Parklands Care Services Limited

# Wyndthorpe Hall & Gardens Care Home

## Inspection report

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## Ratings

| Overall rating for this service | Requires Improvement |
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|---|---|
| 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** |

# Summary of findings

## Overall summary

Wyndthorpe Hall & Gardens Care Home is registered to provide accommodation, nursing and personal care for up to 82 people. The home is comprised of two separate buildings, is set in extensive grounds and is divided into three units. Two units, the Court and the Gardens accommodate people living with dementia. The home is situated in the Dunsville area of Doncaster and has access to shops, public transport and other amenities.

This inspection took place on 6 July 2017 and was unannounced. This was the first inspection of the service since it was taken over by the current registered provider. At the time of the inspection 80 people were living in the home.

There was no registered manager at the time of the inspection. 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 provider had appointed a new manager, who had started work a number of weeks before the inspection. The manager told us they were preparing to apply to become registered.

We found that medication was not well managed in the Hall and Court parts of the home.

For the most part assessments identified potential risks to people, and management plans were in place to reduce these risks. However, this was not always the case for everyone, and in some cases, the records staff kept about the care they delivered to people were not sufficiently detailed.

It was a very warm day and we noticed a smell of urine in two particular areas of the home. However, all other parts of the home looked clean and did not smell.

For the most part, positive caring relationships were developed with people who used the service. Staff spoke to people respectfully, and in a gentle and caring way.

People told us they felt safe living at the home. Recruitment processes were safe and we saw there were sufficient staff on duty to meet people's needs.

Most of the feedback from people living in the home and their visiting relatives was complimentary regarding how nice the staff were, and about the care that people received.

Staff completed an induction and essential training at the beginning of their employment. This was followed by additional training and periodic refresher sessions, although there was a need to provide training to staff in caring for people at the end of their life. Staff also received support and supervision to help them meet people's needs.

People said they were happy with the meals provided, and drinks and snacks were available between mealtimes.

For the most part people were supported to have choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice.

People had been involved in planning their or their family members' care. In most cases, care plans reflected people's needs and had been reviewed and updated to reflect their changing needs.

People had access to social activities, as well as outings into the community.

There was a system in place to tell people how to raise concerns and how these would be managed. People told us they had no complaints, but would feel comfortable raising any concerns with the manager.

There were systems in place to assess if the home was operating correctly, however these had not been effective as they had failed to identify the shortfalls we found at this inspection, including some inconsistencies in staff practice.

Although people using the service and their relatives told us they were involved and consulted about the care, they had not been provided with specific forums to share their opinions, such as 'residents' or 'relatives' meetings. There had been asked to fill in any quality surveys since the new registered provider had taken over the running of the home.

We found breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of governance, safe care and medication. You can see what action we told the provider to take at the end of this report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe.

Medicines were not always managed safely in the Hall and Court areas of the home.

Records regarding the care delivered to people were not always complete, up to date or detailed enough in the Hall and Court areas of the home.

There were enough staff to ensure that people were safe and their needs were met.

Staff were appropriately checked for their suitability before they started working in the home.

### Is the service effective?

**Good**

The service was effective.

People had access to appropriate healthcare services, such as dietetic services.

In most cases, suitable arrangements were in place to support people to maintain a healthy intake of food and drink and people's preferences were taken into consideration.

Appropriate training was provided to staff, but there was a need to provide training to staff in end of life care.

The service was meeting the requirements of the Mental Capacity Act (2005) (MCA) and associated guidance.

Steps had been taken to implement environmental improvements, to help to make it suitable for the people living with dementia who lived in the home.

### Is the service caring?

**Good**

The service was caring.

Most people we spoke with, their relatives and other external

professionals said the staff were caring and we saw staff being gentle and kind.

People's privacy and dignity were promoted.

## Is the service responsive?

Good

The service was responsive.

People received care which was generally responsive to their needs because staff knew people well.

There were activities on offer and a good level of engagement and stimulation for people.

The service had a complaints procedure and people and their relatives were confident to complain if needed.

## Is the service well-led?

Requires Improvement

The service was not always well led.

There was a new manager in post at the time of inspection and overall, feedback was that staff morale was improving.

Systems for monitoring the quality and safety of the service were not always effective enough to identify and address shortfalls or mitigate risks.

Although people who used the service and their relatives said they felt involved and consulted about the care, they had not been asked to comment on the general quality and running of the service by the new registered provider.

# Wyndthorpe Hall & Gardens Care Home

**Detailed findings**

## Background to this inspection

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

The inspection took place on 6 July 2017 and was unannounced. This was the first inspection of the service since it was taken over by the current registered provider.The inspection team consisted of two adult social care inspectors, a specialist advisor who had experience of managing similar services, and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

During the inspection, we spoke with nine people using the service, five relatives, two nurses, seven care staff, two cooks, the deputy manager, the manager and the head of care. We also spoke with two external health care professionals during and after the inspection, including specialist community nurses and the commissioners of the service.

On this occasion we did not ask the provider to complete a provider information return (PIR) before our visit. A PIR is a document that asks the provider to give us some key information about the service, what the service does well and any improvements they are planning to make.

We observed care and support in communal areas and looked at the kitchen, laundry and the majority of the bedrooms. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records about people's care and how the home was managed. We looked at the written records for seven people in total. This included looking at care records, risk assessments, food and

fluid records, 'turn' charts, daily records, professional visits records, diary records, menus, medication administration records and care plans. We looked at a variety of staff records including rotas, training, induction and supervision for all staff and recruitment records for four staff employed at the home. We looked at other records, including the quality assurance and safety audits that were available.

Requires Improvement

# Is the service safe?

## Our findings

Most people we spoke with told us that they felt safe. For instance, one person said, "Staff are helpful. I'm very safe and happy here." One person's relative said, "My [family member] is totally safe here. We are here every day. If we had any doubts we would move [family member]."

We looked at the systems in place for managing medication in the home. This included the storage, handling and stock of medication and medication administration records (MARs). We found that medicines were well manager in the Gardens, but that this was not always the case in the Hall and Court. Medication was kept in locked rooms. However, we found one lockable medication fridge to be left unlocked. We were told this was usual practice. Records were kept of temperature checks to make sure that medication was stored at the correct temperatures, but there were occasional gaps in the records. This meant that the provider could not be sure that medicines were stored within the temperature ranges recommended by their manufacturers.

There were some instances where staff had failed to sign the MAR, when medication had been administered. It was evident that these were errors in recording, rather than in the medication administered to people and had been picked up by the medication audit process in the home. Some records had not been completed consistently, such as the numbers of medication carried forward and daily totals. The staff signature verification sheet, which should show all staff who administered medication, was not up to date, although this was rectified immediately.

Some people were taking medication on an 'as required' basis (PRN), for such things as pain relief. In most cases, where people who used the service had communication difficulties, there were protocols about the use of the medication, explaining how people expressed pain or discomfort to help staff know when people might need pain relief. However, this was not consistent, as some protocols were not in place, incomplete, or unsigned. Additionally, staff did not routinely record whether one or two tablets had been administered when administering PRN pain relief. This meant medication stocks could not be accurately checked.

One person had no photograph on their medication record and no protocols in place regarding the use of their PRN medication. Information about this person's allergy was not sufficiently accessible, should staff who were unfamiliar with the person be called upon to meet their needs in an emergency situation.

Staff accompanied seven people out on a day trip. A senior carer took the lunch time medication for two people who went on the trip and their two MAR charts. However, we saw the staff member put the medication in plastic bags. This is called secondary dispensing and is considered a high risk activity, as the medication could be administered in error. To compound this, the staff member did not include any means of identifying who the medication was prescribed for on the bags. To avoid this level of risk it is urgent that a different method of dealing with medicines for trips is put in place.

Additionally, six of the seven people who went on the trip were prescribed PRN pain relief, but no PRN pain relief medication was taken with them. This meant that these people were not able to have their prescribed

pain relief, if they needed it whilst out of the home.

Some prescription medicines are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs (CD). These were stored appropriately. In the Hall and Court we checked all the controlled drugs against the controlled drugs record. No errors were found. However, we found the numbers of controlled drugs noted on the MARs for two people did not tally with the controlled drugs record. We were told that the staff dispensed these controlled drugs to the district nurse to administer, and then signed the controlled drug record to reflect this. This meant there was an incomplete audit trail, as the actual administration record (MAR) had not been signed to say the medication had been administered.

Topical creams were on the MAR chart and there was a separate folder with body maps that showed where the creams should be applied. However, in one person's records in the Hall and Court we saw that their topical medication ran out in June 2017, but there was no record of it having been discontinued.

Our findings showed that the registered provider had not always ensured that medication was managed safely. This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 Safe care and treatment.

We looked at how risk was managed for people who used the service and found there was a lack of consistency in how this was done in the Hall and Court, so people were not protected. For instance, the written records of people's care were not always detailed enough and some people did not have the necessary risk assessments in place. One person had received end of life care and their fluid intake was being monitored. On one day in July 2017 the records showed occasions when the person had gone several hours without drinking anything and no explanation was recorded for this. There were no risk assessments in relation to this in the person's file, and no record of evaluations of their care since the end of June 2017. Of the people who were assisted to move by use of a hoist, one person did not have their own individual sling, so staff were using another person's sling for this person. We also found that some of the relevant assessments were out of date or not available. This meant that people could have been put at risk, because some of the slings that were being used might not have been suitable for people's particular needs.

Our findings showed that the registered provider had not always ensured that people's care was managed safely. This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 Safe care and treatment.

The staff received a handover between shifts and a record of this was kept in a handover book. This contained issues of that day and not all people who used the service were discussed. Consequently, there was a potential to miss any issues from shift to shift.

We noted a smell of urine in one lounge in the Hall and Court and one lounge in the Gardens, despite evidence of regular cleaning. The need to replace the carpets had been flagged up by members of the management team and action taken to address it. There were some areas of the home that required upgrade or repair. For instance, an area of floor was not sealed in one toilet, leaving it exposed to contamination. Domestic staff we spoke with said they sometimes struggled to fit in all the tasks asked of them within the time available. Despite this, we found the home overall to be clean. We saw staff followed good hand hygiene procedures and protective equipment, such as aprons and gloves were available throughout all of the buildings on the site. The kitchen and dining areas were clean and tidy. All records of fridge temperature checks and food probe temperatures were up to date. Items in the fridge had 'opened on, use by' labels.

We saw that maintenance and servicing certificates were in date for door closers, gas, emergency lights, the passenger lift, hoists, the nurse call system, fire alarms, legionella and electrical equipment Portable Appliance Test (PAT). There was a system in place for staff to report minor issues to the maintenance person. The maintenance book showed that these issues were responded to in a timely manner. We saw evidence that a recent fire inspection found improvements were required. The registered provider had brought in an independent expert to address the issues identified, was working to an action plan and progress had been made.

We asked people if there were enough staff and if they had to wait long if they needed help and support. Most people said they thought there were enough staff. For instance, one person said, "Yes, I have no problems." Another person told us, "I feel safe, absolutely. There seems to be enough staff. I have no concerns about any of the staff." One person's relative said, "There are generally enough staff. They used to have a lot of agency staff, but not so many now." Another relative said, "My [family member] is very safe here. Much better than the last home they were in. we believe that there are enough staff." However, there was one relative who said that if more than one person needed attention at the same time, it could be difficult for staff to respond immediately. There were sufficient staff to enable staff to accompany a small group out on a day trip, while enough staff remained in each area to meet people's needs. Staffing rotas for previous weeks showed that similar staffing levels had been sustained.

Our observations were that enough staff were employed to ensure people received care in a timely way. Feedback from some staff was that this was "A good day" and it wasn't always the case. Two care staff at the Gardens said they struggled to meet everyone's individual needs when staff were asked to go over to the Hall and Court to provide cover. They said this happened periodically, to provide cover for staff holidays or sickness. Other staff, including the deputy manager and a nurse at the Gardens told us there were enough staff to keep people safe, taking into consideration the numbers and needs of people living in that part of the home. Senior staff were clear that they would not release staff to provide cover if there was any risk to people at the Gardens in doing so.

There was a policy and procedure for the safe recruitment of staff. We looked at four staff files. We saw checks had been carried out, prior to applicants being offered posts. These included identity checks, past employment history, references from previous employers and Disclosure and Barring Services (DBS) checks. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups, by disclosing information about any previous convictions an applicant may have.

There were policies and procedures for safeguarding vulnerable adults and the new manager was familiar with how to report any safeguarding concerns. Staff we spoke with told us they had received training in safeguarding people from abuse and the staff records we reviewed confirmed this. Staff had a good understanding of safeguarding people and of the whistle blowing policy.

Good

# Is the service effective?

## Our findings

Everyone we spoke with told us that the food was very good. For instance, one person said, "The food is very nice. I like it all." Another person said, "The food is good and if I want something different they [the cooks] do it for me." However, another person told us, "I enjoy the food mostly," although they did add, "If I don't like it, I just put up with it." One person's relative said, "The food is much better now." They went on to explain that there had been an improvement in the arrangements for cooking food at the Gardens. One relative said their family member had a particular dietary preference, but had been given food that was not suitable, on occasion, in the past, but generally the food was good.

We observed lunch in all three areas of the home. For the most part, lunchtime was a relaxed and pleasant experience for people. People had the correct aids, such as plate guards to help with their independence, there were enough staff to attend to people's needs and, on the whole, staff interacted positively with people.

People's files included screening and monitoring records to prevent or manage the risk of malnutrition. We met the cook. They were aware of people's diets and their preferences relating to food. We saw up to date information in the kitchen about people's specific needs, such as those with diabetes, and people's allergies were clearly documented. All meals and cooking ingredients had also been assessed and documented for allergens.

There was evidence that people had access to healthcare services. People's records reflected that they were seen by a GP when necessary, and had access to services such as opticians, and district nurses and community nurses regularly attended people in the home. One person told us, "I contact my doctor if I need to." While another person said, "If I need to contact my GP the staff do it for me."

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA We saw the registered provider was meeting the requirements of the Act. The manager was aware of the correct procedures to follow under the DoLS process. There were DoLS authorisations in place for five people. Further applications had been made to the managing authority and were awaiting outcomes.

We saw examples where people had been supported to make decisions in accordance with the MCA. Some

people who lived at the home were not always able to make important decisions about their care due to living with dementia and some people's capacity varied from time to time. Documentation in people's care records showed when decisions had been made about a person's care, where they lacked capacity to decide at that time, these had been made in the person's best interests. The staff we spoke with had a good understanding of their responsibilities under the Act and people we spoke with told us staff asked for their consent to any care and treatment offered, and respected their choices. We also saw evidence of this in people's records.

In most cases there were records available to identify if any powers of attorney were in place. However, this was not always the case. Powers of attorney confirm who has legal authority to make specific decisions on a person's behalf when they cannot do so for themselves. These may be in place for financial affairs and/or care and welfare needs. It is important that staff have this knowledge to make sure only those with the right authority make decisions on people's behalf.

There had been some changes made to the environment for people living with dementia. Some effort had been made to make the décor more attractive and to provide landmarks, and memorabilia artwork on the walls. There were light and airy areas, and signage to enable people to find toilets, bathrooms and bedrooms. Although, there could have been more use of contrasting colours to help people to orient themselves and distinguish things like light switches. As well as more prominent use of names and accent colours to help people identify their bedrooms. There were various lounges for people to spend time in. Some people were able to have access to outside space independently, but not everyone. One person told us they would like to spend more time in the garden.

New staff employed at the home were signed up to complete an induction programme that met the requirements of the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily work. Staff we spoke with had received an induction, which they felt was helpful and appropriate. Staff told us that new staff members shadowed experienced staff as part of the introduction to their role.

We asked staff about training opportunities. Most staff were positive about the training provided to them. During and following induction staff were provided with training to make sure they had the required skills and knowledge to carry out their role. We looked at records of the training staff had undertaken. We saw staff had completed courses in such things as fire safety, food hygiene and, health and safety. Staff were prompted to complete and refresh their training at the required intervals.
Staff confirmed that they received supervision sessions and appraisals. Staff supervision is a one to one meeting between the staff member and their manager, intended to provide staff with regular support and guidance. Appraisals are designed to enable staff to discuss any personal and professional development needs. We saw records that staff had received some staff supervision and had annual appraisals, although this had sometimes been disrupted with changes in management. The new manager had set up a system to make sure staff supervision was undertaken more regularly.

Good

# Is the service caring?

## Our findings

The majority of people we spoke with said the staff were caring. For instance, comments included, "Yes, The staff seem to care about me", "They [staff] treat me with respect and are very caring when I need help" and "They [staff] care about me and I think there are enough of them. I've never had any complaints." One health care professional we spoke with said they found the staff kind in their approach. They said there was a homely atmosphere and the staff were obliging.

Most staff we spoke with had been working in the home for some time and knew people well. For instance, five of the care staff we spoke with all had a very good understanding of people's individual needs. People told us they were involved in the overall planning of their care and were encouraged to make everyday choices. For instance, one person said, "I have a regular routine. I can get up and do what I like when I like."

Overall, the staff we observed were kind and compassionate and we did see some warm interaction between staff and people who used the service. For instance, one person told a staff member, they loved them and the staff member responded, "I love you too, because you are a very lovely man."

We used the Short Observational Framework for Inspection (SOFI) to observe care in the Gardens area of the home we saw that staff regularly approached people asking after their welfare and engaged the in conversation or activities.

We looked at how the staff supported people's dignity. The people we spoke with had appropriate clothing on and looked well presented. Observations showed us that people were addressed appropriately. We saw and heard some staff and people using the service chatting and laughing, which indicated that people felt comfortable with the staff. Personal care was undertaken behind closed doors in order to preserve people's dignity and staff knocked on doors before entering.

Most of the written information on display was in an accessible format and had pictures to assist with people's engagement and understanding.

We found there was room to improve care planning and record keeping for people receiving end of life care, as it did not adequately evidence the care provided to people, such as mouth care, position changes and people's fluid intake. We spoke with senior staff who confirmed that training in this area was a need for all staff delivering care, as the e-learning available was not detailed enough. Members of the management team were aware of this particular training need and training was being arranged.

There was a consensus that staff made people's visitors welcome. For instance, one person said, "They [staff] treat me with kindness and respect. My friends and family are made welcome." Another person said, "My [relative] visits regularly and is always made welcome." A third person said, "The management and staff treat my visitors and family very well." One person's relative said, "The staff are marvellous. They care about [my family member] and us."

Good

# Is the service responsive?

## Our findings

Most people told us they were very happy with the care they received and people's relatives were complimentary about how well the staff looked after people. For instance, one relative's comments included, "The staff really treat my [family member] with respect and care. My [family member] has totally personalised care. We visit at all times of day and night. It's never a problem."

We saw that people received personal care which was generally responsive to their needs and most people had a 'life history' completed to help staff understand more about the person and their experiences.

We looked at care plans for seven people. All had a pre-admission assessment and included the person's medical history, medication and risks. People's needs assessments included areas such as their psychological and emotional needs, personal hygiene, communication, behaviour and cognition. If people had any wounds or pressure sores these were assessed and people had a care plan in place. If the person needed to be lifted using a hoist their care plan included the correct sling size. Bathing records indicated that people's care was provided in line with their care plans.

We asked people if they felt involved in the planning of their care. We were told they did. People's relatives we spoke with also felt involved. For instance, one relative said, "I am involved with my [family member's] care plan on a continuous basis. I am happy with the communication with the staff." Another relative said, "I have been involved in [my family member's] care plan. The management are in contact anytime there is a need. Extremely good. They understand care needed for my [family member] very well."

One relative told us that when they visited the home they saw that people were often engaged in different activities. They added that they had visited recently and people were doing chair based exercises. Another relative we spoke with told us there were some activities when they visited, but not always. We saw some activities on offer, and a generally, a good level of engagement and stimulation for people.

During our visit there was music on in some lounges and some people watched TV, or read newspapers, we saw staff members actively engaging with people. People we spoke with told us there were things do, as well as watching the television or listening to music. There were staff employed specifically to provide or coordinate activities for people. There were activity boards that displayed details of the outing to Cleethorpes people went on that day, as well as photographs of previous activities and outings. One relative said, "My [family member] likes music, so enjoys the parties."

Several people told us they were perfectly happy to sit with others in the lounges, and to join in the conversation when they wanted to. One person said, "I do take part in activities when asked and I go to church sometimes." Another person said, "I take part in the games, and enjoy them."

We saw there was a system in place to address any complaints that arose. This included a complaints procedure which was displayed in the home. Most people we spoke with who used the service knew what they would do if they wanted to complain. The relatives we spoke with told us they would speak to the staff

or the manager. One person's relative told us, "If ever we have any concerns we bring it up with the management and it's sorted immediately. We haven't had any relatives' meetings since the change in ownership, but we are in constant dialogue, so no problems." Another relative said, "[Staff] treat my [family member] as an individual. [Family member] doesn't really like or dislike anything these days, but the staff show respect. We can visit anytime and are made welcome. If we had a problem we would speak to the manager. No problems yet though."

Requires Improvement

# Is the service well-led?

## Our findings

At the time of this inspection the service had a new manager, who had recently commenced in post, and they were not registered with the Care Quality Commission. There was a deputy manager who was a qualified nurse and fulfilled the role of clinical lead for the home overall, as well as taking responsibility for the day to day running of the third part of the home, referred to as the Gardens. They shared their time between nursing and management tasks. There was also a relatively newly appointed head of care, to oversee the day to day care at the Hall and Court. Although the new manager was not part of the care rota, they told us they needed more administrative support in the home, as they were often diverted from management tasks to undertake administrative tasks and to answer the phone.

The new manager, deputy manager and head of care came across as capable and very committed as a management team. They were dealing well with the effects of some rapid, unplanned changes in management, as there had been two previous managers in the previous six months. They were aware of the work required, had gone some way to addressing improvements and were planning further changes.

Most care staff said the new manager was supportive and felt the changes of leadership were making a positive difference. Although staff spoke of staff moral improving, we spoke with two staff members who felt bullied by a particular, senior member of staff. We discussed this with the registered provider and new manager, who assured us this issue would be appropriately addressed.

We saw various audits been used to make sure policies and procedures were being followed. This included health and safety, infection control, care plans and medication. However, we identified some areas of concern that had not been identified by the management audit processes. The medication audit had not proved effective, as although some discrepancies had been picked up and addressed by the audit process, it had not identified the range of shortfalls that we found at this inspection. The management team were aware of the need to improve care records, particularly in relation to the care provided to people receiving end of life care, and were taking action to address this.

People expressed confidence in the management team. For instance, on person said, "The manager is nice, very sociable." A relative said, "I don't know of any relative's meetings, but the management are fine. No complaints. I feel confident we could approach the management at any time about anything. Although the people we spoke with told us they felt involved in decisions about the care, they had not been asked to complete questionnaires for some time or to comment on the overall quality and running of the service. Neither had they been invited to meetings for this purpose.

This meant that the registered provider did not have systems that were effective to assess, monitor and improve the quality and safety of services. This is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 17 Good Governance.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The registered provider had not always ensured that people's care was managed safely.<br><br>The registered provider had not always ensured that medication was managed safely.<br><br>This is a breach Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The registered provider did not have systems that were effective to assess, monitor and improve the quality and safety of services.<br><br>This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |