Mr & Mrs Y Jeetoo

Beech Lodge - Thames Ditton

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?	Requires improvement

Overall summary

Beech Lodge – Thames Ditton is a care home providing accommodation and personal care for up to nine people with learning disabilities and mental health needs.

The inspection took place on 10 November 2015 and was unannounced.

The home did not have a registered 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. The current manager had been working in the home since June 2015 and was in the process of applying to be registered.

We found that people were placed at unnecessary risk because hazards in respect of the environment and fire safety had not always been appropriately managed. For example we found that fire exits were not always kept free from obstruction and there were not adequate plans in place to demonstrate how people would be safely evacuated in the event of a fire. We reported our concerns

Summary of findings

to the local fire safety who visited and conducted their own inspection which resulted in requirements being made under The Regulatory Reform (Fire Safety) Order 2005.

The home was unclean and some areas were in need of refurbishment. Whilst a part-time cleaner was employed, the majority of cleaning was left to the people who lived there and they received minimal support and supervision in respect of this. Our shoes stuck to non-carpeted floors as we walked around the home and surfaces in communal areas were sticky to touch. In some of the bedrooms, people's shelves and units were thick with dust and sinks heavily stained. Communal toilets were soiled and unpleasant to access.

Whilst people received most of their medicines as prescribed, the systems in place for checking medicines were appropriately disposed of had failed. We found a number of stock medicines that were out of date and other items that had been opened and not discarded after use. There were no guidelines in place for the use of homely remedies such as paracetamol and cough medicines despite there being a stock of these being held. People were otherwise supported to maintain good health and had regular access to a range of healthcare professionals.

Staffing levels were sufficient to meet people's needs, but were not always deployed appropriately. Not all staff had the specialist skills and experience to support people effectively. The training programme in place for staff did not include key areas such as how to support people with mental health needs. The result of this was that some staff did not engage appropriately with people and motivate them to participate in meaningful activities.

Care plans were personalised and well documented, but were not always followed in practice. Staff were not always good at instinctively giving people choice and control over their lives. For people who did not have their own aspirations, there was a lack of engagement and development.

Staff took appropriate steps to maintain people's privacy and dignity and were respectful of their personal space and belongings. The language used in supporting some people with behaviour that challenges was not always respectful. One person told us that they felt they were sometimes treated as child and we heard other people talking about the need to be "Good" or "Quiet."

There was choice in respect of mealtimes, but this was offered reactively rather than as a matter of course. Whilst people had the capacity and ability to make their own decisions about meals, they felt obliged to seek permission or were heavily supervised in the process. It was not clear how the staff supported people to maintain a sufficiently varied and balanced choice of meals. We have made a recommendation to the provider about this issue.

The provider had a range of audit tools in place, but these were not always effective in identifying quality issues within the home. The manager was seeking to effect change as a result of concerns raised in a recent survey completed by people, but more was needed to provide adequate leadership and development to staff.

Appropriate checks were undertaken when new staff were employed and staff understood their safeguarding responsibilities. People's legal rights were protected because staff routinely gained their consent and understood that each person had the capacity to make decisions for themselves.

Equality and diversity was managed well and people were supported to follow their own religious and cultural preferences. We saw that people who wished to attend church were supported to so and consideration was given to the attendance at religious festivals and carnivals.

We found a number of breaches of regulations. You can see what action we asked the provider to take at the back of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

People were placed at risk because hazards in respect of the environment and fire safety had not been appropriately assessed and managed.

Systems in place to manage medicines did not always ensure that people received them safely.

The home was not clean and was in need of refurbishment in some areas.

Staffing levels were sufficient to meet people's assessed needs although staff were not always effectively deployed so as to provide people with appropriate support and engagement. Appropriate checks were undertaken when new staff were employed.

Staff understood their safeguarding responsibilities, but there were no systems in place to ensure they were up to date with how safeguarding is investigated and managed under the Care Act 2014.

Is the service effective?

Requires improvement

The service was not always effective.

There was a training programme in place, but not all staff were up to date and learning did not cover the specialist needs of the people staff were expected to support.

People did not always receive a sufficiently varied and balanced choice of meals.

People's legal rights were protected because staff routinely gained their consent and understood that each person had the capacity to make decisions for themselves.

People were supported to maintain good health and had regular access to a range of healthcare professionals.

Is the service caring?

Requires improvement

The service was not always caring.

The language used in relation to supporting people with behaviour that challenges was not always respectful to them.

Staff were not always good at offering people choice and control over their lives.

Equality and diversity was managed well and people were supported to follow their own religious and cultural preferences.

Summary of findings

Staff took appropriate steps to ensure people's privacy and dignity were maintained.

Is the service responsive?

Requires improvement

The service was not always responsive.

Care plans were personalised and well documented, but did not always reflect the care provided in practice.

Staff did not always effectively support with those people who were less self-motivated and as such they did not engage in activities that were meaningful to them.

Where people raised complaints, they were listened to and their concerns investigated.

Is the service well-led?

Requires improvement

The service was not always well-led.

The manager was in the process of applying for registration. Whilst they were in the process of effecting change, more development and leadership of staff was required.

The provider had a range of audit tools, but these were not always effective in identifying quality issues with the home.

The culture of the home was such that it did not feel people were always valued as equals by staff.

Beech Lodge - Thames Ditton

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 10 November 2015 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the registered person is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection. We also asked the provider to complete a Provider Information Return (PIR) before our inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

As part of our inspection we spoke with seven people who lived at the home, four relatives, two staff, the manager and two other professionals, including the local fire officer. We also reviewed a variety of documents which included the care plans for three people, four staff files, medicines records and various other documentation relevant to the management of the home.

The home was last inspected in January 2014 when we had no concerns.

Requires improvement

Is the service safe?

Our findings

All the people we spoke with told us that they felt safe at the home. They told us that others were "Nice to them" and being able to talk to staff made them feel safe.

Despite, people telling us that they felt safe, we identified some environmental issues that meant they were being placed at risk of harm. During the inspection we observed a number of concerns in respect of fire safety which indicated that people might not be properly protected in the event of a fire. For example, we noticed that the main fire exit from the communal lounge/dining area was obscured for a large part of the day by a hoover. This was in full view of all of the staff working in the home, including the manager and yet no one had identified the risk until we highlighted it to them. Similarly, we noticed that a number of fire doors around the home did not close fully and as such would not provide the necessary protection in the event of a fire. Training records showed that only two of the current staff team were up to date with their fire training which may be the reason staff were not aware of the risks.

We read that the fire risk assessment for the home was dated October 2011 and had not been updated since. We had concerns that the risk assessment in place was not adequate and people did not have Personal Emergency Evacuation Plans (PEEPS) to identify how they would be safely evacuated in the event of a fire. One of the people who lived in the home smoked and a risk assessment found within their care plan stated that they were not permitted to smoke in the home and that "Staff should be consistent in their approach to this." During the inspection we noticed that this person had smoked a cigarette in their room and staff did not manage this situation in accordance with the risk assessment.

Following the inspection, we contacted the local fire service and a fire officer undertook a fire safety inspection of the property. This highlighted multiple deficiencies and they issued requirements under The Regulatory Reform (Fire Safety) Order 2005 for the home to make improvements.

We observed that none of the windows above ground floor had been restricted to prevent people falling from them. We read in care plans that some people who lived in the home had current or historical experiences of living with depression. The fact that windows were unrestricted had not been assessed to ascertain whether wide openings posed a risk to people.

Failure to assess and where possible, mitigate risks to the health and safety of people using the service was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home was unclean and parts were poorly maintained. We found that floors and surfaces throughout the communal areas were unclean. As we walked through the home our shoes stuck to the areas of the home that were not carpeted and surfaces were sticky to touch. The toilet in the ground floor shower room was dirty and soiled. The shower head in the upstairs bathroom was coated with lime scale. The surfaces in most people's rooms were with covered in thick dust and sinks were heavily stained. One person had a fridge in their room in which we found uncovered food and spillages of liquids that had dried to the inside surface. The person commented to us "It's disgusting isn't it?"

Staff told us that the home employed a part-time cleaner, but that the people who lived in the home were responsible for the daily cleaning of their rooms. When we asked to see a copy of the cleaning schedule for the home, we were presented with a list of people's names and the days they were expected to clean the bathrooms. It was not appropriate that people were expected to clean these areas. People had not been trained in infection control or which personal protective equipment to use to protect them from the risk of infection. One person told us "I don't like the chores, like cleaning." There was no checklist for the employed cleaner to detail what they were expected to clean and how often. As such, areas such as skirtings, ceilings and other hard to reach areas were found to be deeply ingrained with dirt and dust.

Parts of the home were in need of redecoration. For example paintwork was found peeling in many areas, the fridge-freezer was damaged and tiles in the upstairs bathroom were cracked. The manager said that there was an ongoing plan for refurbishment and we saw that some areas had recently been redecorated. There was however no plan which showed the timescale for the completion of the work needed.

Requires improvement

Is the service safe?

Failure to provide premises that were clean, properly maintained and suitable for the purpose for which they are being used was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst people told us that they received their medicines when they needed them, we found there were improvements needed in the way medicines were managed within the home. We found that some of the medicines in the home were out of date. For example, one person self-administered their own inhalers and showed us an inhaler in their room which had an expiry date of May 2015. In the medicines cabinet we found a stock of four further inhalers that were out of date and another medicine which expired in January 2014. We also found creams and eye drops for people that had been opened, but not discarded after use. The home's own checks and audits of medicines had failed to identify that the system of disposing of medicines was not working.

Not all medicines were secured securely. Whilst the main medicine cupboard was locked at all times and the key held by a member of staff, additional medicine supplies were found stored in another room. During the inspection we observed this room to be unlocked and had to alert staff to secure it. The fact that we could access this area meant so could anyone else living in or visiting the home.

Whilst Medication Administration Records (MAR charts) for oral medicines were found to have been completed, we highlighted that staff were not signing for the application of topical medicines. Topical medicines include items such as creams which were applied to people during support with personal care. There were no guidelines in place for the use of over the counter medicines (homely remedies) such as Paracetamol or cough medicines. The manager told us that they only administered medicines that were listed on people's MAR charts, but we found a stock of other homely remedies in the medicine cabinet. Guidelines for the use of people's occasional medicines, such as those used to treat episodes of excessive anxiety were not always in place. As such, the registered person could not be assured that staff administered these medicines appropriately and consistently.

Failure to ensure the proper and safe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had policies and procedures in respect of safeguarding people, with details of who staff should contact if they suspected abuse. It was however highlighted that the safeguarding policy had not been updated since the Care Act 2014 had come into force and as such was not reflective of the most up to date information about abuse and how allegation should be investigated. Staff spoken with however were confident about their roles and responsibilities in respect of safeguarding and said they would not hesitate to report any concerns. The manager made enquiries to source the updated multi agency guidelines during the inspection.

Staffing levels were sufficient to meet people's assessed needs, but staff did not always deploy themselves effectively to ensure people were appropriately supported and engaged with. During the inspection however, we observed that one staff member in particular did not support people effectively. Instead of engaging with people and supporting them, they stood and watched them undertake tasks, with minimal interaction. This did not provide effective care nor meet people's needs. We observed that due to a cancelled in-house activity, one person spent the entire day on the sofa in the lounge. Available staff did not work with this person to engage them in a meaningful activity. We highlighted that the issue with staffing on this occasion was a reflection of staff practice and deployment rather than lack of numbers.

The people living at Beech Lodge were largely independent of their personal care. During the day, people attended a range of day services and employment activities which meant that they were not always in the home. As such, we were told by people and staff that the provision of two staff on duty during the weekdays allowed people to receive the support they required. At weekends, we were told by staff and people that a third member of staff would often be on duty to provide additional support with community activities.

The provider carried out appropriate checks to help ensure they employed suitable people to work at the home. Staff files had all the required information, such as a recent photograph, written references and a Disclosure and Barring Service (DBS) check. DBS checks identify if prospective staff had a criminal record or were barred from working with people who use care and support services.

Requires improvement

Is the service effective?

Our findings

Most people said that they could talk to staff and that they supported them well. One person told us that they sometimes got "Angry and disappointed" and that were able to talk to staff about how they were feeling. Another person however said that staff did not always motivate them effectively and we saw this to be the case. The person told us "My social worker tells me I should be doing more, I do play on it." We noticed that some staff did not always support and communicate effectively with this person and this meant that their needs were not always met.

During the inspection we observed some good examples of staff supporting people who were anxious or aggressive. We also saw one member of staff who did not engage well with people. Discussions with staff supported our view that not all staff were good at motivating people to be as independent as possible and that not all staff had a good understanding of people's mental health needs.

We found that there was a training programme in place for staff, but there were many gaps in the training records. Whilst we read that most staff had completed training in core areas such as health and safety, first aid and managing behaviour that challenges, more specialist training had either not been provided or completed by all staff. The effect of this was that not all staff had the necessary skills and experience to do their job well.

Failing to provide staff with appropriate training to enable them to carry out their duties was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People gave us mixed views about how involved they were in the planning of meals. Staff told us that menus were discussed and agreed at resident's meetings. People generally described the food as "Alright" and "Reasonable." The menu displayed showed that both lunch and evening meals were set. Staff told us that people could request an alternative at lunch and we observed this to be the case, but it also meant that choice was reactive rather than instinctive. For example, we overheard one person ask what was for lunch and staff told them what was on the menu rather than asking what they would like. We were told that each person had the capacity to make decisions about their meals and indeed most were capable of independently making their own choice. It was therefore not clear why the menu was so structured.

One person said that there was a lot of frozen food used and when we looked at the food in the home, we saw a large supply of ready-made foods such as quiches and fish fingers in the freezer. The menu on display also reflected a large amount of processed foods. Staff were not able to tell us how they ensured people maintained a nutritionally balanced diet. Records showed that only three staff had completed training in nutrition and diet.

It is recommended that the registered provider consider how to improve the dining experience at the home so as to ensure that people have greater choice at mealtimes and are appropriately supported to maintain a balanced diet.

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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. People told us that staff always asked for their consent and respected their capacity to make decisions. Staff demonstrated that they understood people's legal rights and had knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). As the people who lived at Beech Lodge had capacity to make decisions about where they lived, no one was being deprived of their liberty. Care records showed that people were consulted with about all aspects of their care and had signed their support plans in agreement. A best interests decision was being considered in respect of one persons finances and the manager had appropriately liaised with the Local Authority in respect of this.

Requires improvement

Is the service effective?

Staff ensured that people had access to external healthcare professionals and received the healthcare support that they required. We found evidence of people attending regular health checks with their doctors, dentists, opticians and psychiatrist. We also saw that one person had been supported to access counselling in respect of a recently identified need.

Requires improvement

Is the service caring?

Our findings

Most people told us that staff were kind and compassionate towards them. One person however said that they felt that staff treated them like a "Child." They told us "When you go to the toilet they shout that you must wash your hands, I am X years old and I know to wash my hands." Another person said that they had heard staff telling a person that if they didn't behave they would be "Thrown out" and went on to say that staff "Argue" with this person when they display behaviour that is challenging.

The language used in reference to people's behaviour that challenged was also not always respectful. For example, we read in the complaints file that one person had complained about the behaviour of another person that had upset them. Whilst it was good that this concern had been taken seriously, the manager had recorded that the person had been "Reminded that [they] can be a very nice, pleasant [person] from time to time and [they] should try to behave more often." When we spoke with people, they frequently mentioned being "Good" and "Quiet." This type language reflects the other person's assertion that they sometimes felt patronised by the way staff spoke to them.

The failure to always treat people with dignity and respect was a breach of Regulation 10 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care records contained a good level of involvement from people who had signed to say that they had been consulted about and involved in their care. The support provided in practice however was not always reflective of the care agreed and recorded. For example, whilst care plans described personalised care and reflected people's capacity to make decisions for themselves, we saw that staff did not always give choice instinctively. We noticed that some care staff told people things rather than engaging with them as equals. We also observed that the routines of the day were task orientated rather than bespoke to the individual.

We saw feedback from relatives of people who lived in the home which expressed thanks to the staff for the support they provided to their family member. In September 2015, one relative wrote a letter of thanks to the manager which included "Please pass on my thanks to all your staff for their stirling work, kindness and compassion which always leaves me feeling very humble when I visit."

Equality and diversity was managed well and people were supported to follow their own religious and cultural preferences. We saw that one person enjoyed reading their bible and time was built in every day to allow this to happen and they were assisted to attend their church twice weekly. We also read in their care plan that it was important for this person to carry a bag containing specific belongings with them at all times and we saw that this happened in practice.

Staff took appropriate steps to ensure people's privacy and dignity were maintained. We saw that staff showed total respect for people's rooms and did not enter them without the person's express permission. People confirmed that this was always the case and that staff were respectful of their belongings and space. We observed that people's personal information was afforded the same respect and documents relating to their care or other private matters were kept confidential and secure.

Requires improvement

Is the service responsive?

Our findings

People told us that they had been involved in the planning of their care and in reviews. We saw in care records that people had signed each section to indicate that they understood and agreed with the contents.

We found that whilst the written care plans were person centred and reflected the information that individuals shared with us, this personalised approach to care was not always provided in practice. For example, care plans described the provision of support that was individual to the person and yet much of the interaction we observed between staff and people was task orientated. There were no identified goals for people to work towards and for those people who lacked self-motivation, it was not possible to see how they were being appropriately supported to achieve maximum independence. Staff told us that there were differences in how staff approached people and gave examples of how differently people interacted dependent upon which staff were working. One person confirmed this and said that they would "Play certain staff". This lack of consistency meant that people's needs were not always met effectively.

We saw that some people lacked engagement and activity during the inspection. An external exercise person had needed to cancel their usual session on the day of the inspection. Despite being aware of this, no alternative activity had been planned for people. For one person this meant that they spent most of the day on the sofa in the lounge area watching television with little engagement from staff. We observed that for those people who were expected to undertake cleaning jobs, these were not always done with appropriate support. As such, not only was the cleaning not done to an acceptable standard, but the person quickly lost interest in the activity itself.

For other people, we saw that they attended external day services and activities that were more meaningful to them. One person talked to us about two jobs that staff had helped them to get. They were really proud of this work and had clearly been effectively supported to develop their independence in this way. Another person told us that they enjoyed going out for walks with a certain staff member at weekends, but this only happened with particular staff. It was apparent to us that this person would most likely spend time watching television if not encouraged to do more for themselves.

The failure to effectively support people who were less self-motivated to receive care that meets their needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We read that care plans were regularly reviewed with people. People were enabled to take appropriate risks to develop their skills and work towards independence. As such, we saw examples where the process of risk assessment had been used effectively to enable people to go out on their own. For one person, this process meant that they were now able to use public transport independently. For another person, they had been encouraged to go out daily to the local shops. Developing such life skills had boosted their confidence and improved their quality of life.

Where people raised complaints, they were listened to and their concerns investigated.A copy of the complaints procedure was on display in the home and we noted that some people had a more accessible version in their bedrooms. Most people told us that they knew how to complain if they needed to. Records of complaints made showed that people did feel confident to voice their concerns and that these had been taken seriously and investigated.

Requires improvement

Is the service well-led?

Our findings

Most people told us they liked the manager and described him as a "Nice chap" and said "He's very quiet and very calm." People said that they had regular residents' meetings, but one person said that "Nothing is resolved."

The manager had been in post since June 2015 and was in the process of applying for registration with the Commission. It was clear that they were they were in the process of effecting change within the home, but more development and leadership of staff was required in order to secure better outcomes for the people living at Beech Lodge.

We read that staff were now having regular supervisions with the manager and these were seeking to address some of the concerns highlighted about improving team work and developing staff. We also saw that staff were being reminded to complete their training, although there was no obvious process in place for ensuring that learning was being transferred into improved practice.

The provider had a range of audit tools, including monitoring reports that had been undertaken by an external consultant. Despite being completed, these checks were not always effective in identifying quality issues with the home. For example, the recent medicine audit had not identified the concerns with disposals of out of date medicines, homely remedies or protocols for managing topical or prn medicines.

The manager said that they were the designated infection control lead for the home. They said that they had not completed any training in respect of this role and the training records showed that he had also not completed the more general infection control course. The recent infection control audit that had been completed by the manager had failed to identify the concerns about the cleanliness of the home as highlighted at this inspection.

The provider's own monitoring systems had therefore not ensured that people were protected against some key risks described in this report.

These matters were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the culture of the home was such that it did not feel people were always valued by staff. We observed that people were not always engaged with in a meaningful way and some staff only spoke with people in relation to the tasks that they wanted them to undertake. The lunchtime meal was functional with limited interaction. In the afternoon, we observed one staff member watching over two people in the kitchen without talking with them. Staff required greater leadership to ensure they supported people in line with values of the service.

In October 2015, questionnaires were completed by people living in the home. We looked at the results of these and identified two areas for concern. Two people stated that they only got to go out and do other things sometimes. Another person highlighted that they didn't always feel that they were treated as an equal. These matters had not been addressed and were identified as a concern at this inspection. We saw that the manager had held a meeting with people in response to the results received and that agreed actions had been set to make improvements and through the action we have asked the provider to take, we will continue to monitor whether these have effected change.

Incident and accident reports were completed as necessary and the manager appropriately reported notifiable incidents to the CQC in accordance with the Health and Social Care Act.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person had failed to appropriately assess and where possible mitigate risks to the health and safety of service users.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **The registered person had failed to ensure that premises were clean, properly maintained and suitable for the purpose for which they were being used.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person had failed to have appropriate systems in place so as to ensure the proper and safe management of medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered person failed to provide appropriate training to enable staff to effectively carry out their duties and understand people's specialist needs.**

Regulated activity	Regulation

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	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The registered person failed to ensure that people were always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered person had failed to effectively support people who were less self-motivated to receive care that meets their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had failed to assess, monitor and improve the quality of services and mitigate risks relating to health and safety.