Veatreey Development Ltd

Ascot Lodge Nursing Home

Inspection report

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Ratings

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

Overall summary

This unannounced inspection of Ascot Lodge Nursing Home took place on 28 January 2015.

Ascot Lodge Nursing Home is situated in a residential area of Southport and is close to local amenities and public transport links. It provides accommodation and nursing care for up to18 people. Accommodation includes a lounge, dining room, 12 single bedrooms and two double bedrooms. A nurse call system is in place. Facilities are in place to accommodate wheelchair access and people with limited mobility. There is an enclosed garden and patio at the rear of the premises and car parking space to the front. Ten people were living at the home at the time of our inspection.

A registered manager was not in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Summary of findings

Although staff told us that people's needs could fluctuate on a daily basis, they said the staffing levels were adequate to ensure people's safety was maintained and needs were met in a timely way. People living at the home said staff responded to requests and call bells promptly.

People told us they felt safe in the way staff supported them. The staff we spoke with knew about adult safeguarding and were aware of how to report any concerns they may have. They were familiar with what whistle blowing meant and said the home had a whistle blowing policy.

People told us they received their medication when they needed it. We observed staff administering it to people safely. Some medication needed to be stored in a fridge. The fridge temperatures were checked daily but on some days the temperatures readings were outside the recommended range. Nursing staff had not received medication refresher training. The medication reference book was out-of-date by six years. You can see what action we told the provider to take at the back of the full version of this report.

People's risk assessments were not always being followed. No risk assessments had been undertaken for people who used bedrails. You can see what action we told the provider to take at the back of the full version of this report.

Recruitment practices were not safe. Staff had started working at the home before references had been obtained and before they had been formally checked to see whether they were suitable to work with vulnerable adults. Staff did not receive regular supervision and appraisal. Staff training was not current or up-to-date. You can see what action we told the provider to take at the back of the full version of this report.

Building work was taking place at the time of our inspection and measures had been taken to minimise the disruption on people living at the home.

People had access to health care when they needed it, including their GP, community mental health nurse and chiropodist.

Arrangements were in place for families to provide consent to various aspects of their relatives care, including consent to the care planning and use of certain items of equipment. Staff had not received awareness training regarding the Mental Capacity Act (2005) and had a limited understanding of how it applied in practice. We made a recommendation regarding this.

Staff were caring and kind in the way they supported people. They treated people with compassion and respect. They ensured people's privacy when supporting them with personal care activities. People had a choice in the gender of staff they wished to receive support from.

Information about people's personal histories was not detailed in the care records. This lack of person centred information meant no information was available about the person's relationships, working life or hobbies for staff unfamiliar with the person to get to know them or plan activities to meet their needs. There was no evidence that recreational activities took place at the home. We made a recommendation regarding this.

The food at lunchtime was plentiful and wholesome. However, we found that some people did not have adequate support to ensure they had sufficient to eat and drink. You can see what action we told the provider to take at the back of the full version of this report.

The registered manager had recently left the service. There was a lack of clarity amongst staff as to who was providing leadership and management at the home. The nurse in charge did not have access to most of the information we needed to confirm the quality monitoring arrangements at the home. Some personal confidential records were not stored securely. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

Inadequate

Although medication was administered safely, medication requiring cold storage was not always stored at the recommended temperatures. Nurses had not received medication update training.

Staffing levels were adequate to ensure the safety of the people living at the home.

Staff were aware of what adult safeguarding concerns and knew how to report any concerns they may have.

The arrangements for recruiting staff were not effective as some staff had started working at the home before checks to determine their suitability to work with vulnerable people had been established.

Fire evacuation plans were in place for people living there.

Is the service effective?
The service was not effective.

Inadequate

People had access to health care when they needed it, including their GP, community mental health nurse and chiropodist.

Staff supervision, appraisal and training was not up-to-date.

Some people were not adequately supported at lunch time to ensure they had sufficient to eat and drink.

Staff had limited knowledge about the Mental Capacity Act (2005) and how it applied in practice.

Is the service caring?
The service was caring.

Good

Staff were caring and kind in the way they supported people. They treated people with dignity and respect. They ensured people's privacy when providing support with personal care activities.

People could have visitors when they wished.

Families were involved in planning care for their relative who lived at the home.

Is the service responsive?
The service was not always responsive.

Requires Improvement

Summary of findings

There was no information in the care records about people's relationships, working life, hobbies and interests to support unfamiliar staff with getting to know each person.

There were no arrangements in place for providing regular recreational or social activities.

Staff advised us that no complaints had been received about the service.

Is the service well-led?

Requires Improvement

The service was not always well led.

The registered manager had recently left the service. It was unclear who was responsible for the management and leadership of the home at the time of the inspection.

Quality monitoring audits and checks had been completed but we were unsure if they were the most recent ones as staff were unaware where all the information we required was stored.

Ascot Lodge 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 was 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 unannounced inspection took place on 28 January 2015. The inspection team consisted of an adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses care services.

Before our inspection we reviewed the information we held about the home. This usually includes a review of the Provider Information Return (PIR). However, we had not requested the provider submit a PIR. The 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 looked at the notifications the Care Quality Commission had received about the service. We contacted the commissioners of the service to obtain their views and took into account the local authority contract monitoring reports.

During the inspection we spent time with five people who lived at the home. We spoke with the nurse in charge, a registered nurse, the chef, the maintenance person and two care staff.

We looked at the care records for 10 people, two staff recruitment files and other records relevant to the quality monitoring of the service. We undertook general observations, looked round the home, including some people's bedrooms, bathrooms, the dining room and lounge areas.

Inadequate

Is the service safe?

Our findings

A small number of people were able to verbally communicate to us that they felt safe living at the home. When we asked a person what made them feel safe they replied, "There are people around." People said they felt comfortable in the way staff supported them and one person said they felt safe because, "They [staff] use the hoist. I feel safe and I don't mind it."

The majority of people living at the home were unable to verbally communicate their views to us. We observed that they appeared relaxed and at ease with the staff. We observed staff supporting them with personal care activities in a safe way.

The staff we spoke with knew about adult safeguarding and were aware of how to report any concerns they may have. We noted the arrangements for reporting safeguarding concerns were displayed in the foyer of the home.

We spoke with people about the arrangements for their medication. People said they received their medication at a time when it was due and one person said, "Absolutely, every morning" when we asked them if their medication was given on time. We observed a nurse administering the medication in the morning. This was done in a safe way and the medication trolley was locked when left unattended. The nurse stayed with each person to ensure they took their medication. We looked at the medication administration records and noted these were completed appropriately. Plans were in place for people who received medication when they needed it (often referred to as PRN medication).

We looked at the arrangements for the safe management of medicines. The medication trolley was stored in a dedicated room and was secured to the wall when not in use. The medication fridge temperatures were checked on a daily basis. We noted many occasions throughout January 2015 that temperature readings were outside of an acceptable range for the safe storage of medication requiring cold storage. The nurse in charge told us they had contacted the pharmacy who supplies medication to the home but the pharmacy could not provide a replacement fridge. No other action had been taken to check why the fridge temperatures were outside of range. Not storing medication at the recommended temperature can affect the efficacy of the medication.

We noted a tub of topical cream in a person's bedroom that had expired in 2012. Once we highlighted this, the nurse in charge removed it. Medication audits were completed monthly and the most recent audit we could see took place in November 2014.

The nationally recognised medication reference book (referred to as the British National Formula or BNF) available for the nurses was dated 2009. This would not provide up-to-date information as the BNF is produced twice a year to ensure the information about medicines is current. Although this reference book can be accessed electronically, not all nurses who worked at the home had access to the computer. The training records informed us the nursing staff were not up-to-date with refresher medication updates. One of the nurses told us they had not had any medication update training in the last five years.

Not providing nursing staff with current information about medicines and the management of medicines was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at the risk assessments and associated care plans for all the people living at the home. Relevant documentation was not always in place to confirm how risks were managed and minimised. For example, we were unable to locate a risk assessment for a strap that was used to prevent a person falling out of their chair.

Furthermore, some of the people living at the home had bedrails in place. Staff confirmed these were used to keep people safe by preventing them from falling from the bed. None of the care records contained a risk assessment that looked at whether the bedrails could pose a risk to the person. Although bedrails are used to reduce the risk of falls from bed, they can introduce other types of serious risks particularly for people living with dementia. A risk assessment is important as it can assist with identifying other potential risks in order to decide whether bedrails are suitable for the person.

Staff were not always following care plans developed to minimise risk to people. For example, we observed that a person had a care plan in place as they were at risk of choking on food. An assessment had been carried out by a speech and language therapist who advised that the person should have a pureed diet given with a teaspoon. We observed a member of staff feeding the person a pureed diet at lunchtime but with a dessert spoon. At one

Inadequate

Is the service safe?

point the person started to choke on the food and the member of staff slowed down with the spoonful's of food. We highlighted to the member of staff that the way they were supporting the person to have their meal was not in accordance with the care plan.

Not taking proper steps to ensure people were protected against the risks of receiving unsafe care was a breach of Regulation 9 (1) (a) (b) (i) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at how staff were recruited. The nurse in charge did not have a key to the filing cabinet that held staff records so we did not have access to the full range of staff personnel files. We located two staff personnel files in the office. The full range of recruitment checks were not in the files but in the absence of a manager we were unable to check if this information was stored elsewhere.

We spoke with staff and asked how they had been recruited to the job. Through our discussions with staff it became evident that some staff had started working at the home prior to references and a formal check being undertaken to confirm they were suitable to work with vulnerable adults.

Not having effective recruitment procedures in place was a breach of Regulation 21 (a) (i) (ii) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The people we spoke with said there were enough staff on duty to ensure they got support when they needed it. Staff said mostly there were enough staff but this depended on people's needs, which could vary from day-to-day. A member of staff said, "At the moment the staffing levels are alright because we only have 10 residents but there have been times there have not been enough staff." Some staff suggested that an extra member of staff would be helpful in the morning even for the 10 people living there because most people needed the support of two staff with some personal care activities. Staff said that if they needed to support people in their bedrooms or carry out tasks elsewhere in the building then the nurse would stay in the lounge to ensure people were safe.

We had a look around the home. Building work was taking place to install additional fire precautions. One of the floors was closed to accommodate this work. Measures were in place to minimise the impact of the building work on people living there, such as the spread of dust. We observed that the fire instructions were displayed high up on a wall which meant they were difficult to read. The care records that we looked at included individual evacuation plans for people in the event of a fire in the home.

We observed a broken chest of drawers in a person's bedroom with a sharp screw sticking out of the wood. The nurse in charge agreed to refer this to the maintenance person.

Inadequate

Is the service effective?

Our findings

People we spoke with were unable to tell us how they were supported to maintain good health and whether they had access to healthcare services. We looked at care records for all 10 people living at the home. We could see that people had regular access to health care professionals, such as the GP, chiropodist and community mental health nurse. Some people had diabetes and we observed that nursing staff made contact with the diabetic nurse specialist if they had any concerns. Equally, a speech and language therapist had assessed people who had difficulties with swallowing.

The nurse in charge provided us with the training matrix, which the previous manager used to monitor the status of staff training. The nurse in charge was unable to confirm if the staff training was up-to-date or whether the training matrix had been updated to reflect the current status of staff training. Based on the matrix, staff training was not up-to-date. Nurses had not completed medication training updates. Lifting and handling training, first aid and adult safeguarding training was required for most of the staff team. The nurse in charge advised us that training in adult safeguarding had been arranged for staff. Many of the people who lived at the home had dementia and most of the staff had not had training in this subject. Two people experienced seizures and staff had not had specific training in this area.

We spoke with a member of staff who was new to the service. They told us their induction consisted of watching DVDs for six hours the day after their interview. The day after the induction they started work at the home and were not supernumerary to the staffing numbers. They received training in lifting and handling but had not received any other training. Another member of staff who had been in post for a number of years confirmed their training was not up-to-date.

The nurse in charge was unable to tell us if staff were up-to-date with their supervision and appraisal. There was no access on the day of the inspection to the staff personnel records to check the status of appraisal. One of the staff had worked at the home for a number of years and told us they had not had an appraisal in that time.

Not providing staff with appropriate training and support was a breach of Regulation 23(1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at how people provided consent to their support and care, including how the home worked within the legal framework of the Mental Capacity Act (2005). This is legislation to protect and empower people who may not be able to make their own decisions, particularly about their health care, welfare or finances.

We noted from the majority of care records we looked at that people's families had been involved and provided their written consent to care plans. Some people had a statement in place regarding their medical care should they become ill or stop breathing. The person's GP had signed this statement and confirmed that arrangements had been discussed with the person's family.

The nurse in charge advised us that the current building work had been discussed with people living at the home and/or their families, particularly as some people had temporarily moved to another bedroom or to another care home. The nurse confirmed that families had agreed to this but was unable to locate the paperwork to confirm consent had been given.

Mental capacity assessment forms were in the majority of care records we looked at. However, they were generic in nature and did not clarify the decision that was being assessed. For example, we saw forms that just stated 'dementia, unable to express needs' and 'short term memory loss' so it was unclear why a mental capacity assessment had been undertaken.

We asked the nurse in charge whether anyone living there was subject to a Deprivation of Liberty Safeguards (DoLS) authorisation. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. The nurse advised us that one of the people had a DoLS plan in place. We could not find any reference to this in the care records so the nurse thought it may have expired. We contacted the Local Authority who had no record of the person being on a DoLS. However, they had received an application for another person regarding the use of a lap strap (device to prevent a person moving out of a chair). The application was being processed by the Local

Inadequate

Is the service effective?

Authority at the time of our inspection. We noted from the care records that one of the nurses had discussed the use of a lap strap with person's consultant psychiatrist and community mental health nurse.

Some people used bedrails. Although this item of safety equipment can be used to keep people safe when they are in bed, it can also be considered a form of restraint or restriction under the Mental Capacity Act. Where a person lacks capacity to consent to the use of bedrails, then the guidelines of the Mental Capacity Act should be followed. This means the equipment can be used if it is deemed to be in the person's best interests. Although a mental capacity assessment had not been undertaken regarding the decision to use bedrails, most families had provided written consent to the use of this equipment in the person's best interest.

Some staff we spoke with were uncertain about the nature of Mental Capacity Act and how it applied in care home settings. They were unsure what DoLS meant and were not clear about what restrictive practices meant. The training matrix informed us that none of the staff had undertaken mental capacity training.

We asked people their views of the food. They said the food was good. One person told us, "It's very good. I don't know what is on the menu today." Another said about the food, "I think it is good." We sampled the lunchtime meal. It was tasty, plentiful and served at a warm temperature. People had a choice and one person had something different because they did not like the choices available. Some people who needed feeding by staff had their meal in the lounge. Their food was pureed and people appeared to enjoy the meal they were having.

Three people ate at the dining room table. The table was not set with place mats, cutlery, napkins or condiments prior to the meals arriving. We asked staff why this was and they said, "The residents pull things off." We did not see people do this throughout the 20 minutes we sat with them at lunch. Two people sat at the table in their wheelchairs but the table prevented the wheelchairs from getting close enough to the table, which meant it was awkward for people to reach their food and food easily spilled onto their clothes. People were given napkins but did not appear to know how to use them.

Some people were using their fingers to eat and others did not appear to know how to use the cutlery. We asked staff if they could provide plate guards (device to prevent food falling off the plate) for some people and we noted people found it easier to eat once these were in place. One person ate very little of their meal and appeared to struggle with using cutlery. We had to ask staff to support the person by cutting their food into small pieces. The person still did not eat their meal and staff said they would give the person a sandwich. We did not see a sandwich arrive for the person during or after lunch. It was important that the person had sufficient to eat as they had a medical condition which meant their blood sugar fluctuated.

Rice pudding was served at the same time as the first course and this meant it had started to go cold before people got to eat it. Drinks were not offered to people until the end of the first course. We tasted the coffee served after lunch and it had gone cold. We observed that none of the people drank their tea or coffee.

Not adequately supporting and monitoring people with their food and drinks meant this was a breach of Regulation 14(1) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We recommend that the service considers current guidance in relation to the Mental Capacity Act (2005) and takes action to update its practice accordingly.

Good

Is the service caring?

Our findings

Throughout the inspection we observed staff calling people by their name and supporting them in a caring, respectful and dignified way. The care staff spoke in an encouraging way to people who needed feeding at lunch time. In the main, we heard staff explaining to people what was happening prior to providing care or support. However, on one occasion we did hear staff providing care to a person who was in bed and noted they conversed with each other rather than with the person receiving the care.

Personal care activities were carried out in private. Staff were patient and unhurried in the way they supported people. The care staff we spoke with demonstrated a warm and genuine regard for the people living there. They took time to try and understand people who were unable to express themselves in a coherent way.

People said if they had a choice about the gender of the staff supporting them. One person said, “Yes, I prefer ladies, I always get ladies.”

A person living at the home had specific dietary needs related to their religion and the chef confirmed they received meals based on their dietary specifications.

Two of the people living at the home told us they could have visitors at any time and staff confirmed visitors, including pets, could visit whenever they wished.

We could see from the care records that families had been involved in the planning of care for their relative. Families had signed documents, such as consent to the provision of care and consent to use of specific items of equipment. One person did not have family to represent them and they had been referred to the Court of Protection. The Court of Protection was created under the Mental Capacity Act (2005) and is a specialist court for all issues relating to people who lack mental capacity. We also noted they person had been referred to an independent advocacy service in April 2014.

Most people had their own bedroom but two people were sharing a double bedroom temporarily while the building work was taking place. The nurse in charge said this arrangement had been discussed and agreed with both people’s families. Measures were in place to ensure the privacy and dignity of the people sharing a bedroom. We noted a person was occupying an extremely small bedroom in the basement with very little room for anything other than a bed. The nurse advised that this also was a temporary measure until the building work was finished.

The environment had a homely feel. We saw notices in the foyer about staff training and other information related to staff. This would be best positioned elsewhere so the service retained a homely feel focussed on the people living there.

Requires Improvement

Is the service responsive?

Our findings

Two people told us staff supported them in a way that they liked. One person told us staff supported them to get up at their preferred time of 10.00 am. We asked people living at the home if they were encouraged to maintain their independence. A person responded with, "I wash my own hands and face. I like to do as much as I can." Two people living at the home told us the staff responded promptly to call bells. One person said, "They come quickly."

Although there was information about people's health and medical conditions in the care records, there was either limited or no detail about each person's background. This lack of person centred information meant there was no information about the person's relationships, working life, hobbies and preferences in order for staff unfamiliar with the person to get to know or start a conversation with the person. The term 'person centred' means that people's individual needs, wishes and preferences are at the centre of how the service is delivered. In addition, we did not see information about people's preferred daily routines. This information is important as most people living at home experienced confusion and two of the staff who were on duty during the inspection were new to the home.

We asked two people how they spent their day and about the activities they liked to participate in. One person said, "I like to stay in my bedroom." Another person responded with, "I don't like the television. I play the piano but I have gone off it a bit lately. There was a keyboard next to the person. No recreational activities took place during the inspection and we did not see any information to suggest a programme of activities was in place. There was no information in the care records to indicate what activities each person would like to participate in.

We asked staff about recreational activities for people living at the home. One of the staff said, "They don't do much now. The residents we have are not capable. They can't play bingo. In the afternoon we put the radio on. Nobody takes any notice of the television." We noticed that the television was on in the afternoon and only one person appeared to be looking at it.

We asked one person if staff listened to their opinions and concerns. The person said, "It would have to be yes. That is what they [staff] are here for and they have to do it." The nurse in charge told us the home had received no complaints. We asked to see any information related to complaints, including documentation related to previous complaints and the nurse did not know where this was kept. We found a 'complaints book' in the office but the last entry in this was dated 3 January 2012.

We asked if any surveys were undertaken to seek people's views of the service. The nurse in charge said they did not think questionnaires were sent out.

We asked the chef if people living at the home were involved in menu planning or provided feedback on the meals. The chef advised us that they completed a mealtime questionnaire in 2014. They told us they were in the process of conducting a more in-depth questionnaire. The chef told us they take the questionnaire around and complete it with each person individually.

We recommend that the service considers current best practice guidance about person centred care for older people, including planning for recreational activities.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was not in post as they had left the service at the end of December 2014. We were informed by the provider (owner) just before the inspection that a new manager was due to start at the home at the beginning of February 2015. It was intended that the new manager would apply for registration with the Care Quality Commission.

We asked who had been managing the home since the previous manager left. The nurse in charge advised us that the registered manager from one of the provider's other local care homes was managing the home and carried out monitoring and auditing of the service. We spoke with this manager the day after the inspection who advised us they were not managing the service but had just been involved to undertake an investigation. This meant there was a lack of clarity amongst staff and for us as to who was responsible for the management and leadership of the service.

The nurse in charge told us they had limited access to information about the service, in particular quality monitoring information. Some of the filing cabinets contained information we needed to see but were locked and the nurse in charge did not have a key. The nurse was unsure what quality monitoring information was held in paper format and what was held electronically. The nurse could not access the electronic information on the day of the inspection as their password was not functioning at that time. We noted that two staff personnel files containing very sensitive information in relation to staff performance were located and easily accessible on top of a work surface in the office.

By not keeping records secure and making them available when required was a breach of Regulation 20 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The nurse in charge was unsure when the previous manager last carried out monitoring checks of the service and advised us that the staff team had not usually been provided with feedback on the outcome of audits or investigation into incidents or complaints. We found a file in the office that contained completed audits. These mainly related to the environment and equipment. A 'Planned maintenance and grounds audit' was dated 4 February 2014. Other information in the file included a water safety check (6/1/2014), gas safety check (5/1/2015), portable electrical testing (7/11/2014) and housekeeping audit (4/2/2014). Hoists were checked on 23 January 2015. In the absence of a manager, we could not be sure these were the most up-to-date audits.

Staff told us care plans were usually reviewed each month. We observed that some had last been reviewed since November 2014. Some care plans had not been revised or discontinued even though people's needs had significantly changed. The nurse in charge was aware of this and said they were due to update the care plans. The most recent care plan audit we found in the office was dated 4 February 2014.

We located two incidents reporting books in the office that were being used simultaneously. The nurse in charge was unsure whether incidents were analysed to identify emerging themes and patterns.

Staff told us that periodic staff meetings were held but there had not been a meeting for some time. The most recent staff meeting minutes we could locate were dated 24 June 2014. We gathered from our conversations with people and staff that meetings for people living at the home and their relatives were not held.

We asked staff what support systems were in place for staff and staff felt there was no support since the previous registered manager left. A member of staff said they felt "abandoned" since the manager left.

Staff told us the home had a whistle blowing policy. They were aware of whistle blowing meant and said they would not hesitate to use it if they were concerned about how people living at the home were being treated.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **People living at the home were not protected against the risks associated with the management of medicines because nursing staff were not up-to-date with medication training and the information about medicines available at the home was not current. Regulation 13.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **People living at the home were not protected against the risks of receiving unsafe care because risk assessments were not always undertaken or they were not being followed by staff. Regulation 9 (1)(a)(b)(i)(ii).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The provider did not have safe and effective recruitment procedures in place. Regulation 21(a)(i)(ii)(b).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **Staff had not received appropriate training, supervision and appraisal to enable them to deliver care to people safely and to an appropriate standard. Regulation 23(1)(a).**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs People were not effectively supported at meal times to protect them from the risks associated with inadequate nutrition and hydration. Regulation 14(1)(c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Records requested as part of the inspection could not be located or were not accessible. Some records containing personal confidential information were not held securely. Regulation 20 (2)(a).