Amore (Watton) Limited

Buckingham Lodge Care Home

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

Summary of findings

Overall summary

The inspection took place over two days, the first being unannounced, the second announced. The dates were on 21 and 22 November 2017. The last inspection to this service was on 8 and 10 February 2017. At this inspection the service was rated as requires improvement throughout except for caring. There were also a number of regulatory breaches of the Health and Social Care Act 2014. These included Regulation 9: Person centred care, Regulation 14: Meeting nutrition and hydration needs, Regulation 17: good governance and Regulation 18 staffing. Following the inspection the provider sent a detailed action plan telling us what actions they would take to achieve full compliance and improve the service. A new manager was in post from September 2016 prior to our last inspection and is now registered with the CQC. At our inspection in November 2017 the regulatory breaches were repeated.

There was a registered manager in post at the time of our most recent 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 service is a purpose built home which can accommodate up to 73 people who may or may not have a nursing need and whom may have a diagnosis of dementia. The home has three floors, ground, middle and top and people on the ground floor receive a residential service where people on the other two floors fall within the category of nursing although some people on these floors did not require nursing care. The residential floor was overseen by a unit manager whilst the first and second floor were overseen by a registered nurse. The home was situated at the edge of Watton a small town in Norfolk. At the time of our inspection there were 61 people using the service.

During this inspection the service demonstrated to us that improvements have been made but progress was slow and had been compromised by poor levels of staffing. There were repeated breaches of regulation from the last inspection. We observed variable care practices depending largely of the levels of staffing and the skill mix on shift. The provider had recognised that the action plan implemented from the following inspection had not been fully acted upon. They had put in a team of internal auditors, (quality team) to support the management team and staff to make and sustain improvements within the service. Some improvements were still in their infancy and the provider had not been able to demonstrate how they would sustain these improvements. They did provide us with an updated action plan and further plans to show how the improvements would be maintained. The registered manager was off sick and there was an interim manager in post who was experienced and familiar with the service.

We found the biggest concern was staffing levels which had not been consistently maintained, partly due to high staff sickness rates and unfilled staffing vacancies. Agency staff and bank staff were heavily relied on to meet the needs of people using the service. There was however an improving picture in terms of staff

recruitment with all substantive nursing posts filled apart from one night post. Analysis of staff sickness and exploration of why staff retention was poor was underway and was viewed in context of the geographical area and local recruitment issues. The service had employed a person specifically to drive up recruitment. The impact of low staffing had meant people experienced variable patterns of care and social stimulation. It also meant not all staff were familiar with everyone's needs or responding adequately to them.

We found risks to people's safety associated with their care and welfare were mostly well managed. Staff regularly checked people to help promote their safety. Basic care was being provided and there were no immediate imminent risks we were aware of. We did not identify anyone with pressure areas but did identify people whose nutritional needs were not being met.

Staff had a reasonable understanding of what constituted abuse and knew how to raise concerns and were confident they would be addressed by senior management. All staff knew about external agencies they could report and refer to. We saw records of safeguarding concerns which had been reported as required but records did not provide a clear audit as to the stage of investigation or lessons learnt.

Medication practices were good and regular audits and staff training were designed to ensure staff administering medication were competent to do so. We raised concern about the length of time it took to administer some medication and the possible implications this had of the right spacing between individual medication doses.

The service was spotlessly clean and only a few odours were identified in a few isolated areas but this was soon addressed. The staff team were short but coped extremely well.

Monthly analysis of accidents, incidents and falls were carried out. They identified any trends and helped ensure that necessary action was taken to mitigate the risk of any future occurrences. However we were not always able to see examples of actions taken and whether lessons were learnt.

There were processes in place to support new staff and ensure they had the necessary skills and competencies for their role. Training was ongoing and staff received supervision although not regular. However there were no observations of practice or mentoring for staff who were not performing to expected level. Nurses did not have regular support to enhance their clinical skills and most were new to post so were still within their probationary period.

The CQC is required to monitor the Mental Capacity Act (MCA) 2005 Deprivation of Liberty Safeguards (DoLS) and report on what we find. Whilst MCA assessments had been carried out, decisions made in people's best interests were not always documented and some initial assessments of capacity were contradictory. We could not see how relatives were always consulted and involved in the decision making processes.

People were not always supported to eat and drink in sufficient quantities. Records demonstrated that there was clear monitoring of people's needs in regards to hydration and food intake. However people who were unable to initiate for themselves when they were hungry and thirsty did not always get support in a timely way.

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People's health care needs were mostly met but we found gaps in staff knowledge so could not be assured staff were always adequately responsive.

People's records sufficiently documented their needs and most staff knew them and responded adequately. However at times the skills mix on shift was poor and staff sometimes worked with other staff who did not

people they were supporting well .This put pressure on the whole team and meant the care was not always individualised. We found some days only peoples basic care needs were being met and people could not always choose when to take a shower or bath where they required assistance. We also found records were not always completed fully so we could not see the care being provided. People received some emotional stimulation but when staff were busy this was compromised. The range and scope of activities provided had improved but was still limited and needed to be developed further. There were no volunteers at the service which limited people's opportunity to take part in different activities

Very few complaints had been received about the service. There was literature advising people and their relatives about the complaints process and some relatives expressed concerns with us on the day of the inspection. We found there was poor engagement from the organisation in terms of asking people for their feedback and encouraging them to raise concerns as appropriate. Surveys aimed at establishing people's level of satisfaction had not been completed since the previous inspection and relative/resident meetings were poorly attended and we could not see how feedback was acted upon.

The service had not been consistently managed despite best efforts of the manager and deputy manager without strong clinical oversight and regular nurses in post the service had struggled to meet people's needs. The turn- over of staff and sickness rates had impacted on the care and created a variable pattern of care across the unit and across the days of the week.

At this inspection we found the heavy involvement of the management team and internal members of the organisation supporting staff to implement improvements and continue to strengthen the improvements already made. We saw a great deal of auditing going on which highlighted weaknesses and action to address these areas. Staffing levels had been increased and reviewed in line with people's dependencies and where additional hours were required the service had asked the Local Authority to reassess and review funding.

However our concern were around how the service would embed and sustain improvements and why actions had not been timely following our last inspection. We were also concerned that what was driving improvement did not seem to take into account the views of experiences of people using the service. A lot of audits were around inputs rather than observations of practice both of staffs skills and competencies and people well- being.

We found a number of breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the 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.

We still had concerns about levels of staffing and the skills, competencies and deployment of staff across the home.

Medication practices within the home were safe and people got their medicines as intended. However not everyone administering medication had been assessed as competent so there was a risk.

Staff were knowledgeable about what constituted a safeguarding concern and how and who to raise concerns to. Records with regards to safeguarding concerns did not always show what stage the investigation was at or if an outcome had been reached.

Lessons learnt from incidents, accidents and near misses were shared and information collated to ascertain if actions taken were sufficiently robust.

The service was clean and there were good infection control procedures in place to help reduce the spread of infection.

Staff recruitment practices were acceptable and helped ensure only suitable staff were employed within the service.

Is the service effective?

Requires Improvement

The service was not always effective.

People's needs were assessed but we could not see that all staff were adequately trained or assessed as competent to undertake some tasks or follow best practice.

Staff were not adequately supported in their role and there were not clear systems to help evidence that staff had understood their training and it was embedded in their work practices. People's health care needs were not always met effectively due to the turn-over of staff particularly nursing staff.

People only had care and treatment after their consent was

sought and staff acted in their best interest. However paperwork did not provide a clear picture of how people were supported adequately.

People were not always supported to eat and drink enough sufficient to their needs because the meal time organisation meant that some people did not get the support in a timely way. Staff monitored what people ate and drink to try and reduce the risk of malnutrition and hydration.

Staff teams did not always worked inclusively across the whole service which meant people did not receive support with was of a consistently high standard.

The environment was appropriate to the needs of people using the service and was well maintained and clean.

Is the service caring?

Requires Improvement

The service was not always caring.

People were treated with kindness and compassion.

Staff helped promote peoples well- being, dignity and independence.

Staff knew people well and were responsive to their individual needs and helped people stay connected to their pasts.

People were consulted about their day to day care but it was less clear how they were consulted about the wider service.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans documented people's needs and showed how they should be met. They were kept under regular review and staff were responsive to changes in people's needs.

People were supported until the end of their life by staff who had received training. We had identified a number of things that could be improved upon.

Social interaction in the service was compromised by the numbers of staff. There was a full time activity coordinator who clearly enhanced people's well-being. However a lot of people due to their illness and mental cognition would benefit more from regular one to one input.

Feedback about the service was used to shape the service provision including compliments and complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

Leadership of the service was reported to be strong but in the absence of a well -established staffing team with sufficient expertise and specialist knowledge care for people was fragmented.

Support from the internal quality team was now in place but it will take a while to establish and embed change and we were concerned in the meantime people could potentially be exposed to poor care.

Staff had the right level of training but were not given the support to help ensure their training was firmly embedded in their working practices.

The internal quality assurance systems in the home were poor. Although there were a lot of audits very few of them were seen to capture people's experiences of living in the home or the frustrations some of the relatives felt.

There were systems in place to increase the level of compliance and encourage and share good practice across the home and through the wider organisation.

Risks on the whole were well managed with oversight and review so lessons could be learnt.

Buckingham Lodge 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.

We inspected the service on 21 and 22 November 2017. The inspection was over two days and was unannounced on the first day, announced on the second. The service was inspected earlier this year and according to our methodology would not have required another inspection until up to a year. However we brought this inspection forward as we had been advised that the registered manager was absent from the home. In addition we were told about some concerns about the service from other regulators including concerns about staffing levels and the management of incidents.

The inspection team included two inspectors and an expert by experience who is a person who has personal experience of using or caring for someone who uses this type of care service. As this is a large nursing home we also used two specialist advisors one for each day of the inspection. They were both registered nurses.

Before the inspection we spoke with others regulators, we viewed information already held about the service. This included: notifications, which are important events the service is required to tell us about. We reviewed "Share your experience" forms which gave feedback from people who used the service or their representatives. We also received a provider information return. 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.

During the inspection we spoke with the managing director, area manager, members of the quality team and the interim manager. We spoke with the deputy manager, and clinical lead. We spoke with four care staff, activity staff, catering staff, housekeeping staff, and the three nurses on duty which included two agency staff. We spoke with 15 people who used the service, and seven relatives. We observed staff

practices including medication administration, activities and the lunch time experience. We reviewed the care plans for six people who used the service and other records relating to the management and oversight of the service. We completed a medication audit and looked at associated records. We also reviewed the personnel records for six staff members.

Requires Improvement

Is the service safe?

Our findings

During our previous inspection which was carried out on 8 and 10 February 2017 we rated this key question as requires improvement with an identified breach of regulation 18 of the Health and Social Care Act 2014. This was because we found that staffing levels were not effective at meeting the individual needs of the people who used the service. We brought our planned inspection forward as we had received concerns about this service and in particular in relation to staffing.

At our most recent inspection we found staffing numbers at the service were good but we were told by staff, relatives and people using the service that this was not always the case. We identified some concerns about the skills mix and levels of staff competence because some staff were new to post and had not received an induction. This meant we were not assured people's needs were always met in accordance with their needs or in a timely way.

Some people who used the service and relatives told us there had been a reduction in staffing numbers over the last four to six months. They told us this had resulted in increased pressure on staff and some more experienced carers had left. One person told us about the service, "It is generally good but had "gone down of late." We asked why they thought that and they explained that they had noticed less staff available. They said staff used to have time to pop in and chat for two minutes but that tended not to happen now. They commented that "staff are friendly enough but they seem to have no time". Another said, "There isn't enough staff. Staffing numbers have gone down and sometimes there are only two on. They've no time to chat and talk to you. They can't be in the lounge at the same time as helping people who need two carers."

The majority of people spoken with told us their call bells were answered quickly. However two people told us, "They don't always come when you call and it can be frightening." Another bed bound resident said "sometimes I have to wait 10 to 15 minutes for a bell."

The care staff we interviewed stated "We try to give people the best care, but there are not enough staff." Another explained that each day was different and they were not always able to give the care people needed. One relative told us about the concerns they had about staffing levels and were not assured staff were familiar with their family member's needs. Another said, "There were always different faces and a lack of continuity.' Another relative said, "Sometimes I've found them (person who used the service) still in bed at 2pm. Staff were really stressed and really struggling about two weeks ago and they told me they weren't allowed to call agency staff." Another relative said, "It's just some of them, (staff) aren't attentive. It's as much attitudes as numbers."

On the first day of our inspection visit we went on to the ground floor and there were three permanent staff and one agency on their first shift on this floor. Staff told us staffing levels varied significantly mostly due to high levels of sickness. They told us sickness absences were generally as a result of the same staff and that this had negatively impacted on the service provided. Staff said due to people's high dependency they really struggled when staffing levels were lower or when working with agency who were unfamiliar with people's needs. For example on the ground floor they said at times there were only three staff which

included a senior member of staff who was responsible for such tasks as the administration of medication and dealing with visiting professionals, family etc. As a result, staff told us that this left only two staff to deliver care and support to people who used the service, nine of whom needed two staff to assist them. On the first floor on the first visit of our inspection there were five staff. Staff told us numbers had only just increased and at times there were not enough staff. Again staff identified a high level of need amongst people using the service and said people were mobile so at higher risk of falls.

The service did use a dependency tool but admitted this was not effective as it did not take into account all factors such as the environment and lay out of the building. For this reason they were trialling a different tool. We found a lack of evidence that the service regularly took into account both observational evidence and feedback about staffing levels to assure themselves that these were adequate.

This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014

We could not be assured people were protected fully from the risks of abuse including neglect given the concerns raised about staffing levels. However, people spoken with indicated they felt safe within the home. Staff received timely and updated training in recognising abuse so could know when a person was at risk. Staff were confident in raising concerns and said that they knew their concerns would be acted upon. There were contact details for reporting abuse or safeguarding concerns in the nurse's station on all floors. Nurses leading the floor confirmed they had completed an online safeguarding course on commencement of employment.

During our discussion with a person we were made aware of a matter which had been disclosed to a member of staff. This had been dealt with appropriately and referred to the safeguarding team for investigation. Another concern was brought to our attention by a family member. They had not raised a formal complaint but had discussed it with the manager. We were unable to see how the manager had responded to their concerns or if they had raised a safeguarding. It was in regards to a person's health which had declined rapidly and the concern was whether staff had responded to their decline in a timely way. We asked for more information regarding this which had not been received at the time of writing the report. Concerns had also been raised about staff practice. The staff record indicated some minor concerns and this was subject to supervision but the staff member had not had observational supervision as identified in their original disciplinary supervision.

Staff we spoke with had received training on safeguarding, and understood how to identify, document and report signs of abuse or neglect. We also saw how incidents were used to improve practice. For example one staff said about a person who had fallen but this had not been reported from one shift to another to ensure good monitoring of this person's needs. They said this had resulted in improved practice and communication across the shift. They said there was now a clear shift plan and handover to discuss every person and allocate staff and duties so everyone was clear who was doing what.

Staff told us there was an internal confidential company telephone number if they wished to report concerns. Staff were aware they could report directly to CQC.

Risks to people's safety had been identified and documented to help staff manage them effectively. Both the environment and individual risks had been assessed to help ensure there were sufficient controls in place to reduce the level of risk. One person told us, "I'm well looked after here." Another said, "I feel safe here; we're not forgotten in our rooms. They do check on you and they are trained."

Records included assessments and risk assessments for people's nutritional needs, hydration, mobility, falls, moving and handling and pressure ulcer risk. Risk assessments were personalised and relevant to the individual. Risk assessments were usually reviewed regularly but the frequency of review varied which meant we could not be assured a change in need would be identified quickly. We identified gaps in records. For example there was a record of a person with a 'sore bottom'. There was no evidence of a photograph of the area or a body map in the records. The carers interviewed were asked where the sore bottom was located. The carers stated it was in the lower back region in the area of the buttocks. They were shown a pressure ulcer grading chart and they reported that on occasions the sore area includes an area of broken skin. They stated that they apply cream prescribed and that it will heal and then break down again. The records had evidence of another red and sore area in the groin having been assessed by a dermatologist and that cream had been prescribed for this area. This may suggest that the care plans were not recording all wound sites with a risk that the staff may be using creams that have been prescribed for a different area and condition. This meant record keeping in some instances were poor and did not accurately reflect the care and support people required.

Incidents of distressed behaviour were recorded in a timely way. Daily reports clearly stated strategies to employ in the event of repeated incidences. 'Distressed behaviour charts' were used to identify potential triggers. Staff were able to describe a range of options available to prevent distress in people. These included use of quiet spaces, doll therapy and encouraging people to socialise with specific people. Prescribed when necessary medication (PRN) were available to manage acute distress for people where this has been discussed and agreed with the GP and mental health team.

Medicines were well managed and administered to people as prescribed. Medicines were secured safety in in line with manufacturer's instructions. Room temperatures and fridge recordings were seen to be within normal range and recorded daily. There was also evidence of audits for the cleaning of equipment. Clinic rooms and trollies where medications were stored were clean, tidy and well organised.

Arrangements for the storage and disposal of medications were safe. Staff liaised regularly with the GP for advice re medication including anticipatory end of life drugs. We looked at all the controlled drug records and these were accurate. We also looked at a sample of medication records against the stock held and these were correct.

Staff administering medication had access to the necessary guidance and a current copy of the British national formula (BNF) in the trolley. People received their medication either from the nurse or senior carer. The senior carer had received online training from a local pharmacist and had their competency assessed. The agency nurse on the first day of our inspection had received on-going training from outside the organisation and was highly skilled in medications management. Both staff administering medications felt confident they had the skills and knowledge to undertake this role safely. Not all nurses had been assessed as competent before administering medication which was a concern that this might increase the risk of errors being made. We also observed medication administration on the middle floor took a disproportionate amount of time, over four hours where on the other two floors it was much timelier. This was because a new nurse had been employed and were not familiar with the round but no assistance or support was provided to them.

We observed two staff on separate floors administrating medication. They wore 'do not disturb' tabards and sought consent from the person. However one staff member was observed standing at the door way asking people if they needed PRN medicines such as analgesics for pain relief. As the person being asked was hard of hearing this led to some confusion and resulted in the staff raising their voice. It would be more appropriate to enter their room and ask them whilst by their side. Details of how the person preferred to

take their drugs were recorded and followed. The staff member explained to the person what each drug was for and how to take it.

PRN protocols were clear, stating when the drug was to be used and the maximum daily dose. The internal records were used effectively by staff and showed PRN drugs were used in line with the persons care plan and advice from the multi-disciplinary team (e.g. mental health teams and ophthalmology.) However the home was not consistently following their medication policy. A person who used the service who required PRN insulin for type 2 diabetes did not have a PRN chart; instead staff were using a less clear chart copied from another organisation. It was not clear from this care record or the medication records that all staff understood their diabetes management care plan. This was being addressed via an internal audit but the auditors notes only served to make the record more confusing in the interim. Following the robust internal PRN procedures already in place and ensuring all staff understood the diagnosis and terminology to be used would have prevented this.

The premises were clean and there were adequate steps taken to reduce the risk of infection and cross infection within the service. Cleaning and tidying was ongoing throughout the shift by housekeeping staff. We observed the registered nurse washing their hands and wearing gloves when administrating medication. Staff observed general hygiene procedures and there was sufficient personal protective equipment: gloves and aprons within the service. Staff were alert to the risks of cross contamination and consistently maintained the cleanliness of surfaces when people were offered drinks and snacks. Wipes and tissues were available in communal areas, juice jugs were covered and there was a constant supply of clean beakers. Staff wore aprons and gloves to serve food. However staff in the dining room also wore blue gloves to assist people to eat, this does not value people and does not provide a homely atmosphere.

Domestic staffing numbers were depleted due to long term sickness but were seen to be managing well.

The service had processes in place to monitor risk in relation to incidents, accidents, falls and near misses. Analysis of these helped to identify when things had gone wrong and what could be done differently to reduce the likelihood of things occurring again or reducing the impact. The service recorded information and acted on it monitoring themes and trends.

We looked at staff recruitment and were confident that the processes were sufficiently robust when recruiting new staff. Effective recruitment helped ensure only suitable staff were employed. For example files had documentary proof of staff's identification, proof of address and any relevant qualifications. There was also job references both regards to their previous employment and character reference. There was a checkable work history and a disclosure and barring check. This was to check that staff did not have a criminal conviction which might make them unsuitable to work in care. Interview notes showed how the person had the necessary attributes and skills. However we did not feel this was always sufficiently robust or explored the staff members work history and clear reasons for changing posts and roles. The interview questions for nurses did not sufficiently reflect the role they would be undertaking so we were not assured nurse recruitment was as effective as it could be.

Requires Improvement

Is the service effective?

Our findings

During our previous inspection on 8 and 10 February 2017 we rated this key question as requires improvement with an identified breach of regulation 14 of the Health and Social Care Act 2014. The service was failing to meet the nutritional and hydration needs of people using the service. We brought our planned inspection forward as we had received concerns about this service. During our latest inspection we were much more confident that people were adequately supported with their hydration and nutritional needs. However we were not confident they had fully met the breach.

We spoke with people about the food and their meal time experience. People told us the food was enjoyable, that they had plenty to eat and drink and that it was home cooked. One person told us, "The food is lovely; it's a credit to them." However, another person said, "It's not that good, it's generally cheap." A third person told us the food was, "Boring and it's a bit basic." The cook told us that the budget was difficult to manage when specialist diets were required.

People told us they were not aware of the menu. We explained to one person the options that included 'Pasty' and they commented, "We have a lot of those." The week's menu choices were displayed on the wall in the corridor which might explain why people had not seen it. A menu on each dining room table or in people's rooms would be more appropriate.

We observed some people did not get timely support around their dietary needs. One relative told us they felt obliged to come in over lunch to help assist. Some people were left unattended which meant their meals grew cold and people were not encouraged to eat. We observed at least two people who made no attempt to eat their meals and staff were not observed as providing any support to them. Two other people told us their food was not always served hot. We concluded that staff were mostly attentive and supervised people rather than enabling people's independence. With the level of staffing we observed people should have got the support they needed with their meal. Less able people did not always receive appropriate supervision.

Most staff were aware of people's communication needs. However communication aids might support people's choices. For example one person was unable to understand the two meal options. Staff neither used a picture menu nor did they show them the two plated options.

This was further evidence of a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

However there was clear monitoring of peoples food and fluid intake which helped to reduce the risk of malnutrion and dehydration. People's weights were regularly monitored to help identify any one with unplanned weight loss. Steps were taken to refer people to other health care professionals when necessary and to provide people with high calorie food and snacks to boost weight gain.

We observed lunch time on each floor. People had two main alternatives and staff were responsive to individual dietary requests. For example one person was given a suggested alternative of ham and chips.

Drinks were readily available with two options of fruit drink and water. Cake was served at afternoon tea and a light supper in the evening. Fruit was available throughout the day but most people opted to have biscuits with their tea or coffee. People who were unable to eat biscuits were offered yoghurt.

We were not assured that all staff had the key competencies and skills for their job roles. The staff team had changed in recent months with most of the nurses new to post. Some had been recruited from the agency so had already worked in the home.

The registered nurse working on the second day of our inspection had not received any induction and was awaiting their induction pack. They had not been assessed for any competencies, but were observed administrating medication. The clinical lead who had been in post two weeks also reported that they had not received any induction. However the provider told us they had received their induction pack and were subject to a three month probationary period. They would receive a combination of online and face to face training and probationary review. There was an induction process for agency staff but we saw for a new agency member their induction record was blank. They were however working with another member of staff which lessened any risk.

In the absence of clear induction or assessment of competencies we asked one nurse when they last had training in the care of people with gastrostomy tubes. They told us they thought it may have been 2 years ago. They were observed administrating medication to a person through a gastrostomy tube. However, they were observed crushing up the medication and mixing them together before administrating the medications. The guidance for best practice states that medication should only be mixed together under the directions of the GP. This was raised with the quality assurance lead and they were shown the flow chart for guidance on the administration of medication through a gastrostomy tube. This was also raised with the nurse practitioner as to whether the GP had recommended mixing the medications together as there was no indication on the associated medication administration record. The nurse practitioner stated 'I don't know why you would do that'. There is a potential risk of harm to people as if medications are combined there is the possibility of adverse interactions.

The policy and protocol for the care of gastrostomy tube did not have clear guidance on the administration of medication through a gastrostomy tube. The policy was also not available on the unit and was kept in the manager's office or the administrator's office. The policy did state that staff new to the home should not be administrating medication through a nasal gastric tube without having been assessed as competent. The policy was specific for the care of people with nasal gastric tube and the policy did not have similar protocols for the administration of medication through gastrostomy tubes. The quality assurance lead was made aware of this discrepancy on the day of the inspection.

We reviewed staff records, like other records in the service we found these bulky and not easy to navigate. Records did not demonstrate that supervisions were undertaken regularly. Annual staff appraisals were seen on the files we inspected.

This was further evidence of a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We interviewed staff who were positive about the induction they had received. Staff said they had been very well supported in their role. They told us they had undertaken lots of on line training and a few face to face courses such as manual handling. They said their probationary period had been six months. However one member of staff told us that they felt rushed through the induction and made the comment that they were, "Dropped in the deep end" because they had previous experience. They said they worked with a supportive

team and manager and enjoyed working in the home, and had regular access to training. Training was mostly up to date across the service and was demonstrated by individual staff records and an overall training matrix. 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).

Staff consistently sought consent before providing care. Before moving people, assisting them to adjust clothing, eat or drink staff always asked permission and waited for a verbal or non-verbal response. However we found the initial assessments of capacity were not accurate and the service did not always consult with people in a way we would expect.

We saw from people's records that mental capacity assessments established where people lacked capacity to make decisions about their care and welfare. Some of these were not dated but had been revisited and changes to capacity reviewed in light of infection or illness. We noted some conflicting information relating to MCA assessments. For example one record stated a person was consulted and agreed to a decision but later on we saw it written that staff had recorded the person lacked capacity to make their own decisions other than for simple decisions. A further document said they did have capacity so all the records contradicted each other. As records were not always dated it was difficult to see the most recent.

One relative told us they had not been consulted about important decisions about their family members care despite having active enduring power of attorney for their care and welfare. They were concerned that staff did not always understand the nature of their relative's dementia and the fact they were not able to consent or anticipate their care needs. Examples they gave were staff saying they did not want a shower when actually with support they could be encouraged. This was echoed by another relative who also had enduring power of attorney. The relative told us their family member's tablets were given covertly and we saw there was a protocol for this and it had been agreed by the GP. Staff had recorded this was in the persons best interest and said it had been discussed with family. However they said it had not and they had not signed the best interest documentation.

There was evidence in the records reviewed that consent to care and treatment had been obtained and signed by a relative of a person assessed as having the capacity to make decisions. Do not attempt resuscitation (DNAR) notices were seen in two records reviewed and a DoL's assessment completed 27 March 2017 was in one of the records reviewed. The nurses said information about DNAR was easily retrievable. Shift leaders on two of the three floors were unable to tell us who had a DoL's in place.

We saw risk assessments had been completed for vaccination's, bed rails, sharing of information, the administration of medication and for photographs to be taken. The consent forms had been signed by a relative for a person who had been assessed as lacking mental capacity to make decisions.

Staff had completed DoL's training and online training in MCA However we found that's staff understanding of the MCA and their responsibilities within it were weak. Applications for DoLS were being made. It is not always clear that staff have considered all forms of restriction in the application process. Applications state DoLS were required as people cannot leave the home but do not always consider the level of supervision required or restrictive practices such as bedrails.

This was evidence of a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The service worked with other regulators and agencies to help improve the service provision. The nurse practitioner from the GP surgery visited the units to review people's care and management. The registered nurse was unable to liaise effectively with the nurse practitioner as this was only their second day in employment and they did not know all the people and their individual needs. The nurse were observed requesting that some people were reviewed the following week.

The nurse practitioner was observed reviewing people's health needs and reported that they would liaise with the GP with regard to any concerns. Referrals went through a single point of access for other services such as for a falls referral. There was a weekly GP visit to the home and as required.

People's health care needs were assessed and monitored. There was evidence in people's records that people with a diagnosis of diabetes were being seen regularly by the chiropodist and having their vision assessed in line with current guidelines. People received input from outside agencies including continuing health care assessments, speech and language (SALT), dietetics, dementia intensive support team, ophthalmology and chiropody. A treatment plan was in place showing how people's health care needs were being addressed. There was evidence that the care plans had recently been reviewed and a person who had a gastrostomy tube in place and was nil by mouth had a care plan stating that they should receive daily oral care. However records did not support this with gaps in recording. The quality insurance lead was made aware of the above on the day of the inspection.

The premises were fit for purpose and were clean, well maintained and free from any immediate hazards. The only concern we raised whilst inspecting the home was the temperature of the service varied from floor to floor and on the upper floors at times felt stifling. Recently concerns had been raised by a visiting professional who said some of the bedrooms were too cold for people and as a result daily temperatures were being taken. We asked the manager to monitor temperatures given recent changes to the weather.

Communal areas and corridors were well decorated and maintained with no noticeable odours and no presenting slip/trip hazards. Ambient temperature presented as suitable on the ground floor. The rooms were light and airy with ensuite facilities. There were adapted baths, showers, WC's and handrails.

One person had a prominent crack on their bedroom wall. They stated they 'disliked the colour and the curtains' and stated they intended to ask again about repairing cracks and redecorating, which had been promised by the home. We visited other people in their rooms and they were generally satisfied by the condition, décor and cleanliness of them.

Dining rooms were noted to be well presented with table cloths and place settings. Tables were suitably spaced and not overcrowded. There were lots of areas in the home which were underutilised such as separate quiet areas, and the lounges upstairs. There was a cinema and activity lounge in use.

Requires Improvement

Is the service caring?

Our findings

During our previous inspection on 8 and 10 February 2017 we rated this key question as good. During our most recent inspection we were concerned that a lack of supervision and oversight of staffs practice meant that pockets of poor practice might not be identified quickly or addressed in a timely way. Most practice observed was good but we did identify some concerns.

We found that daily logs did not consistently reflect a person centred approach and show respect for the person. Records were task focused and did not describe the person's daily experience or wellbeing. Staff activities were recorded as tasks and did not describe how the social, emotional or cognitive wellbeing of people were promoted. Staff occasionally did not use language which valued people. People nursed in bed were referred to as 'bedbound' and 'bedridden.' This was attributed to the poor monitoring of staff practice and clear organisational values not being promoted throughout the whole staff team

Whilst observing lunch we noted on one floor everyone was given squash in plastic glasses. There were no condiments on the table and we heard one person asking for salt. Not everyone was able to ask so we felt people's independence and choice was not upheld in this respect.

Staff used safe moving and handling practices to assist people to mobilise and when hoisting people from bed to a chair. Staff worked together and ensured the dignity of the person. However one person said, "Staff are kind and work hard. Sometimes the agency staff can be a bit rough when they're moving you, but when you tell them they'll do things right." Another said, "There are some good girls; some of the men can be a bit rough."

We identified one area of poor practice and spoke with the staff about what we had observed. The majority of care staff were attentive and alert to the needs of people. One staff member failed to act on what they had observed or check that the person was okay until we intervened. They told us they were tired having worked a number of shifts. We did not verify this..

People were consulted about their care and relatives were involved in the review of their needs. Consent was sought from people before care or treatment was provided and people were consulted about their care. We observed positive communication throughout the day between staff and people using the service. All staff were confident in their interactions with people and relatives. All staff who were approached by people responded to the request and did not direct or defer people to another staff member. However communication could be improved upon. We noted there was no evidence of any pictorial aids being employed to assist a person with dysphasia or other cognitive impairment to communicate their needs. Some relatives raised concerns with us which were not known by the service. Relatives said relatives meetings were infrequent and minutes of the meetings were not made available so they did not know what actions had been taken.

People were mostly treated with kindness and compassion. Overwhelmingly feedback received was positive. One said, "They're (staff) very nice and kind." Another said "I'm quite happy here. I get fed well and

the staff are very friendly. If you want anything they'll try and get it for you; they'll try and keep you satisfied." The care staff were observed treating people with kindness, respect and compassion. People and relatives reported that the staff were caring. One person said, "It's a very nice place and very friendly" others said, "It's very good, brilliant, they do all the washing and ironing, take good care of me and my things." A relative who visited to have lunch with their family member told us, "They are brilliant, I am always welcome, it's very good, and I can visit anytime." Another relative stated, "The care is fantastic, I can't praise them enough". A third relative said, "There's a proper element of personal care; [family member] is absolutely treated with respect and dignity". A carer reported, "I love my job but we don't have enough staff to give be the care they need."

Some people with higher dependency levels were in the lounge and were offered other things to meet cognitive needs including soft toys and sensory toys were available. A carer brought in a newspaper for one person and we saw copies of the daily sparkle, a magazine which featured articles from a bygone era. Some people's bedrooms contained a range of items which showed their engagement in hobbies and interests including dolls, music, magazines and books.

There was evidence in people's records that people were supported to express their views and their likes and dislikes. Life story documentation was useful and relevant. The homes paperwork included prompts to staff to support life story discussions and how life events might impact on current approaches to care. People felt staff knew them well and what they liked. Carers took pride in the care they gave, one said, "We are the carers that care.'

People's privacy, dignity and independence was respected. Staff were aware of how to protect privacy and knocked before entering people's bedrooms as well as ensuring privacy when providing personal care by ensuring curtains were pulled and doors closed. Staff told us how they promoted people's independence and maximised people's ability by encouraging them to do as much as possible with support if they needed it. People were well dressed in matching clothes with accessories and jewellery and took pride in their appearance. We noted that, for one person who used the service, the staff had considered their dignity by ensuring their clothes were appropriate.

We observed lunch and saw that staff assisted people to eat with due regard for their dignity. People were offered the choice of disposable aprons. One person told us they liked them as, "They are not the overhead ones I don't like those and these are soft, not plastic I don't like those, these are ok, I have nice clothes so I like this on top." Staff who assisted people to eat went at the persons own pace, were encouraging and ensured people where in a safe comfortable position for eating and drinking.

Requires Improvement

Is the service responsive?

Our findings

During our previous inspection on 8 and 10 February 2017 we rated this key question as requires improvement with an identified breach of regulation 9 of the Health and Social Care Act 2014. At our most recent inspection we saw that most people got good standards of care and those more able a good programme of activity to promote positive well- being. However for those less able we were concerned about their isolation and lack of opportunity.

People received care around the identified needs but the service was not able to be as responsive as we would have liked. For example a relative told us that not all staff knew their family members needs or knew how to support them appropriately. They said they found their family member at times, "Unclean" but did acknowledge they could be reluctant to accept personal care. They did say however that they could be persuaded. They also said they did not often leave their room and would need support and encouragement to do so but said they were not aware this happened regularly. They told us that unless staff initiated things their family member would not be able to ask.

Another relative was equally concerned about the care of their family member. They told us drinks were left with them and the person could not drink independently and would not initiate when they were thirsty. They were concerned about others going into their room, the lack of care around their personal hygiene and said staff did not support them to go the toilet when they needed it. They said this had led to numerous accidents. They also said at times mealtimes ran late leaving an unacceptable gap between meals. They were not confident in the service or how staff had responded to their concerns and felt they had to micro-manage the service. One relative described staff as inattentive and putting themselves before the needs of people using the service. For example eating separately and before people had finished.

We looked at people's care plans and they were difficult to navigate due to their unwieldy nature. Care records although detailed were not used by staff as a frame of reference. Care staff told us they had a verbal handover at the beginning of the shift which helped them know about changes in the person's needs rather than reading the care plans.

Some documentation was not dated so it was difficult to see what was current. One relative raised concerns about their family members care and we looked at the persons care plan. We found the assessment was not dated. We found areas of need identified by the relative were not planned for and some contradictory information. This meant we could not be assured the person's needs were appropriately planned for or met in a consistent way.

However we found some positive aspects about the care plans. They included a document 'This is me' document that provided a good overview of the presenting preferences and likes of the person and important information. Care plans gave a good overview of healthcare diagnosis and care needs relating to people's primary care needs and cognitive needs. Care plans clearly stated peoples preferences for activities of daily living. Supplementary charts included food and fluid, nutrition and repositioning logs were completed by care staff. Supplementary charts were completed clearly, accurately and legibly. Care plans

were reviewed regularly and highlighted changes in people's needs and actions to address it. There was evidence in the records reviewed that referrals were being made to other agencies. For example we saw regular liaison with the pharmacy and wider multi-disciplinary team. Where recommendations had been made these were recorded in an updated care plan. For example a manual handling assessment was updated to take into account for a new prescription of lorazepam which might impact on the person's balance and alertness. There was evidence that the needs of a person with an indwelling catheter who had not passed urine overnight were responded to promptly and a re-catheterisation was performed with good results. Care plans showed how care staff reported observed changes in people to senior staff or nurses and how these had been then acted on. One person had been having difficulty eating and this was referred to the GP and dentist and their situation resolved following dental treatment. The care plans recorded each assessment and the advice given. They were securely held in the nurse's station and accessible to those with agreed access but locked when unattended

The service employed an activities coordinator and there was an advert and shortlisting for a second staff member to replace a person who had left. We observed staff supporting activities. However, with only one staff member trying to engage with so many people inevitably some people did not benefit from the activities provided either because they were not suitable or there were insufficient staff to support them. People liked the activities provided. One said, "I really like the singer." Another said, "I like the singing and I went to a film they had on Friday which was good." A relative said, "This is the first time I've seen entertainment here. [The activities coordinator] has been putting on a massive amount of effort to make this happen." Another relative said, "The activities coordinator is very good, but doesn't have enough time now the other activities coordinator has left." One relative said their family member had not been out for eighteen months. They told us the service had a minibus but they did not know if it was used. They said activities were not rotated evenly around the home. The relative told us their family member, "Sat there from day to day and they have noticed a decline in their mental health."

We observed a ball game activity in the lounge on the ground floor. The activity was fun and sociable and the people who attended appeared engaged and to enjoy it as they waited for the main entertainment to begin. There was an activity plan and we found the activity staff member had a really good overview of the home and insight into people's individual needs. They were a really good motivator and worked inclusively with people and staff but were stretched very thin. They assisted with lunch, helped with personal care and planned and provided activities. They told us there was a budget for activities and they could organise outside entertainers and trips which helped enhance people's experiences. However they also did organised fundraising to enhance people's opportunities.

People who remained in their rooms for long periods were at risk of social isolation and had a lack of cognitive stimulation. One person in their room had their television on but when we asked what they were watching, they said, "I have no idea." The record of one person who had dysphasia stated that they liked to listen to music. However, on the day of the inspection there was no music playing in their room and no other form of stimulus or activity was observed. Their use of speech was very limited so it was not clear how they expressed their needs. There was no visual information or information technology used to enhance this person's communication. We asked their relative about social interaction and they said occasionally their family member was dressed and taken into the lounge but this did not happen often. We asked why that was and they said there was not enough staff to do this. Staff reported they 'pop in regularly for a chat' to people in their rooms and were able to describe the interests and hobbies of individual people.

On the day of the inspection no one in their room on the dementia unit engaged in any activity other than the occasional chat with a passing member of staff or where available some people had a television on. There were activities available in the lounge. Two members of staff played dominoes with one person using

oversized wooden pieces. They enjoyed the activity and it provided social and cognitive stimulation. Not all activities set out were appropriate for people. One table had a 1000 pieces jigsaw tipped out, no one was able to use this but it remained on the table all day. A board game was also put out but no-one was asked or assisted to play this. We noted the radio downstairs was playing modern songs and it was not clear for whose benefit it was.

End of life care within the service was not always managed well. Staff have received end of life training and could describe important aspects of supporting people in their final days, including pain relief, and time with family. One family had not been consulted about a significant change in their relatives need and had therefore been denied precious time with them. We looked at this person's records and saw that their wishes in relation to their anticipated death were not being sought. The records did not show that some of their basic health care needs had been provided such as mouth care.

This was evidence of a repeated breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014

The service could not clearly demonstrate how they listened to people and took into account their experiences when developing the service. There was an established complaints procedure and people seemed aware and happy to use it. People we spoke with were aware of who the staff were and recognised regular staff members, they were able to identify who was in charge and when asked a person told us 'if I want to complain I talk to him' indicating the senior carer. Staff wore different coloured uniforms and the relative we spoke with was aware of who was who, noting all the regular staff wore purple. People were aware of who the manager was but not how often they were in the service. People and relatives were not aware the manager was sick. One person said, "You can talk to her (the manager), but you don't see much of her." Another said "If I had any problem I'd certainly talk to one of the staff about it." A relative told us of their frustration about trying to get something resolved involving specific equipment. They told us despite raising it with manager they said there had been no progress in this over the previous 10 weeks. Some relatives raised concerns with us which were not known by the service. Relatives said relatives meetings were infrequent and minutes of the meetings were not made available so they did not know what actions had been taken.

We saw a number of complaints had been recorded and these had been responded to within the appropriate timescale. Concerns and complaints were dealt with in an open way and concerns and responses acknowledged.

Requires Improvement

Is the service well-led?

Our findings

During our previous inspection on 8 and 10 February 2017 we rated this key question as requires improvement with an identified breach of regulation 17 of the Health and Social Care Act 2014. At our most recent inspection we were confident with some aspects of the service and felt progress was being made all be it slowly. There were plans in place to address areas of concern.

However given the history of the service in terms of previous non- compliance and repeated breaches we were not confident about the provider's ability to sustain improvements in a timely way. The service had an established compliance team and had also developed a quality team whose role it was to support the manager to implement the changes and strive for excellence. This team had not been in place long so were not yet able to demonstrate their effectiveness. They appeared to have been pulled in since the registered manager's absence rather than because of concerns about the service which had been known since the last inspection

There were satisfactory management arrangements in place on the day of our inspection in the absence of the registered manager. The service had employed a relief manager and there was a deputy manager and a newly appointed clinical lead. However relatives we spoke with were unaware of this and were frustrated that their concerns had not been addressed. One relative told us, "I don't know the best way to communicate with the home and who is in day to day control."

We received positive feedback about the home's registered manager. Staff told us she was approachable and had a positive relationship with staff who described her as 'wonderful'. Staff who had worked at the home for a while said the current registered manager was the best. One staff said, "I have seen four managers in the last five years." They said staff were never sure how long the managers were going to stay which put a strain on the service. This was a large home to manage and without adequate senior teams in place it would be difficult to have adequate oversight and manage the service effectively

We observed some clear leadership from the nursing staff but this was confined to one unit. We observed for most of the shifts, tasks were delegated effectively. Staff sought advice from each other and their seniors within the unit. We felt staff were not supported by the home's wider quality management team and indeed were at times hindered by them as carers and nurses were drawn away from people focused tasks. The visitors did not identify themselves to staff or people many of whom commented, "It's busy here; I've no ideas who they are." This does not value or respect the people in whose home they were working.

We had concerns about the recruitment and retention of staff. The use of agency staff meant adequate numbers of staff were on shift but were not able to offer the same continuity of care There were also concerns about sickness levels which put additional strain on the service. Regular staff were working longer hours picking up shifts on overtime which could make them less effective at work. At the last inspection we had identified a breach of regulation 18 which regarded staffing and felt the provider was still in breach of this regulation because actions taken since the last inspection had been ineffective. The managing director told us they were addressing this. They said staff who regularly took time off sick now how to report directly

to them and staff were supported by the human resources department and back to work and exit interviews were completed. They said they had never intentionally understaffed the service and had tried all means to cover shifts and records showed they were overstaffing by introducing 'floating' staff who could assist staff on each floor as needed. They told us there was a full recruitment and retention plan. In addition they told us they were forward planning by block booking agency staff to help achieve greater consistency. They were reviewing how they used their dependency tools to consider if staffing was adequate for people's needs. They said there were daily visual checks which should help to identify any issues in regards to staffing and whether people were getting the care they needed. They told us about their vacancy rates and said they had employed a person whose specific role was to manage recruitment and this should help.

We found that new staff were not always receiving inductions at the commencement of their employment. Neither were they being assessed as competent for the tasks they were required to perform such as medical interventions or the administration of medication. Staff were not receiving regular supervision of their practice and we could not see how their training was embedded into practice or how staff worked consistently across the service.

The policies and protocols for the care and management of gastrostomy tubes were not readily available on the unit and did not include sufficient information and guidance on the administration of medications.

We were unable to see clear evidence of how the service was run in people's best interest or feedback used to plan and improve the service as part of the overarching quality assurance system. Quality satisfaction surveys had not been issued this year to family, stakeholders or people using the service so we could not see if improvements reflected in the staff survey were echoed by those using the service. Relatives meetings were not firmly established. They were planned and run but only a few families attended these despite the manager trying to rotate the times these were held. The reasons for low attendance had not been explored. Relatives told us they did not feel listened to and there were no minutes of meetings to show what feedback had been received and how it had been acted upon. There was a 'you said we did' board but there was nothing on it. There was poor engagement with the local community to help enhance peoples experiences of help them stay part of their community. There were no locally planned trips and no local volunteers. However the activities coordinator was able to tell us about engagement with the local church, pets for therapy, primary school children coming in at Christmas and work with young students on work experience.

The managing director told us they did engage with people and there were comment cards in reception and they had a rolling programme of quality audits and surveys to engage people and ask for their views. If responses received were low this would trigger a quality audit. Given the poor outcome of the last inspection we would have expected to see regular quality reviews but this had not happened until very recently.

This was evidence of a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Quality satisfaction surveys had been used recently to gauge staff opinion. We saw the outcome of a recent staff survey. This reflected a shift in staff attitude and greater job satisfaction and staff confidence. Most staff reported enjoying their job, feeling well supported and familiar with their role and the role of the organisation. We found members of the quality team and managing director open to feedback and willing to work hard for the greater good of the service. The only results from the staff survey which did not score highly was staff's confidence that actions would be taken as a result of their feedback. In addition the service had annual staff appraisals which looked at individual performance and objective setting. Staff performing well could be put forward for an award: team award, divisional awards and pride award which recognised good practice with a monetary reward such as a voucher.

The service had embraced the need to change and had put together an action plan and a longer term plan to help try and ensure that improvements were maintained. We looked at the development plan which gave clear actions within a given timescale for completion. This included how they were acting on feedback, for example one relative raised concern about frozen vegetables and there was an assurance that fresh vegetables would be available. We were confident that with a full staff compliment and strong clinical lead the service could move forward. Learning across services was facilitated by input from internal teams and opportunity for senior members of staff: managers and deputy managers to meet and discuss the changes, risks and opportunities. By sharing the outcome of negative feedback for example from the clinical commissioning group or Care Quality Commission the managing director could look at common themes across the homes and where generic improvements might be required. Hot topics identified included MCA and DoLS. This is where the organisation had recognised they needed to improve throughout their services. Staff from the quality team told us they communicated regularly at least monthly to update or add to action plan to show progress made against actions.

Budgetary matters were discussed in relation to an increased spending on staffing which the regional director said was up and above that expected, provided for by the Local Authority. We however had concerns about spending on food which was flagged by some as a concern in terms of quality.

We looked at a sample of audits which included night care audit, dining experience and the maintenance and overview of equipment and safety procedures. These were in order and identified any shortfalls. However we were not assured of their effectiveness given the concerns we identified not identified by the provider. Oversight of risk was in place and meant that actions proportionate to the levels of risk could be taken and safeguards were in place to reduce known risks to people's safety.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care provided was not always individualised and based around people's assessed needs and wishes. Regulation 1 (b) (c) 3 (b, c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment must be provided with the consent of the relevant person and records should clearly how the service supports people who lack capacity to make decisions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's needs in relation to hydration and nutrition must be met

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Oversight of the service was not sufficiently robust and did not always take into account peoples experiences and care received.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care

Staffing numbers within the service were not always maintained in sufficient numbers to meet the assessed needs of people using the service.

Staff employed were not receiving appropriate support, training and supervision to enable them to carry out their duties.
Regulation 18 1, 2. (a) (c)