Leyton Health Care (No 7) Limited

Hollycroft Nursing Home

Inspection report

8-10 Redhill, Stourbridge,
West Midlands, DY8 1ND
Tel: 01384 394341
Website: www.leytonhealthcare.co.uk

Date of inspection visit: 21 and 24 November 2014
Date of publication: 02/02/2015

Ratings

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

Overall summary

This unannounced inspection took place on 21and 24 November 2014. At our last inspection in September 2013 the service were meeting the regulations of the Health and Social Care Act 2008.

Hollycroft Nursing Home is registered to provide accommodation, nursing or personal care for up to 37 people. At the time of our inspection 32 people were using the service. People using the service may have a range of needs which include dementia, physical disability or old age. Whilst some people lived there permanently the service also provides care to people on a short term rehabilitation basis, often following discharge from hospital.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Staff were knowledgeable about how to protect people from harm. The manager was able to demonstrate learning and changes to practice from incidents and accidents that had occurred within the service.

We looked at staff rotas and observed there were a suitable amount of staff on duty with the skills,

Summary of findings

experience and training in order to meet people's needs. People and their relatives told us they felt confident that the service provided to them was safe and protected them from harm.

People's nutritional needs were monitored regularly and reassessed when changes in people's needs arose. We observed that staff supported people in line with their care plan and risk assessments in order to maintain adequate nutrition and hydration.

The staff worked closely with a range of health and social care professionals to ensure people's health needs were met, for example physiotherapists and occupational therapists.

People's ability to make important decisions was considered in line with the requirements of the Mental Capacity Act 2005. However, documentation in relation to people's resuscitation status was not always completed accurately and lacked clear involvement of the individual or those closest to them in making such important decisions.

Staff were responsive when people needed assistance and interacted with them in a positive manner, using encouraging language whilst maintaining their privacy and dignity. People were encouraged to remain as independent as possible.

People were not routinely provided with written information about the day to day routines within the service or about how to make a complaint. Although people lacked information about the service, they told us they were able to ask staff or other people using the service any questions they had. Information regarding how to access local advocacy services was displayed in communal areas.

Activities within the home were limited as the manager was in the process of recruiting a dedicated activities coordinator. During our visit we saw that people were in good spirits and laughed and chatted happily together.

Visiting times were restricted in the evening for those people using the service on a short stay basis; the manager said they would review this following our visit.

People, relatives and visiting professionals spoke positively about the approachable nature and leadership skills of the registered manager. Structures for supervision allowing staff to understand their roles and responsibilities were in place. Staff we spoke with were unclear about the how they could access or how they would utilise the providers whistle blowing policy.

Quality assurance systems had failed to identify issues with recruitment processes and medicines management that may put people using the service at risk. Feedback was sought from people, their relatives and stakeholders as part of the provider's quality assurance system, but results were not analysed or shared to improve people's experience of the service.

Recruitment practices within the service were not robust. We saw in some records that appropriate last employer references were not in place and that gaps in staff employment history had not clearly been discussed and reasons for these documented. The manager had failed to document discussions and undertake a risk assessment for staff who were working within the service with a disclosed criminal record. 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?
The service was not safe.

Recruitment practices within the service were ineffective and not in line with the providers own policy.

Staff were knowledgeable and had received training about how to protect people from harm. People told us they felt safe using the service.

Medicines were handled and stored safely. We saw that systems for auditing medicines were not robust.

Requires Improvement

Is the service effective?
The service was effective.

Staff were provided with a variety of training and had a good level of knowledge and skills to meet people's needs.

People's ability to make important decisions was considered in line with the requirements of the Mental Capacity Act 2005.

People were supported to access specialist healthcare professional input from outside the service to meet their needs.

Good

Is the service caring?
The service was caring.

People and their relatives were complimentary about the staff and the care they received. We observed staff interacting with people in a kind and compassionate manner.

Information about the service or their care was not routinely made available to people.

We observed that people's privacy and dignity was respected by the staff supporting them.

Good

Is the service responsive?
The service was responsive.

Care plans were detailed and contained information about people's preferences, how they wished to be supported by staff and how care should be delivered.

Visiting times were unnecessarily shorter in the evenings for people using the service on a short term basis. Maintaining links with family and friends through open visiting times is vital to minimising people's social isolation.

Good

Summary of findings

People were not in receipt of written information about how to make a complaint but told us they would approach the manager in the first instance with any concerns or complaints.

Is the service well-led?

Requires Improvement

The service was not well led.

People were complimentary about the manager and how the service was run on a day to day basis.

Staff received regular supervision and used this as an opportunity to discuss their development and training needs. The manager was well supported by more senior managers within the service.

Quality assurance systems including feedback from people about the service were ineffective.

Hollycroft 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 checked 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.

The inspection of Hollycroft Nursing Home took place on 21 and 24 November 2014 and was unannounced. The inspection was undertaken by one inspector.

Before the inspection we looked at and reviewed the Provider's Information Return (PIR). This questionnaire asks the provider to give some key information about its service, how it is meeting the five key questions, and what improvements they plan to make. We also looked at notifications of incidents that the provider had sent us. Notifications are reports that the provider is required to send to us to inform us about incidents that have happened at the service, such as accidents or a serious injury.

During our inspection we spoke with 10 people who used the service, four relatives, one member of kitchen staff, one nurse, three care staff, the registered manager and the regional manager. We observed care and support provided in communal areas and spoke to people in their bedrooms.

We reviewed a range of records about people's care and how the service was managed. These included pathway tracking five people by reviewing their care records, looking at the staff training matrix, four staff recruitment records, three people's medication records and the quality assurance audits that the registered manager completed. We looked at some policies and procedures which related to safety aspects of the service and also looked at the whistle blowing and safeguarding policies. Prior to our inspection we contacted several healthcare professionals who had regular contact with the service, including commissioners to obtain their views about the care provided by the service; we spoke to or received feedback about the service from four of the professionals we contacted.

Requires Improvement

Is the service safe?

Our findings

Recruitment processes within the service were not safe. We looked at four staff recruitment records for staff employed by the service within the past six months. In three of the records gaps in staff's employment history were noted without any documented reasons for this. In one record we saw that no reference was sought from the person's previous employer. In another although a reference had been sought the person providing the reference was not in a suitably senior position to provide the verifying information requested. We saw that risk assessments were not in place to support decision making when commencing staff in employment within the service who had a disclosed criminal record. This meant that the suitability of staff employed to work within the service had not been demonstrated which may place people using the service at unnecessary risk.

This is a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People and relatives told us that they believed the environment was safe and that staff were equipped with training to ensure people were protected from harm. One person told us, "I feel safe here". A relative told us, "I know staff will be there if my relative needs them, they always come quickly to answer the call bell". Professionals we made contact with prior to our visit told us that the felt the service was safe.

During our visit we found that the atmosphere was relaxed and observed people asking staff for assistance without hesitation. Staff were knowledgeable about their responsibility for reporting and responding to any concerns in regard to abuse including the services policy and procedures. They had also undertaken training with respect of how to keep people safe and protect them from harm in a variety ways, for example fire safety and safe moving and handling procedures. Staff were able to describe the different types of abuse, discrimination and avoidable harm that people may potentially be exposed to. One staff member told us, "Any issues you can always speak to the manager without any worries".

We found people were not restricted in the freedom they were allowed and observed that they were protected from harm in a supportive respectful way. For example we observed that staff provided the same level of support and assistance to people who chose to spend much of their time in their room; thus ensuring their safety whilst respecting their choices.

Staff had completed and regularly reviewed assessments in respect of any risks to people with reference to their personal health and support needs. These referred to the individual's abilities and outlined activities where assistance may be required in order to reduce any related risks and avoid harm.

Records in regard to incidents or accidents were comprehensive with any learning outcomes or changes to practice in the service that had occurred clearly documented. Staff recorded any changes to practice following any accidents or incidents, for example, after a person suffered a fall records advised that equipment that would alert them to the person's movements and to reduce the risk of further falls had been installed. Staff told us that changes to practice following incidents or accidents were shared with them by the manager. This meant that on-going learning and changes to practice to protect people were promoted.

We saw that there were sufficient numbers of staff available to meet people's needs and keep them safe. One person told us," There is always somebody about all the time". Staff told us they felt that there were enough staff on duty throughout the day and night to meet people's needs. The manager used a staffing tool to review any changes in people's level of dependency; which determined the quantity and skills of staff required on duty.

We reviewed how medicines were obtained, stored, administered, handled and disposed of. We reviewed the medicine administration records (MAR) for three people. We observed that medicines were provided to people in a timely manner. People told us they were satisfied with how their medicines were provided and that they received their medicines on time. One person told us, "I can always ask for pain killers if I am struggling". Discussions took place with people at the point of admission about how they would choose to have their medicines provided. The option for self-administration was offered to people. Staff told us most people preferred to have their medicines administered to them. We saw effective systems were in place for those people who had chosen to self-administer their medicines. We found that records were completed fully and no unexplained gaps were seen. Medicine storage

Requires Improvement

Is the service safe?

cupboards were secure and organised. Labelling of each individual medicine was clear, making medicines easy for staff to identify and locate. The controlled drugs cupboard was used effectively and records relating to the medicines kept there were accurate. Medicines for disposal were kept in a suitable container and disposed of appropriately.

Arrangements were in place to ensure that medicines were audited each month which included checking a small sample of people's medicine stock levels. We found in one record that medicines had been administered on several occasions but the number of tablets allocated specifically to that person had not reduced by this amount. This meant that the person's own supply of this particular medicine had not been used. We spoke with nursing staff who could not account for how this may have happened. Audits undertaken by the provider each month sampled only a small number of people's medicines when checking stock levels, which may mean that those people living at the home on a short stay basis may not have their medicine stock level checked during their stay against their medicine administration record. This meant that systems for ensuring people had received their correct medicines were inconsistent.

We found that supporting information for safe administration of medicines was not always available. We looked at three people's records who were prescribed medicines to be given 'when necessary' or 'as required' for pain relief; these records lacked any supporting information that enabled staff to make a decision as to when it was appropriate to administer such medicines. Staff told us they would supply as required medicines when the person expressed pain or asked for them. However they were not clear about the area of the body, diagnosis or complaint the medicines were prescribed for only that it was for unspecified pain. We further noted that two people had been given their 'as required' medicines every day for an extended period but this had not been reviewed with the prescribing doctor. A review would ascertain if a regular dose was needed or to investigate why a medicine was needed to be given so often.

Good

Is the service effective?

Our findings

People using the service told us they felt staff were well trained and able to meet their needs. One person told us, "I wouldn't have stayed here if staff hadn't been competent". A second said, "The carers are wonderful". A relative told us, "Staff do all the care, all the right way".

We spoke with staff about how they were able to deliver effective care to people. They told us the service provided a range of training in a variety of subject areas that were appropriate to the people using the service. A staff member said, "Training is good, there is something on offer every month". Another staff member stated, "I spend time talking to people asking them what they want or need and how I can help them". We spoke to an occupational therapist who regularly provided assessment, guidance and advice for staff in regard to people's on-going moving and handling needs. They told us that staff were capable and efficient when following any instructions given to them to ensure the welfare and safety of the person using the service.

We saw that in addition to mandatory training a number of staff had or were in the process of completing training linked to the Qualification and Credit Framework (QCF) in health and social care to further their knowledge and skills. Two recently employed staff members told us their induction had included shadowing more senior members of staff and completing basic mandatory training before they worked independently. They said they felt this had equipped them with the skills required to undertake their role. The Provider Information Return completed by the manager told us about the improvements that were planned at the home. The manager described plans to access bespoke Dignity in Care training for staff which would incorporate equality and diversity issues. Visiting professionals provided staff with updates and guidance in regard to best practice. Staff told us they had good links with local training providers and visiting professionals. A staff member told us, "Training is on offer almost on a monthly basis, on a variety of subjects". We saw that a range of training including dementia care and end of life care had been received by several members of staff to complement their mandatory training sessions.

Staff had a handover meeting at the beginning of each shift. Staff told us this was an opportunity for them to communicate with each other and receive the most up to date information about people, allowing them to be clear about changes to people's needs. We spoke to four staff members, three of them told us they did not refer to care plans contained in people's individual care records. However we saw that staff were clear about people's needs by speaking with them directly, handover meetings and referring to the white board in the nurses station which outlined each individuals specific care needs for staff to refer to. One staff member commented, "I feel an important part of the handover meeting and it keeps me up to date". This meant that staff had access to the most up to date information to meet the specific needs of people they cared for.

Staff had received training and had a basic understanding of their responsibilities under the Mental Capacity Act (MCA) 2005 and Deprivation of Liberties Safeguards (DoLS). DoLS is a legal framework that may need to be applied to people in care settings who lack capacity and may need to be deprived of their liberty in their own best interests to protect them from harm or injury. Records showed that people's mental capacity had been considered as part of their initial assessment. We observed that people's consent was sought by staff before assisting or supporting them. The manager had a wider understanding of the MCA and DoLS and knew the correct procedures to follow to ensure people's rights and choices were protected. At the time of our visit no one using the service was deprived of their liberty.

We reviewed the records that related to the resuscitation status of three people using the service. Two of the records did not clearly document whether the person or those closest to them were involved in the decision making process, and one document had not been fully completed. These records should clearly demonstrate how the decision was made, who was responsible for making the decision when Cardio Pulmonary Resuscitation (CPR) is not to be attempted and how people who use services and those close to them, where applicable, should be involved in these decisions.

We saw that people were supported to access food and drinks appropriate to their needs and choices. One person told us, "The food is nice and we are offered a variety of drinks all day". Another said, "If you don't like what's on the menu, you can ask for something different". Staff told us they had received training in food hygiene and were aware of safe food handling. Menus were displayed in the dining

Good

Is the service effective?

room. People told us they had been consulted about the menus by kitchen staff. We observed that meals were nutritionally balanced and looked appetising, with extra portions available and freely offered to people.

We met with kitchen staff. They told us that any specific dietary needs or changes to people's nutritional needs were communicated to them by staff on a daily basis. One member of kitchen staff said, "The system works". We saw records were updated accordingly in respect of people's specific dietary needs. One relative told us that staff had responded to their relative's weight loss by consulting with them and made alternatives available for them. People were asked to complete a food questionnaire each evening to choose their food for the following day. One person told us, "Staff put you a sandwich and drink together when you have to go out for appointments, just in case of delays, they are very good like that". Staff we spoke with knew which people were nutritionally at risk and those who needed their fluid intake to be monitored. We observed that people who chose to have meals in their rooms or required staff assistance, received their meal in a timely manner. This meant the service was able to meet people's individual needs in respect of nutrition.

Records showed people had been supported to access a range of healthcare professionals including chiropodists and physiotherapists. We saw examples in care records of staff accessing more urgent reviews by a doctor in response to people's changing health needs. One person told us, "Staff organise transport for you if you have any hospital appointments". Another said," The nurse got the doctor to come and see me when I told them I felt unwell". Professionals who visit the service regularly were contacted prior to our visit; they were complimentary about staff's responsiveness to maintaining and improving people's health. They confirmed that staff always asked for timely advice, prescriptions and visits. One professional told us that outcomes for people using the service had been beyond their expectations, many showing significant improvements whilst there. They identified that people who were initially thought may need longer term full time support or a residential setting had actually been able to return to their own home with minimal or no formal support. This supported further our findings that the service people were supported to maintain good health.

Good

Is the service caring?

Our findings

People were complimentary about the respect staff displayed towards them and the promotion of their dignity. One person told us, "Staff are kind and respectful". A second said, "They are nice people, good and kind". A relative told us, "If I had to choose a place for my relative longer term, I would choose this one". We observed staff displaying kindness and compassion towards people when they interacted with them. There was plenty of chatter and laughter between residents and staff throughout the day. For example, we saw one person was feeling anxious and was attempting to mobilise unaided which was unsafe; staff offered assistance to them in a gentle reassuring manner, which the person responded well to.

People's religious needs had been considered, for example one relative told, "My father has been able to continue to receive Holy Communion whilst staying here, this means a great deal to him". People we spoke with said that they had been asked about any specific needs they had on admission in regard to religion or spiritual needs.

We saw that staff were responsive to people's requests and their needs were met without any significant delay. People who we spoke with who spent most of their time in their rooms told us that staff came to them quickly enough when they pressed their call bell. One person told us, "They come as quick as they can, I have never had to wait long".

People and their relatives told us they were involved in any decision making in regard to their or their relatives care needs. One person told us, "I have been at the centre of any decisions made about my care". Information in regard to their condition or progress made was verbally provided to them by staff and visiting professionals. All of the people and relatives we spoke to told us they had not been provided with any written information about the service but all stated they felt able to ask staff or the manager if they had any unanswered questions. One relative stated, "I haven't been given any information, a leaflet or booklet would have been useful to refer to". The manager showed us a folder which contained a wealth of useful information about the service which was located in the reception area. This folder was not routinely offered to people or their relatives to read and was not available in a variety of formats to suit people's communication needs. The manager told us they intended to review access to information about the service for people following our visit. This meant that people did not have easy access to information about the service to refer to, to keep them informed and up to date.

Staff we spoke with were clear about how they would access advocacy services for people. Information was available in communal areas about local advocacy services including contact numbers for people to refer to. People we spoke to were aware of where this information was situated. This provided people with accessible information they may require in regard to independent advice and support.

We observed that staff respected people's dignity and their right to privacy, for example, ensuring they knocked before entering people's rooms and ensuring toilet doors were closed when people were using them. Staff demonstrated they knew each person's individual likes and dislikes and we observed that people were supported to make choices in a dignified manner. One person told us, "Staff are always kind and courteous. They always speak to you nicely". One relative said, "Staff always knock the door and wait for us to tell them to come in".

We saw that people's preferences and wishes were understood and they were encouraged to remain as independent as possible. One person told us, "They get you on your feet as soon as they can, but you know they are there for support if you need it". People told us that staff respected their privacy when assisting them and would encourage them to try to do as much for themselves as possible.

Good

Is the service responsive?

Our findings

People and their relatives were involved in all aspects of their assessment and care planning; we observed people's care was delivered in line with their care plans. One person told us, "I have been asked what I want to achieve and they are helping me to get there". Staff were knowledgeable about people's support needs as well as their preferences and personal history. A relative told us, "Communication about dads care needs has been excellent; they have involved us at every stage".

Records contained an assessment which identified people's support needs. We saw that care plans were personalised, detailing how people's needs should be met, including their specified preferences. Care plans had been regularly reviewed and updated. People's rooms had been personalised and displayed items that were of sentimental value or of interest to them.

The provider was keen to ensure that they were responsive to people's needs, for example, four members of staff were provided with sign language training in order to meet the specific communication needs of a person who was admitted to the service on a short term basis.

People told us that activities were on offer but most said these were limited. One person told us, "We don't get bored; we get on well as a group". We spoke with the manager who told us that they were in the process of recruiting an activities coordinator but that at present they relied on sourcing visiting entertainers and staff to provide activities for people, such as a sing along.

We saw that visiting times were shortened in the evenings to those people using the service on a short term basis only. The manager told us that this was due to visiting professionals needing to access people to support them in their rehabilitation, without interruption. Whilst this was understandable, we confirmed that such visits from professionals were not provided in the evenings. One relative told us, "Extended visiting times would be nice". The manager intended to review the services policy in regard to these restrictions. Flexibility of visiting times is an important factor for people in maintaining links to family and friends during their stay and avoiding social isolation.

People told us they had not received any documentation that directed them about how to make a complaint to the provider or alternatively any external agencies. One relative told us, "I would go and see the manager, they are very approachable". People told us they would in the first instance speak to the manager and felt their concerns would be listened to and acted upon. Concerns and complaints about the service were documented and any responses were made in a timely manner. Acknowledgement letters were sent out to the complainant prior to any investigation taking place with clear timescales provided in line with the provider's policy. We saw that complaints were used as a learning opportunity by the service. Following one complaint, systems for people to consent to the service looking after people's money were made more robust. Information about how to make a complaint about the service was contained in a folder in the foyer, people we spoke to were not aware of its existence. No one we spoke with had had cause to complain.

Requires Improvement

Is the service well-led?

Our findings

People told us the manager was visible and approachable. Positive feedback was received from everyone we approached in regard to the accessibility of the manager. One person told us," The manager listens to you". A staff member told us, "Any issues, you can always speak to the manager". We observed people and staff informally approaching the manager for support and advice throughout our visit. One staff member said, "The manager is accessible and always makes time for you".

Compliments were kept in the form of cards and letters received by the service. One person stated, "This place is the next best place to home". A relative told us, "I am very, very impressed with the place". People we spoke to praised the service; with several people stating they would recommend the service to others. The manager spoke passionately to us about their role in providing people with a quality service.

Processes were in place to gain feedback from people who were involved in or had experience of the service. We saw that the service sent or handed out questionnaires to people using the service, their relatives and stakeholders. No scheduled or regular pattern for gaining this feedback was in place. The manager told us that they aimed to send out these questionnaires twice yearly but that this was not always achieved. No system was in place for analysing or sharing the information from the questionnaires received, they were simply put away in a file. This meant that documented feedback from people who had experience of the service was not shared or analysed as a means of quality assurance. People and their relatives we spoke with could not clearly identify having been asked for formal feedback about the service; although they did feel they were able to informally offer their thoughts. The Provider Information Return completed by the manager prior to our visit told us that 'an analysis of the responses from questionnaires was completed and then appropriate action plans were drawn up'. However, the manager was unable to show us any analysis or action plans that had been developed in regard to improvements from comments received. Feedback gathered about the quality of a service should be analysed and shared with people, their relatives, staff and external stakeholders in a consistent way. Opinions about the service were not shared or analysed as a means of quality assurance.

People and their relatives said they gave informal feedback to the manager through regular dialogue with them. One relative said, "Communication between us and staff is regular and you can raise any concerns you have, they are very approachable". One professional who regularly visited the service described the feedback from people using the service as usually favourable and that people told them they were happy with the support they received during their stay.

Records of incidents were appropriately recorded. We saw that learning or changes to practice were documented by the manager and staff following incidents and accidents. For example, following one incident the learning in relation to this had been to ensure that all new admissions to the service were physically checked over by nursing staff at the earliest opportunity and any injuries or bruising was recorded or investigated accordingly. Staff we spoke with were aware of the learning and changes to practice following this incident. This meant that learning from incidents had enabled improvements to further protect people to be made.

Staff told us they received regular supervision and appraisal from their manager. Staff told us this gave them the opportunity to review their performance and discuss their development and training needs. The manager told us these sessions allowed them to meet with staff to share elements of good practice and to ensure that learning was embedded within staff practices. Staff told us that feedback from the manager about their performance and discussing their development needs made them feel valued and helped them to understand their roles and responsibilities. One staff member told us, "I can see the manager at any time to ask about other training, they are always willing to help you where they can".

The manager told us they received regular support from the regional manager, who visited two to three times per month. The manager told us the provider was supportive in respect of accessing identified training for them and their staff. Staff we spoke with were clear about the arrangements for whom to contact out of hours or in an emergency. There was a list of numbers for staff to refer to at such times.

The manager understood their legal responsibilities for notifying us of deaths, incidents and injures that occurred at the home or affected people who use the service. We

Requires Improvement

Is the service well-led?

reviewed the notifications we had received from the service prior to our visit and saw that they were submitted in a timely manner with detailed information regarding incidents that had occurred.

The manager showed us the whistle blowing policy which staff could refer to if they had concerns about the service and wished to report these to external agencies. All of the staff we spoke with said they were unclear about what the whistle blowing policy was and did not know how to access this information. The manager told us that the provider was in the process of implementing an electronic version of the staff policies and handbook, which staff will be able to access via the log in details they will be provided with. At the time of our visit policies were kept in a file in the office and staff were asked to read them when they commenced employment. We reviewed the whistle blowing policy and this lacked the contact details for external agencies. This meant that the provider was not actively promoting an open culture amongst its staff by supporting them to know how to raise concerns or whistle blow.

The manager told us that they periodically performed "spot checks" including weekend visits. Staff we spoke with confirmed that the manager completed regular checks. A number of professionals who provided regular input to the service commented that the service was monitored closely by the manager and that they seemed keen to ensure the on-going quality of the care provided to people.

We saw that a system of internal auditing of the quality of the service was in place which covered a number of elements of the service, for example people's finances. During our visit the regional manager was supporting the manager of the service in auditing. Where omissions or areas of improvement were identified an action plan was developed. The regional manager told us that part of the audit they undertook involved checking that previous actions had been achieved. However the issues we identified in regard to recruitment and medicines management, both areas which were considered within the service's audit process had not been identified. This meant that the provider's quality assurance systems had failed to protect people from the risks related to unsafe recruitment and ineffective medicines management.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers People were not protected against the risks associated with ineffective recruitment checks and procedures operated within the service.