

manager told us, “The home has lacked clear leadership and direction and I want to lead by example.” Throughout the inspection, the manager was seen engaging with staff, people, attending handover and providing clear leadership.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care 9 (1) The care and treatment of service users must be – (a) be appropriate, (b) meet their needs and (c) reflect their preferences. 9 (3) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include – (a) Carrying out, collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12(2)(g) the proper and safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to – (a) Assess, monitor and improve the quality and safety of services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services).

This section is primarily information for the provider

Action we have told the provider to take

(b) Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk.