Homebeech Limited

Cherington

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on 24 and 25 September 2018 as was unannounced.

Cherington is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Cherington is registered to provide nursing care for up to 42 people living with dementia. At the time of the inspection there were 35 people living at Cherington. Accommodation is on three floors, accessed by a lift, and included shared lounges and a dining room.

At the time of the inspection the registered manager was on extended leave, and we had been notified. An acting manager was covering the role, with support from the general manager. 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.

At the last inspection on 28 July 2016 we rated the service good, but found a breach of regulation 13. This was because people's liberty may have been deprived without lawful safeguards and so we rated the key question of effective as requiring improvement. Following that inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question of effective to at least good. At this inspection these concerns had been addressed and people who needed them had capacity assessments and authorisations. However, we found breaches of other regulations.

The provider had not ensured clear management oversight of the service and good governance. The quality assurance framework was not sufficiently robust and had not identified all the issues we found during the inspection. When actions had been identified, the quality assurance process had not always ensured that these were completed. The provider had not ensured that we were notified of all incidents, which they are required by law to do. The provider had not ensured that CQC were notified about authorised deprivation of liberty safeguards. We took criminal enforcement action by way of a fixed penalty notice.

Risks about people and the premises were not always appropriately assessed, monitored and mitigated. The provider had not ensured that staff were providing support to people in line with any assessments made.

People were not always treated with dignity and respect. Staff did not always respond when people living with dementia tried to engage with them and interactions were not always explained and discussed with the person.

People's social needs had not always been assessed and planned for. Whilst some people's preferences were recorded, these were not always met. Staff's interactions with people were tasks led rather than social and person centred.

People's personal information was not always kept confidentially. Staff did not always have access to up to date information about people and the support they needed, or know where to find this information. Records were not always clear and up to date to support the delivery of safe and consistent care.

There were sufficient staff available to meet people's immediate needs. Procedures were in place to ensure safe recruitment and staff told us they were supported with supervision and training.

When people did not have capacity to make decisions, there were assessments which included their views and those of relatives and professionals, where relevant.

People were supported to access healthcare professional when they were unwell, and staff worked in partnership with other agencies.

People and relatives told us that if they raised concerns these were addressed by the staff team. We saw that complaints were responded to in a timely manner.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The premises were not always safe and suitable for people. Infection control risks were not always well managed.

Risks to people were assessed but not always followed by staff.

There were sufficient staff to meet people's immediate needs.

People received their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

People's needs and choices were not always assessed and reflective of their current needs.

People's capacity to make choices was considered and other parties involved in decision making where relevant.

Staff were trained to meet people's needs and were supported with supervision.

People were supported to access healthcare services.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with dignity and respect.

People's information was not always kept confidentially.

Visitors were welcome without restriction.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's social isolation and occupation was not consistently considered and planned for. There was a lack of meaningful engagement with people.

Complaints had been addressed and responded to.

People were supported to be comfortable at the end of their lives.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of clear management oversight.

The quality assurance framework was not robust and had not identified and addressed the concerns we found.

The service had not correctly notified us of things that had happened at the service.

Cherington

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 24 and 25 September 2018 and was unannounced.

The inspection team comprised of two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the notifications that the provider had submitted to us. These are about things the provider is lawfully required to notify us of. Due to technical problems on our part, the provider was not able to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection we talked with five people using the service and two relatives and visitors of people using the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed what happened during the day. We spoke with the acting manager, the general manager, the chef, a nurse, five care staff and one visiting health and social care professional. We reviewed a variety of records, including care records relating to seven people, six staff files and other records relating to the management of the service, such as policies and procedures, accident/incident recording, records relating to the management of medicines and records of audits undertaken.

Following the inspection, we spoke with one other professional who has contact with the service for feedback on the location to be included in the report.

Requires Improvement

Is the service safe?

Our findings

There was not an effective system in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of people.

Risks to people were assessed, but where support needs were identified, they were not always followed. For example, inspectors had to intervene to prevent possible injury when one person was being supported to move from a chair to a wheelchair. This was because the person was unsteady on their feet and the brakes had not been applied to the wheelchair. There was a potential risk that the wheelchair could move away from the person while they were transferring. Another person was being transferred from a stretcher to their bed using slide sheets. The person was calling out which staff told us was a sign they were agitated. Another person was supported to move from chair to chair by standing and transferring themselves. When we viewed the assessments of risk, all three of these people had been assessed as requiring a hoist to transfer safely. When we asked staff why they had not used a hoist for the person transferred using slide sheets, we were told that there was not enough room for both a stretcher and hoist in the person's room. No further assessments, to ensure transfers were completed safely, had taken place in light of staff not being able to follow this person's guidance for safe transfers.

The premises were not always suitable for people. One person's bedroom was 14 degrees celsius. Due to this person's health needs they were being cared for in bed. Staff had supported the person with personal care earlier in the day but had not acknowledged the room temperature or taken any actions to rectify it. We raised this with the manager who was not aware of the temperature of this person's room. The manager explained the low temperature was due to the boiler was not working properly and that it was due to be replaced. The issue with heating had been identified twenty days earlier. When we visited the person's room later in the day, the temperature had improved, as maintenance had attended to fix the boiler. However, until we raised concerns with the manager this issue had not been acted upon, despite there being known issues with temperature regulation within the service.

Infection control risks were not always well managed. We saw that in one person's room personal care was provided and the used continence pad was put in the waste bin rather than being taken to a clinical waste bin. Clinical waste bins were situated in corridors where the contents could easily be accessed by people. Therefore, there was a potential risk of people living with dementia coming into contact with items which could be harmful to their health. Following the inspection, the provider shared a risk assessment that had been completed about the clinical waste bins being situated in corridors. The provider advised us that, following the inspection, the clinical waste bins have been moved.

The key to the front door was left on a table in a communal area. There was a risk that this could be removed or mislaid by people or members of the public, some people living at the service had a history of leaving previous locations unescorted and were under Deprivation of Liberty Safeguards which included the front door being securely locked. Following the inspection, the provider shared a risk assessment which demonstrated that a keypad was also used to secure the front door, with the key being a secondary measure. However, the key had not been kept securely during the inspection. The provider could therefore

not be confident of the security of the service and people.

The provider failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of people. This was a breach of Regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by nursing staff around their skin integrity and the dressing and care of wounds. Care was provided in line with these specific assessments.

When we spoke to staff, they did not always have access to the up to date information about risks to people in their care documentation. We identified this was partially due to the accessibility of the care documentation, which we have reflected in the well-led section of this report.

There were sufficient staff available to meet people's immediate needs. People who needed support with eating and drinking received this support, and staff assisted people with moving and handling.

Staff were clear on how to respond in the event of an accident or incident. Incidents and accidents were recorded, but details of what happened before, during and after the incident were not always clear. The manager told us they had recently spoken to staff about this and there were some improvements in the detail recorded in the most recent documents. There were some improvements needed in the analysis of incident information, to ensure lessons were learnt and changes made when thing went wrong.

Staff had received training and knew how to report safeguarding concerns. The staff had raised safeguarding concerns with the local authority appropriately. Clear records were kept of any safeguarding enquiries.

People were receiving their medicines as prescribed. Nursing staff offered people their medicines and administer these safely. People told us they received their medicines at the right times. Storage was clean and well organised. The temperature of the clinical room and medicines fridge were monitored and recorded. Care staff administered emollients and creams. Nursing staff told us they would check the documentation every shift. Medicines were audited weekly and monthly. There were protocols in place for 'as required' medicines. When people were prescribed medicines such as patches to apply to their skin, a record of the application sites were kept.

There were plans in place in case of an emergency. People had personal evacuation profiles which detailed the support they would need to evacuate in an emergency. There were regular checks of the fire alarm and other equipment.

Recruitment procedures were in place to assess the suitability of prospective staff. These included application forms, references and evidence of being able to work in the UK. A Disclosure and Barring System (DBS) check had also been completed, which identifies if they had a criminal record or were barred from working with children or adults. This meant that the provider had assessed the suitability of the staff they employed.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

At the last inspection, on 28 July and 1 August 2016, people's liberty may have been deprived without lawful safeguards, as expired DoLS authorisations had not been reapplied for. This was a breach of Regulation 13 Safeguarding Service Users from Abuse and Improper Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan explaining they had reapplied for the expired DoLS authorisations and that they had devised a list to prevent this reoccurring. At this inspection we found that sufficient improvements had been made and the provider was no longer breaching this regulation.

Accurate, complete and contemporaneous records were not kept for all people. People's needs and choices were not always assessed and reflective of their current needs. For example, the manager told us that one person was receiving end of life care and we saw this care being provided. The person's assessments had not been updated to reflect this. Staff did not have effective guidance to support the delivery of consistent care to this person.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At this inspection, we checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. People who needed them had DoLS assessments and the conditions of these were being met. However, the list which the provider devised to track which people had DoLS authorisations or applications was not up to date. This placed people at potential risk that dates for the re-application of Dols could be missed and therefore people's rights infringed.

The provider had not ensured that accurate, complete and contemporaneous records were kept. This was a breach of Regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Mental Capacity Assessments were clear and included the views and involvement of the person. Staff told us that they sought people's consent, and when people were not able to verbally communicate would read their body language. When people would not consent to personal care, for example, staff told us they would leave and try again later.

There were confirmation documents when people had others legally appointed to make decisions on their

behalf, such as Lasting Powers of Attorney. For example, one person had been assessed for the use of bed rails. The assessment included their family's views and an observation of the person's response to the rails.

We saw people receive support around eating and drinking. For example, a member of staff supported someone, explained what the meal was, and discussed the food with the person they were supporting. They provided support at the right pace for the person.

Snacks were available throughout the day. The chef told us that they could provide finger food but that people were not always responsive to this.

Some people ate in the dining room, other remained in lounges or their bedrooms. People who were eating in the dining room had cutlery and drinks on the table before their meal. These visual prompts can be important for people living with dementia around mealtimes. People who were eating in the lounges did not have these prompts until they were given their meal.

People told us they chose their meals, sometimes the night before and sometimes in the morning. One person said, "They do the best they can. It's a small kitchen. It's cooked well and tasty." Another said, "Lunch is varied, more than edible." One person was given their meal but did not want it. Staff encouraged them to sit and eat, but when they refused their decision was respected and the meal covered. Staff told the person it could be reheated when they wished. People could change their minds and have an alternative meal. The chef had a good awareness of people's dietary needs, such people who needed fortified meals to ensure they had a higher calorie intake.

The premises were suitable for people living with dementia. Signage supported people to move around the service independently. The provider had created a post box and wall with a shopfront mural in one of the hallways for people to interact with.

Staff told us that information was communicated between shifts during handover. When they had been away from the service for a longer period, other staff would provide a verbal update. We saw staff communicate with each other during lunchtime about people required support with their meals.
Staff told us about the support they received when they started work at the service. This included shadowing an experienced member of staff. Staff told us they had training about manual handling, safeguarding and dementia. Nursing staff told us they had recent learnt how to verify expected deaths. Staff had supervision and told us, "If things come up we can discuss them as and when." Nursing staff received clinical supervision with the manager.

There were opportunities available for those staff who wished to develop their skills and knowledge to complete a Regulated Qualifications Framework (RQF) in Social Care. An RQF is a work based award that is achieved through assessment and training. To achieve an RQF, candidates must prove that they have the ability and competence to carry out their job to the required standard.

People had access to healthcare support. We saw people leave the service to attend healthcare appointments. Staff told us they worked with other healthcare professionals such as community psychiatric nurses to support some people living with dementia. One person told us, "The medical staff are superb, they listen to you." A health and social care professional told us, "The day to day registered nurses do ask for advice appropriately and act on it."

Requires Improvement

Is the service caring?

Our findings

We received variable feedback from health care professionals about their experiences of staff. One health and social care professional told us, "Staff are caring the majority of the time, but are lacking in person centred care." Another professional told us, "I have observed staff as responsive and kind although stretched."

People were not always treated with dignity. For example, a person was enjoying musical entertainment with a tambourine which they had placed over their head and around their neck. They were enthusiastic and clapping their hands. A member of staff attempted to remove the tambourine without asking the person. The person tried to resist the removal of the tambourine however the member of staff managed to remove it. This was done with discussing with the person living with dementia or explanation and therefore did not uphold the person's choice and dignity.

One person had recently had a bereavement and spoke to staff about this saying they missed the person. Staff repeated short questions and responses with the person. This communication did not show that staff were empathetic or allow the person to discuss their grief. A health and social care professional told us, "Emotional support to residents and their families can be challenging to achieve and sometimes there are language barriers."

People were not always treated with respect. We saw that one person was quite withdrawn and was covering their face. They had a bowl of crisps placed in front of them. When this person lifted their head a staff member took a crisp from a bowl in front of them and put it into the person's mouth, without discussion or the person's consent. The member of staff then did this a second time. The person's consent was not sought on either occasion and this interaction was not respectful of the person's dignity.

We saw one incident when a person's movement was restricted and their choice was not respected. The person was sat in a large recliner chair and made repeated attempts to shift their weight to the end of the chair to stand up. A staff member asked, "Where are you going?" The person raised their voice in response. The staff member tried to distract the person by engaging them with activities. The person raised their voice again. The person then tried to transfer from the recliner chair to another nearby armchair. The member of staff blocked this by sitting in the armchair and turning the person in their recliner chair. The person was later supported by another member of staff to stand and sit in the armchair they wished to sit in. We raised this with the manager during the inspection to address immediately.

One person was trying to speak with a staff member who was making notes at the table in the centre of the lounge. The staff member provided the odd response but did not turn to face the person or engage or explain why they were not able to respond to them at that time.

Another person, who was cared for in bed, had very little clothing on and their skin was exposed which compromised their privacy and dignity.

People were not always treated with dignity and respect. This was a breach of Regulation 10 Dignity and Respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's information was not always kept confidentially. We were shown a room where information about people was archived. This room was not locked and was situated in an area accessible to people. Information about people was also held in the staff office. On three occasions during the inspection we found this office door open without staff in it. On one of these occasions the computer screen was open on a person's care plan which included their photograph. The provider had not ensured that people's information was kept confidentially, in accordance with data protection legislation.

We did observe some positive practice regarding people being involved in making decisions and expressing their views. We saw that staff involved people in decisions about their care, such as checking whether they were comfortable and providing explanations before undertaking tasks like moving people. Relatives told us they were kept up to date and involved by the nursing staff.

Staff told us how they helped to protect people's privacy by ensuring they knocked on doors before entering rooms and ensuring doors and curtains were shut before providing personal care to people.

The manager told us the service had an open visiting policy. One person told us there were not any restrictions on visitors, but their family knew not to come at the start of a mealtime.

Some people had a good rapport with the staff team and we saw people laughing and talking together. One person told us, "I find that the staff are just lovely people. Very caring, friendly and considerate."

Requires Improvement

Is the service responsive?

Our findings

There was not a consistent system in place to consider risks of people's social isolation. People's social needs had not always been assessed and planned for which meant that staff did not have guidance on how to engage with specific people living with dementia. When people's social needs had been assessed their preferences were not always considered. For example, one person's care plan said that they may enjoy television, a classical radio station and the presence of people. We observed a pop radio station playing loudly in their room.

People did not always receive support to follow their interests or join in with activities offered. We observed interactions between people and staff in the lounge area. One member of staff introduced a wooden block with holes through which string could be threaded. This was passed from person to person. People did not engage with this activity and there was no evidence that it linked to people's interests. Staff walked towards people saying, "You're next" or, "Now the next one." When we left the lounge, the member of staff stopped engaging with people.

Staff brought a coloured abacus to one person and place it on a table in front of them. The staff member explained the beads could go back and forth but did not engage with the person further. The person did not touch the abacus but just looked at it for the next thirty minutes.

We observed that people went long periods without interaction or engagement by staff. Some staff did engage with people by saying hello, but there was a lack of meaningful engagement with people. Although we felt people's immediate needs were met, interactions were focussed on the completion of tasks. A member of staff told us, "I think we need more staff to meet resident's needs. We have to cut conversations short, and be task focused." A member of staff told us they supported people being cared for in bed, "We give them drinks and we provide personal care." This was reflected in the daily notes in people's bedrooms. We spoke to one person who was cared for in bed, who told us, "Nobody will come yet, they are all busy."

We got mixed feedback from people about activities. One person told us, "We don't get activities here." Another said, "I am bored, there is nothing to do." However, another person told us they walked along the seafront with staff on occasion.

Staff told us that an outside activity provider came in for an hour each weekday to provide entertainment. We saw people participate in a musical activity by using tambourines and maracas. Some people, who were seated in a separate lounge, were offered to take part in the activities. However, three people in this lounge were not given this opportunity. This activity did not include any of the eight people who were being cared for in bed.

Lack of personalised activities and meaningful occupation meant that people didn't always have enough to do and people were at risk of social isolation. Their personal preferences were not considered and some people were not supported to take part in activities that were available. This meant that people's need for social engagement and their personal preferences were not consistently met.

The provider had not ensured that people's social needs had been assessed and that people were offered activities that were person centred to their preferences and interests. This was a breach of regulation 9 Person Centred Care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify, record, flag, share and meet people's information and communication needs. When a person's communication was affected there were clear communication care plans which detailed how their condition affected their communication and actions, and how staff could support them with this.

Complaints were responded to and used to improve the quality of care. The complaints procedure was displayed in the service. One person told us that if they had a complaint they would speak to the manager or a nurse. They had complained in the past and told us that staff had told them what they had done about the complaint. One person's relative told us, "Anything we've worried about has been addressed." The service recorded if complaints had been received each month. When a complaint had been raised, the provider had created a clear action plan to address concerns.

People were supported to have a comfortable, dignified and pain-free death. During the inspection one person was receiving end of life support. Staff were providing regular mouthcare and ensuring their comfort. Nursing staff were in contact with the person's family and had ensured that medicines to manage pain and symptoms were in place should they be needed.

Inadequate

Is the service well-led?

Our findings

The registered manager was on extended leave at the time of the inspection. The manager was being supported by the general manager. A handover from the registered manager had been planned, but had had to occur more quickly than planned.

Systems did not enable the provider to assess, monitor and improve the quality and safety of the services provided. There was a quality assurance framework in place. This was not sufficiently robust and so had not identified and addressed all the issues identified during the inspection.

There was no system in place to ensure that staff were providing support in line with people's risk assessments and care plans or to check the quality of the recording. Following the inspection, the manager set up a system of Resident of the Day, for nursing staff to review information about people regularly and discuss with care staff.

The provider could not be sure that staff were referring to the correct information to provide consistent support to people. The provider had recently started to use an electronic method of care planning. There were only four points of access to this system within the service, two computers in the manager's office, a computer in the staff office and a laptop. Use of the laptop was limited to certain areas of the service due to the wi-fi availability. The general manager later told us they were going to move a computer into the lounge area to improve accessibility for staff. There was confusion about where staff should find this information. Staff told us they had not read the care plans on the computer system. Files in the staff office included printed care plans and correspondence. The general manager told us the care plan documents were not up to date but had been printed to cover a short period when there had been an issue with the computer system. However, some staff members told us this was where they would look for information about people. Others told us they used the information held in people's room files to guide them on how to support people.

Quality assurance processes did not always ensure that appropriate action was taken. For example, high priority actions identified by a fire risk assessment of the service had not all been completed. The manager had competed an audit indicating appropriate action had been taken, we found that this had not always happened. For example, a practice night evacuation had been planned for but not completed and the evacuation plan had not been changed from horizontal to full evacuation.

Records of accidents and incidents were not detailed. This lack of information about incidents meant that it was difficult for the provider to establish what may have caused the incident. The general manager completed a trend analysis form monthly about falls and accidents but trends and themes were not always recognised. For example, two falls had been recorded for the month of July, both had occurred in the same place. This was discussed with the general manager during the inspection who acknowledged this.

A weekly environmental cleanliness checklist audit tool was completed regularly. This had not identified and mitigated the risk of clinical waste being stored in corridors.

The system in place to monitor which people were subject to DoLS was not accurate and complete which meant that the provider could not effectively assess and monitor this. It was not clear which applications had been authorised and when. There was a potential risk that applications for DoLS may not happen at the right times, meaning people could become unlawfully deprived of their liberty. We were told that two people were currently subject to authorised DoLS. There were only records of authorisation in place for one person, but had been advised by the local authority about the authorisation of the status of the second. Following the inspection, we received information that a third person was subject to an authorised DoLS. We contacted the manager who confirmed this was the case and they provided us documentation to evidence this and that the conditions of the DoLS were being met.

The provider had not ensured good governance. This was a breach of Regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not ensured the correct notification of all incidents notifiable to us. Providers are required to notify us how and when people's liberty is restricted. This enables us to monitor actions taken and ensure that is in the least restrictive way possible. Deprivation of Liberty Safeguards had been authorised by the local authority for three people living at the service. However, we had not been notified. The provider had not ensured that CQC were notified about authorised deprivation of liberty safeguards. This was a breach of Regulation 18 Notification of Other Incidents of the Care Quality Commission (Registration) Regulations 2009. We took criminal enforcement action by way of a fixed penalty notice

People and their relatives' views had been sought. We saw an action plan had been created following feedback from people and relatives in March 2018. This included acknowledging that relatives wanted improved details in people's room records, to tell them more about the person's wellbeing. However, we saw that room records remained task focused at the time of the inspection.

The provider worked in partnership with other agencies. One person's relative told us that their family member had had a medical issue so a three-way meeting had been set up with the family, the service and the GP. They said, "We are delighted with it. The nurses have good involvement."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that people's social needs had been assessed and that people were offered activities that were person centred to their preferences and interests.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured people were treated with dignity and respect.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not ensured the correct notification of all incidents notifiable to us.

The enforcement action we took:

Fixed penalty notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensure good governance had been maintained.

The enforcement action we took:

Warning notice.