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Ashley Manor Nursing Home - Southampton

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

Ashley Manor Nursing Home provides accommodation and nursing care for up to 45 older people. The service is in a rural location near Shedfield, and provides accommodation over three floors in a converted residential dwelling. At the time of our inspection 13 people were using the service.

The inspection took place on 28 and 29 June 2016 and was unannounced. This was a comprehensive inspection that was carried out to check on the provider's progress in meeting the requirements made as a result of our inspection on 7, 8 and 11 January 2016 which resulted in the service being rated Inadequate. As a consequence of this judgement the service was placed in special measures and we took enforcement action in response to this failure to meet the required standards. We have placed a condition on the provider's registration that they must not admit any new people to Ashley Manor Nursing Home without the prior written consent of the Care Quality Commission.

The previous inspection report in January 2016 identified 12 breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. At this inspection we found action had been taken to address the concerns we identified. Sufficient improvement had been made for the provider to meet the requirements of nine of the twelve previously breached regulations. We found the provider still needed to make further improvements in three regulations in relation to good governance, consent to care and treatment and staff supervision before these requirements could be met. You can see what action we asked the provider to take at the back of the full version of the report.

At the time of the inspection the service was not running at full capacity and provided care to a low number of people. More time would be required for the service to complete their action plan and test out the robustness of the improvements and systems in place to ensure it would be able to continue to provide an improved service when new people were admitted. The service would need to sustain the improvements made before people could always be confident that they would receive a high standard of quality individualised care that always met their needs and ensured their safety. Following this inspection the service had not been rated as inadequate for any of the five key questions and has therefore been taken out of special measures.

Ashley Manor Nursing Home did not have a registered manager in post on the day of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider had recruited an acting home manager in January 2016. The acting home manager planned to register with CQC to ensure the provider would meet their regulatory responsibilities in relation to their registration.

Staff were complimentary about the acting home manager and people and relatives felt the service was well

led. We found however, that the acting home manager did not have a good overview of the service's audits and action plan that would have been reasonable for them to have known. They did not always show strong leadership and a good understanding of their responsibility for ensuring progress against the action plan was monitored and evaluated; there was a risk that progress with the plan might be delayed or fragmented.

The audits and checks the provider had in place to monitor the medicines management, catering and infection control arrangements had been effective in driving improvements in these three areas. However, other monitoring systems such as the daily record checks, staffing deployment and staff performance monitoring to identify and monitor risks to people, had not always been operated effectively so that action could be taken to reduce the likelihood of harm to people. We found additional processes and assessment tools had been introduced to ensure judgements of risk and service quality would be evidence based. More time was needed for the culture of the service to develop further. So that people could be assured when the provider was made aware of shortfalls and took action taken to address these; they would make their judgements based on thorough root cause investigations and the consideration of current best practice.

Action was being taken to address the shortfalls in staff training and staff supervision was starting to take place. Further improvement was needed to ensure all staff would receive regular opportunities to discuss their development needs and evidence they had the competence to undertake their roles effectively. All staff had not received regular supervision to enable them to discuss their performance and identify areas where their practice needed to improve. If the provider was to employ new staff there was a risk they would not receive a structured induction to adequately prepare them for their role in accordance with national good practice guidance.

We found improvements were still needed to ensure people's consent to their care and treatment was gained lawfully. Nurses had received additional training to support them to assess people's capacity and undertake decisions in people's best interest when needed. However, where people had lacked the capacity to make decisions independently, the decisions made in their best interest, had not been reviewed to ensure they met the requirements of Mental Capacity Act 2005 (MCA). There was a risk that people's rights would not be upheld if they lacked the mental capacity to make decisions about their care.

At our previous inspection in January 2016 we found people did not always receive the appropriate care and support they required to keep them safe. At this inspection we found people's risks to their health and safety had been identified and arrangements had been put in place to keep people safe. Staff understood people's risks and how to keep them safe. However, people's care plans and daily records were not always up to date and completed when people received their care. These records did not include all the information staff required in order to keep people safe or to judge whether people had received the care they required. If new people were to be admitted to the service that staff did not know well or new staff unfamiliar with people's needs were to refer to people's records, they might not have all the information they required to keep people safe.

People had received their medicines as prescribed. The medicine audits had improved the safety of the service's medicine management and we found the number of medicine errors had significantly decreased. The service's medicine checks had effectively identified these errors and action had been taken promptly to reduce the risk of harm to people from not receiving their medicine as prescribed. The provider had sourced a new community pharmacist to support the service from 18 July 2016 to further improve their medicine practices.

We found the environment and equipment clean throughout. New housekeeping staff had been appointed and one of the nurses had taken on the role of infection control lead to ensure good infection prevention

arrangements were put in place. The service had effectively implemented an infection control improvement plan with the support of the West Hampshire Clinical Commissioning Group (WHCCG) and continued to monitor the improvements to ensure they were sustained and all areas of concern addressed.

The required notifications of significant events had been made appropriately. The service had reported concerns that could indicate abuse or neglect to the local safeguarding team and CQC so that these concerns could be investigated to ensure people were safe. Plans were in place for all staff to complete their safeguarding training by 15 July 2016. Staff had a good knowledge of their responsibilities to keep people safe from abuse.

The provider had improved their recruitment practices and we found all the required staff pre-employment checks had been completed to ensure staff would be suitable to work at the service.

Improvements had been made to ensure people received the support they needed to eat and drink sufficiently to remain hydrated and well nourished. People told us they did not always like the food. The provider was working with people to improve the menu and time was needed for this to be completed.

People told us there had been an improvement in their relationship with staff. They experienced day staff as kind and caring but their experience of the night staff were still not always positive. Time was required to ensure these improvements had become sustained in the service so that people would always be treated with dignity and respect by all staff.

There were sufficient staff to meet people's needs and staff attended to people's request for assistance promptly. However, the current staffing level was not clearly determined by people's individual support needs or risks, or the skills and knowledge of staff. If people's needs changed, staff had to attend training or new people were admitted that staff did not know well, the current staffing levels and staff skill mix may not be sufficient to meet their increased needs.

People told us they were generally satisfied with the care they received and that it met their needs. We saw that although people's care plans had been reviewed and provided more details about their preferences, there was little written evidence that people and their relatives had been involved in care planning. The provider was taking action to involve people and their relatives in the monthly care reviews.

The provider had investigated people's complaints and people told us they knew how to complain if needed. Time was needed to ensure these improvements had become sustained in the service so that complaints investigations would always be comprehensive and complaints monitored over time.

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 consistently safe.

People's risks to their health and safety had been identified and staff knew how to manage people's risks. However, people's care plans and daily records did not always included all the information staff would need to be able to support people safely if they were to rely solely on the care records when delivering care.

There was sufficient staff to meet people's needs and they knew what action they needed to take to protect people from abuse.

The service was clean and arrangements were in place to protect people from infection.

The provider had appropriate arrangements in place to safely manage people's medicines and people received their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Further improvement was needed to ensure best interest decisions made on the behalf of people who lacked the mental capacity to make their own decisions, were made in accordance with the MCA.

All staff had not received regular supervision or appraisal to enable them to discuss their performance and identify areas where their practice needed to improve.

People's health needs were met and nurses sought guidance from health care professionals when required.

People were supported to maintain a balanced diet and received the support they required during meal times.

Is the service caring?

Requires Improvement

The service was not consistently caring.

All people told us day the day staff treated them with respect and kindness. They felt the day staff knew them well and they had built good relationships with them. However, some people felt improvements were still needed to ensure all the night staff showed people care and respect.

Staff did not always initiate conversation with people when supporting them with care tasks so that they were given the opportunity to remain engaged and involved.

We saw throughout our inspection that people were given the opportunity and support to make decisions about their care and indicate their preferences.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People told us they were generally satisfied with the care they received and that it met their needs. The provider was improving the involvement of people and their relatives in care plan reviews to ensure people's care met their wishes and preferences.

People knew how to complain and their complaints had been investigated. Time was needed to ensure complaints investigations would always be comprehensive and complaints monitored over time so that trends could be identified and investigated.

The provider had created more opportunities for people to provide feedback about the service and they were taking action to improve the activities and meals offered in the service.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider's audit systems and action plan had led to improvements in some areas of the service but had not been effective in driving the required improvements across the service as a whole.

Although staff told us the culture in the service had improved, the leadership was not always strong. The acting home manager had not always monitored the culture in the home to ensure people's experience of the night staff would reflect the caring values of the service.

The provider had displayed their inspection ratings and had notified CQC of significant events as required by the regulations.

Ashley Manor Nursing Home - Southampton

Detailed findings

Background to this inspection

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

This inspection took place on 28 and 29 June 2016 and was unannounced. The inspection was carried out by two inspectors, a pharmacy inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses nursing and dementia care services.

Before the inspection, we reviewed all the information we held about the home including previous inspection reports and notifications received by the Care Quality Commission. A notification is information about important events which the service is required to tell us about by law. We used this information to help us decide what areas to focus on during our inspection. We did not request a Provider Information Return (PIR). 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. We gathered this information on the day.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. During our inspection we spoke with 11 people using the service and two people's relatives. We also spoke with the provider's representative, the acting home manager, three nurses, three care workers, the cook, the laundry assistant, two cleaning staff, the administrative assistant and a visiting GP. We also spoke to the commissioners prior to our visit.

We reviewed records relating to eight people's care and support such as their care plans and risk assessments. Additionally medicines administration records for every person living in the home were reviewed. We also reviewed training and supervision records for all staff and personnel files for five staff, and other records relevant to the management of the service such as quality audits.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in January 2016 we found people did not always receive the appropriate care and support they required to keep them safe. People did not always receive their medicines as prescribed. The service was not cleaned effectively which put people at risk of infection. This was a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made and this regulation had been met.

Risks to people's safety had been assessed using universally recognised screening tools. The risk assessments that were in place had been reviewed and the information relating to people's risk management plans was more comprehensive to ensure people would receive safe care. Staff had an understanding of people's risks including what action to take to keep people safe in accordance with their care plans.

People were assessed monthly for the risk of them developing pressure ulcers. Care plans showed where people had been identified as at risk, arrangements had been made to prevent their skin from deteriorating. People were prescribed topical creams to hydrate and protect their skin in order to minimise their risk of developing pressure ulcers. Nurses told us and daily care records confirmed, care staff applied people's topical creams when providing their personal care. People who could not change their position independently to relieve the pressure on their skin were supported to reposition regularly to protect their skin from pressure damage. People's daily notes sometimes demonstrated that staff had changed people's position when they assisted them with personal care; which took place at regular intervals throughout the day. However, this repositioning was not accurately recorded on people's repositioning charts in accordance with good practice to show people had been repositioned at the required frequency. Accurate repositioning charts were required to be maintained for people to evidence people had not in the same position for too long. This would ensure that nurses had all the information they needed, to evaluate whether the preventative action they had instructed care staff to take to protect people's skin, had been implemented appropriately.

Staff understood the importance of ensuring people at risk of skin deterioration had sufficient to eat and drink to protect their skin. Arrangements were in place to monitor people who were at risk of de-hydration and to ensure they had sufficient to drink. Daily fluid charts were completed and records informed staff of the amount each person had to drink daily to ensure they remained hydrated. The fluid charts reviewed showed people had received enough to drink. However, the charts had not been totalled at the end of the day as would be good practice, so that nurses could see at a glance whether people had had enough to drink. The provider had identified this as an area requiring improvement and had instructed the night nurses to total all the fluid charts. This information would then be recorded for the day nurses at the beginning of the morning shift to inform their planning of people's hydration support for the next shift. Time was needed for this process to become embedded in the daily activities completed by night nurses.

People's medicine care plans did not always include all the risks relating to their prescribed medicine. One person used anti-coagulant medicine. This medicine thins the blood and can have significant side effects

including, prolonged and intense bleeding and bruising. This person used a bedrail to prevent them from falling out of bed and there was a risk they could bruise when bumping against the bedrails or experience intense bleeding if they were to fall. Although staff could tell us how they would identify these side effects and the action they would take to keep people safe, staff had not received clear written guidance to ensure they would know how to keep people safe when they used this medicine if they were to solely rely on the information provided in their care plans.

People's diabetes care plans did not always have guidance so staff would know how to recognise when people's blood glucose where to become dangerously high and the action they needed to take. Staff might therefore not always have all the information they needed to be able to identify when people became unwell and if an urgent referral to the medical team would be required if they were to solely rely on people's care plans.

People who were at risk of weight loss and associated malnutrition had been identified. We asked a nurse how the staff determined people's unplanned weight loss percentage when completing their Malnutrition Universal Screening Tool (MUST). MUST is used to assess people's risk of malnutrition. They told us nurses looked at the person's previous month's weight and compared it with their current weight. MUST guidance states a person's total weight loss over three to six months should be used to determine unplanned weight loss percentages. Otherwise small amounts of weight lost over a period of time which might accumulatively indicate a concern, could be overlooked. Time was needed for the service to develop a comprehensive understanding of this risk screening tool to enable nurses to accurately determine people's risk of malnutrition over time.

Arrangements were in place to monitor people's weight monthly to ensure their nutritional plans were effective in managing their risk of unplanned weight loss. However, further improvement was needed in relation to the recording of people's weights where they had been identified as at high risk of weight loss. Nutrition plans had been effective at meeting the needs of these people and they had gained the required weight. Their records however, did not demonstrate that they had been weighed weekly as required and their care plans had not been updated so nurses would know how often they needed to be weighed. Nurses we spoke with at times relied on their memory to satisfy themselves that people had been weighed as required, in the absence of a record. This might support staff to monitor people's weight loss risk for such a small number of people. However, if more people were to be admitted to the service a more robust system would be required to monitor people at high risk of weight loss. This would ensure any changes to people's risk would be picked up promptly.

Mobility plans were in place for people at risk of falls and we observed staff supporting people who were walking to remain safe. They reminded people to walk slowly, highlighted trip hazards and reassured people if they became unsteady on their feet. The provider had implemented new falls and mobility risk screening tools over the past month to support nurses to identify when people were at risk of falls. Some time was needed for nurses to become experienced in using these tools effectively. Following people falling, staff documented what had happened and the action they had taken to keep the person safe. For example, records showed that following a fall, the GP was informed and post-falls observations were completed on the person. This was to ensure nurses would be able to identify any immediately non visible injuries that might require medical attention. Time was needed to ensure people's falls risk assessment and mobility care plans were evaluated after each fall to ensure current risk management arrangements were still appropriate to keep the person safe.

The provider had checked all wheelchairs following our previous inspection to ensure they were in good working order. People used wheelchairs with footplates to protect their feet from becoming entangled in the

wheels, when the wheelchair was in motion, so not to cause injury. Two people preferred to use their wheelchairs without foot plates and others stayed in their wheel chairs during lunch time. Staff could describe the reasons for this and how they supported people to remain safe. Time was needed to ensure when people spent extended periods in their wheelchairs and used pressure cushions to alleviate the risk of pressure ulcers, this was always documented in their care plans. It would ensure all staff would know what arrangements had been put in place to keep people safe when using their wheelchairs if more people were to be admitted to the service.

Although staff understood people's risks and how to keep them safe, people's care plans and daily records were not always up to date and completed when people received their care. Care plans and daily records did not include all the information staff required in order to keep people safe or to judge whether people had received the care they required. If new people were to be admitted to the service that staff did not know well or new staff unfamiliar with people's needs were to refer to people's records, they might not have all the information they required. The provider did not maintain an accurate, complete and contemporaneous record for each person, including a record of the care provided and of decisions taken in relation to the care provided. This was a breach of Regulation 17 of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received support to manage their medicines from appropriately trained nurses. Medicine Administration Records (MAR) showed that people had received their medicines as prescribed. Whilst medicines were stored securely by staff, the storage did not follow the provider's policy and time was needed for this to be reviewed. All medicines, including those requiring refrigeration, were kept within recommended temperature ranges. Liquid medicines and eye drops all had "dated opened" written on their labels, so that nurses could dispose of medicines when required to prevent the risk of contaminants. Some improvement was needed in the recording of the "date removed from fridge" for insulin pens to ensure these pens would remain effective within manufactures timeframe.

Homely remedies (medicines which the public can buy to treat minor illnesses like headaches and colds) were available within the service. Information about people's allergies, "how I like to take my medicines", "when required" and "variable dose" medicines was held within each person's MAR. This supported nurses to know how they needed to support people to take their medicine as prescribed

Infection prevention arrangements were in place, the environment and all equipment was clean throughout the service. Light pull cords in toilets and bathrooms which were deeply discoloured previously had been replaced. This ensured when staff pulled the cord they would not come into contact with an unclean surface which may expose them to residual contamination. People told us they did not have any concerns about the cleanliness of the service and were satisfied that their rooms and the rest of the service were clean. Two new cleaners had been employed and they were working to a new cleaning schedule. Records showed all areas of the service were cleaned daily. Cleaning staff were clear about their responsibilities and could describe the different cleaning arrangements for bedrooms and bathrooms and any areas used by people who had a known infection to prevent cross contamination. The kitchen had received an inspection from the local authority's Environmental Health team on 14 April 2016 to check the cleanliness of the kitchen and the standard of food hygiene. The service had received a maximum five star rating to indicate that the food hygiene maintained in the service was judged as being 'Very Good'.

One nurse had taken on the role of infection control lead and was overseeing the work of the cleaning staff. They had also worked closely with the clinical commissioners to address infection control concerns and records showed progress has been made against the service's infection control audit action plan. For example, the hoisting equipment was cleaned after each use and there was a new fridge cleaning schedule

for fridges in people's rooms. We found the fridges to be clean. We saw staff wearing gloves, aprons and footwear as appropriate to protect people against the risk of infection.

More time was needed for the provider to complete their infection prevention action plan and to ensure the improved cleaning arrangements and staff practice had become sustained in the service to protect people from cross contamination.

At our inspection in January 2016 we identified, although there were sufficient staff people did not always get up when they wanted and staff did not always respond promptly to people's request for assistance. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had made improvements in this area and this part of the regulation was now met.

People and their relatives told us and we saw, people had call bells within their reach and staff responded promptly when people rang. People told us they were able to get up when they chose. There were sufficient staff numbers to support people. People were not left waiting to be attended to and staff were visible throughout the service during our inspection.

The provider had reviewed their staff roles following our last inspection. Three senior care staff had been appointed to support care staff to complete people's records appropriately, to supervise care staff and to co-ordinate the care activities on each staff shift. An activities co-ordinator had also been employed to support with developing and providing activities for people within the service. Staff were positive about the new roles. They told us there were more social opportunities for people and that senior care staff checked whether care staff had completed at the required tasks at each shift. We found the senior care staff did not always complete their daily records checks accurately. Senior care staff and the acting home manager told us time was needed for them to develop a good understanding of their new responsibilities and to co-ordinate each shift effectively.

The provider had reduced the number of care staff on the day shift following our previous inspection in January 2016 as the occupancy of the service had reduced. The acting manager told us they had not been involved in a review of people's dependency levels and was not sure what information was used when deciding to reduce care staff to ensure people's needs could still be met. Nurses supported care staff when there were unplanned care staff absences. Staff supervision records showed staff had expressed concerns that they felt rushed and could not always support people to bath when the planned number of care staff were not on shift. Two people also told us staff were not always as quick to respond to their calls for assistance at night. Staff told us at times staff cover could not be found so they could attend training. There was the potential risk that the provider's staffing contingency arrangements might not always be effective and staff might be stretched at times when there were staff absences.

The current staffing level was not clearly determined by people's individual support needs or risks, or the skills and knowledge of staff. If people's needs changed, staff had to attend training or new people were admitted that staff did not know well, the current staffing levels and staff skill mix may not be sufficient to meet their increased needs. There were enough staff to keep the current number of people safe. However, the absence of a systematic approach to determine and review the number of staff and range of skills required meant we could not be sure sufficient and suitably skilled staff would always be available if more people were to be admitted.

At our previous inspection in January 2016 we found the provider had not implemented safe recruitment practices as all the required staff pre-employment checks had not been completed. This was a continuing

breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made in this area and this regulation had been met.

The provider had reviewed their recruitment and selection procedure. All of the required information was available in the staff files reviewed. Records showed appropriate checks had been undertaken to identify if applicants had any criminal convictions or had been barred from working with vulnerable adults. A full employment history with written explanations of gaps in employment was available. References had been obtained from previous employers to alert the provider to any concerns in relation to staff's conduct in previous employment that might make them unsuitable to work with people using care services.

We asked the acting home manager what action they would take if the available pre-employment information raised concerns about an applicant's suitability, for example if they had a previous criminal conviction. They were not clear how they would systematically evaluate the risks applicants could pose to people prior to making a making a decision about their suitability or deciding whether additional monitoring would be required during their probation period to confirm their suitability. Time was needed to ensure the acting home manager developed their understanding and experience in assessing the risks to people prior to making the decision that applicants' would be suitable to work in the service.

At our previous inspection in January 2016 we found the provider had not reported concerns that could indicate abuse or neglect appropriately to the local safeguarding team and CQC so that these concerns could be investigated to ensure people were safe. This was a continuing breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made in this area and this regulation had been met.

The acting home manager was developing an understanding of their safeguarding reporting responsibilities. The service operated an effective accident and incident reporting system. Following safety incidents, staff documented what had happened and the action they took to keep people safe. The registered manager reviewed the incident reports and assessed if any further notification was needed. Where incident reports could indicate possible abuse or neglect these concerns had been reported to the relevant agencies as required. This included medicine errors. The acting home manager told us staff were still developing their knowledge of the reporting procedure and how to complete the electronic reporting forms correctly. The administrator told us ''The manager sits with me, talks me through the information I must put on the form and checks it before I send it off''. The provider had attended recent inter-agency safeguarding meetings and completed investigations as required.

People and relatives told us people felt safe living in the service and did not have any concerns about abuse or bullying from staff. Staff could describe how they would identify and respond to potential abuse, discrimination and harassment and the action they would take to minimise the risks of avoidable harm to people from abuse. Staff said they would report any poor practice or abuse they suspected or witnessed, to the senior staff or directly to the registered manager. Staff were also aware they could report externally to CQC or the local safeguarding team if needed.

Additional safeguarding training had been provided and 16 of the 31 staff had completed safeguarding training. Time was still needed for all staff to complete their safeguarding training and further training was taking place on 15 July 2016 to ensure all staff would be up to date with current local safeguarding arrangements.

The communal lounge doors were open so that people could access the garden if they wished . The garden was not fenced from the main road. At the time of our inspection people who could not maintain their road

safety were cared for in bed and were therefore not at risk of harm. However, adjustments would need to be made to the building access and garden if the service was to admit people who could not independently manage the risk posed by the road if they were to access the garden independently. The current environment would also not provide sufficient protection for mobile people if they were in the future to require constant supervision to remain safe as they could leave the building and grounds if adjustments were not made. These adjustments would also need to balance the wishes of those people who could manage the risk without unduly restricting their freedom to access the outdoor space independently.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection in January 2016 we found a continuing breach of Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff had not received regular supervision to enable them to discuss their performance and identify areas where their practice needed to improve. At this inspection we found the provider had taken some action to address this concern but further improvement was needed before the requirements of this regulation could be met.

Action had been taken to improve staff training to ensure staff would have the skills and knowledge needed to meet people's needs effectively. Staff had received fire safety, safeguarding, infection control, first aid and moving and handling training following our previous inspection. Time was still needed to ensure all staff would had received all the training they required and the provider was arranging training for those staff who still needed to attend. Records showed all nurses still needed to complete specialist training for example in falls awareness, tissue viability, the use of syringe drivers and prevention of choking. There was a risk if the service was to admit people with increasingly complex nursing needs nurses might not have the skills to support them effectively.

Staff told us they felt better supported and said the nurses and senior care staff were always available for guidance. Regular team meetings attended by the provider, were taking place which gave staff the opportunity to remain up to date with the service improvement plan as well as discuss any areas of concern. Records showed these had not been attended by the night staff. Supervisions had started taking place. Records showed most of the day care staff had received a supervision session in the past six months. However, records showed the night staff and some day nurses had not received supervision. The provider had been made aware at the previous inspection that people had concerns about the nights staff's approach not always being caring. The provider had not taken action to provide the night staff with regular supervision to ensure they would have the support, skills and competence to undertake their role effectively. At our previous inspection we were told that appraisals were planned for January 2016. However, no staff had received an appraisal. For those staff who had not received supervision, this meant they had not been provided with an opportunity to review their leaning and development needs and for their manager to appraise they performance. Any additional skills and knowledge that may be required from staff if the service was to admit any new people with complex needs might therefore not have been identified so that action could be taken to ensure appropriate training was provided. There was a risk that staff might not be able to fulfil the requirements of their role if people's needs changed or people with more complex needs were admitted to the service.

The induction programme in place for new staff were not sufficient to prepare staff for their role. The acting home manager provided us with a copy of the induction checklist which only included information about the service's operational procedures. It was not a structured programme that showed how new staff would be supervised until they can demonstrate the required levels of competence to carry out their role unsupervised. The provider told us they had ordered the Care Certificate induction workbook for new care staff to complete. However, the acting home manager was not familiar with the Care Certificate standards and how these needed to be used to ensure new staff were supported, skilled and assessed as competent to

carry out their roles. The Care Certificate standards are nationally recognised standards of care which care staff need to meet before they can safely work unsupervised. If the provider was to employ new staff there was a risk they would not receive sufficient support to adequately prepare them for their role in accordance with national good practice guidance.

Staff had not all received the supervision and appraisal necessary to enable them to carry out the duties they were employed to perform. This was a continuing breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people living with dementia did not have the mental capacity to independently make decisions about their care arrangements. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We could see that where appropriate and required the provider had submitted correctly completed applications to ensure that restrictions to people's liberty had been legally authorised.

At our previous inspection in January 2016 we found staff did not understand their responsibilities under the Mental Capacity Act 2005 (MCA). Where people lacked the capacity to make decisions independently, the decisions made in their best interest, had not been recorded. This was a continuing breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had made some improvements.

The provider had implemented the Hampshire County Council MCA toolkit to record when mental capacity assessments were undertaken and the best interests made on people's behalf. Nurses responsible for completing mental capacity assessments and best interest decisions had received training to support them to understand this legal process and the nature of the required recording they needed to complete.

Care staff understood the importance of gaining people's consent before undertaking care tasks. Staff were observed seeking consent before carrying out tasks and explaining the procedures they were about to carry out, for example, when asking a person if they wanted their medicines. People's daily records showed that staff asked their consent prior to undertaking personal care tasks. Some care staff still needed to complete their MCA training and to develop their understanding of the principles of the MCA. This would enable them to identify when people's mental capacity might be fluctuating and to understand their role in contributing to best interest decisions. The provider had made arrangements for future MCA training.

The service had not needed to make any new decisions on people's behalf since out previous inspection. Previous decisions made on people's behalf in relation to for example, the use of bedrails had not been reviewed to ensure they met the requirements of the MCA. We could therefore not judge whether the service had improved their recording of best interest decisions, made on people's behalf, as required by the MCA principles. More time was needed for staff to embed learning into practice to ensure mental capacity

assessments and associated best interest decisions would always be completed in accordance with current best practice guidance. This was a continuing breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in January 2016, we identified people did not always receive the support they needed to ensure their nutritional and hydration needs were met. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities). At this inspection we found the provider had made improvements in this area and this regulation was now met.

Staff understood the importance of supporting people to drink enough to prevent dehydration and associated complications. People told us drinks were placed within their reach and we saw people were encouraged to drink throughout the day. People at risk of losing weight were supported to make sure they ate and drank enough. One relative told us ''[My relative] gets his meals on time, they ensure he gets pureed meals and complan to supplement his diet and this is recorded". Nurses had reviewed people's portion sizes and calorific meals were provided. The GP and community dietician had been involved to provide nutrition guidance when required.

Staff provided examples of adjustments made to support people with soft or pureed food to eat enough when they experienced difficulty chewing or swallowing. People at increased risk of choking were referred to the Speech and Language Therapist (SALT) for an assessment when needed. The service kept people's choking risks under review and records showed nurses had again contacted the SALT for advice as people's ability to safely swallow changed. The service had introduced a new choking screening tool and further time was needed for the provider to evaluate the effectiveness of this tool in identifying people's risk of choking appropriately.

The cook was kept informed of people's dietary needs and they were able to describe how they provided meals that met the needs of people with swallowing difficulties and allergies. We saw the information they had about people's nutritional needs was up to date.

People received a varied diet and this included a different vegetarian option throughout the week. People gave us mixed views about the food. People's comments included "The food suits me fine, I've never left anything on my plate during the three years I've been here", ''The food is without flavour, they don't use salt or butter", "Sometimes really nice, otherwise grotty" but this person said that something else would be offered if they did not like the meal. Desserts were noted by one person to be 'too sweet', but said cheese and biscuits were offered as an alternative. The provider was aware that people were not always satisfied with the choice and preparation of food. They had started recording people's feedback about the food after the main meal every day. We saw changes had been made following their feedback. For example, less sausage dishes were provided, more salads and time was needed for the menu review to be completed. The provider was working with people to improve the menu and time was needed for this to be completed.

People were supported to access specialist health practitioners when needed. One person told us ''Yes, they meet my health needs safely''. Records showed people were routinely able to see a number of health care professionals including, a chiropodist, physiotherapist and optometrist as required. A local GP visited the home twice weekly in order to treat anyone who was unwell and made extra visits if there was an emergency. Some people required routine monitoring of their blood pressure (BP). We saw this did not always take place at the required weekly for one person as stated in their care plan. The nurse could explain why this person's BP had not been taken but this had not been recorded so that nurses would know this was not an oversight. Another person's care plan did not inform nurses how regularly they needed to take people's BP to ensure they would remain healthy and how to identify any concerns that needed to be

shared with the GP. Nurses might not always identify when people with known blood pressure concerns, were becoming unwell so action could be taken to maintain their health.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection in January 2016 we found the provider had failed to ensure people were treated with dignity and respect; this was a continuing breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities). At this inspection we found improvements had been made and the requirements of this regulation were now met. More time was required to ensure these improvements had become sustained in the service so that people would always be treated with dignity and respect by all staff.

Staff were able to describe to us the measures they took to uphold people's dignity in the provision of their personal care. This included keeping the door shut, closing the curtains, giving people choices and informing them of what they were doing. We observed that most staff were generally careful to ensure that peoples' dignity was not compromised, they listened to what people wanted. They only entered people's rooms after knocking and being invited in and spoke pleasantly to people throughout our inspection. One relative told us ''They treat him with dignity and will always ask me to wait outside''. Staff treated people's environment with respect and ensured people's rooms and the communal areas were kept clean and pleasant. Staff made sure that whenever hoists were used, that peoples' dignity was maintained and their clothing was adjusted to protect their modesty. People were supported in a calm, unrushed manner and reassured whilst the hoist was used.

People however, told us they did not always experience consistent kindness and respect from all staff. All people told us day the day staff treated them with respect and kindness. They felt the day staff knew them well and they had built good relationships with them. However, some people felt improvements were still needed to ensure all the night staff showed people care and respect. People's comments included, ''Staff are on the whole very, very good. But the night staff do not know the people and treat everyone the same'', ''Staff are marvellous and the night staff are good, on the whole'', ''Very kind and caring. Nothing is too much trouble. Night staff are not so good, they don't know people. They are more abrupt, but are not unpleasant. They will get you a drink at night '' and ''Night staff are sometimes polite but always grumpy''. Overall people were treated with dignity and respect by the majority of staff but further improvement was required to ensure this was the consistent experience for people from all staff.

At lunch we observed the tables were laid with clean tablecloths, cutlery, napkins and condiments ready for people to sit down and eat their lunch. Staff provided people who required clothing protection napkins in the dining room and in their bedrooms as they served their meal; this was more dignified for people than sitting waiting for their meal wearing one. People who could eat independently were served at about the same time so they could enjoy their meal together. However, two people required support with eating and had to wait for staff to support them. They were seated at the table for some time having to watch other people eat whilst they waited for their meal. Senior carer workers had started reviewing the allocation and coordination of lunch time tasks to ensure people received their support when needed. Time was needed for these improvements to be fully completed to ensure all people received their meals in a dignified manner.

We saw throughout our inspection that people were given the opportunity and support to make decisions

about their care and indicate their preferences. For example, people decided what they wanted to eat, when they wanted to get up, provided feedback on their meal and were asked if they wanted to take part in a card game in the afternoon. Although staff provided people with the support they needed, some staff did not always chat with people and give them the opportunity to engage in their care. We saw some staff engaging in conversation with people whilst providing their lunch support. They spoke clearly and provided people who found it difficult to talk, the time they needed to make their wishes known and used the care tasks as an opportunity to provide the person with social interaction. However, other staff were seen to be looking out of the window or sat in silence whilst supporting people. Some time was needed to ensure people were always engaged by all staff so that they would always have the opportunity to express their views and feel listened to.

Requires Improvement

Is the service responsive?

Our findings

At our inspection in January 2016 we were concerned that people had not received personalised care as we could not see how people's care had been planned to meet all of their needs. This was a continuing breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities). At this inspection we found improvements had been made in this area and this regulation had been met. However, more time was required to ensure these improvements were fully completed and had become sustained in the service.

Following our inspection in January 2016 all people's care plans had been reviewed by the nurses. Information was available about people's allergies, brief personal history, daily routine, whether people could make their needs known or were in pain. People's oral care was now included in their personal hygiene plan. People's sleep care plans informed staff what time people would like to go to bed. We saw care plans were generally more comprehensive and the information gave details about the level of support people required as well as the things they could do independently. These helped staff understand more about the person they were supporting.

Time was needed to ensure people's care plans were fully individualised so that staff would always know what support each person required. For example, the care plans for people living with diabetes had improved but some were still not fully personalised. Changes made by the GP to the frequency of one person's blood glucose reading had not been recorded. Nurses were taking the person's reading weekly but the GP said it did not need to be done this frequently, only when the person presented with concerns. Nurses had stopped taking weekly readings. However, they had not recorded the guidance from the GP, had not requested a written instruction to this effect or updated their diabetes care plan to reflect the new guidance. Staff might therefore not have all the information they needed when people's care needs changed to enable them to monitor whether people's support met their needs and preferences.

Handover meetings took place at the change of each shift to ensure staff were up to date with people's care needs. They were also kept up to date with information about people's social visits and activities that would enable staff to strike up a conversation with people. Nurses had a handover sheet and care staff had a separate one. This ensured staff received the information relevant to their role.

People were positive about the welfare and activities co-ordinator who had been recruited in February 2016. A weekly activity plan was agreed with people including activities for people who were nursed in bed or chose to stay in their rooms. Records confirmed that these activities took place to prevent people from becoming socially isolated. People told us they enjoyed the pampering and baking sessions and the quizzes and games. One person told us ''The activities person tries hard to get it up and running and to get people more interested.'' At the time of our inspection the welfare and activities co-ordinator was on leave and we saw staff continued to provide some activities for people. We observed a care staff member playing cards with three people. All seemed to enjoy this activity. Those who showed an interest were encouraged to play. Relatives and people told us some time was needed for the weekly activities to reflect all the people's interests and hobbies, especially those who found it difficult to express their views.

People told us they were generally satisfied with the care they received and that it met their needs. We saw that although people's care plans had been reviewed and provided more details about their preferences, there was little written evidence that people and their relatives had been involved in care planning. Monthly reviews did not indicate whether people or their relatives, where appropriate, were satisfied that people's care was being delivered as they required. For example, the service had reviewed their allocation of a 'bath day' as it did not demonstrate individualised care. Instead people were being supported to express and follow their personalised bathing routine. However, monthly reviews did not indicate whether this change was meeting people's needs and the acting home manager could not confirm whether people had been supported to bath regularly. One person told us they were asked by night staff to go to bed earlier than they wished. We saw their care plan stated that they like to go to bed late after 9pm. We discussed this with the acting home manager and they told us they were not aware of his concern. Records showed this person had not been given the opportunity to be involved in their monthly care review to discuss these concerns. The acting home manager told us people had been allocated a named member of staff who would be reviewing their care plans with them now that they had all been re-written. A relatives meeting had also been arranged for 29 June 2016 to invite relatives to take part in people's care plan reviews. Time was needed for this improvement to be completed to ensure people had regular opportunity to be involved in reviews of their care so that adjustments could be made if their care arrangements did not meet their needs or preferences.

At our inspection in January 2016 we found the provider had failed to always thoroughly investigate people's complaints; this was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities). At this inspection we found improvements had been made and the requirements of this regulation were now met. However, more time was required to ensure these improvements were fully completed and had become sustained in the service.

Following our inspection in January 2016 the provider had ensured all people had a copy of the provider's complaints policy informing them of how to make a complaint. A suggestion box and feedback book was available. We saw several notes had been made in the book since January 2016 noting the improvements that had been made to the cleanliness and appearance of the service. Monthly residents meetings were taking place and the minutes of these indicated that people's main concerns related to the quality of the food. The provider had taken account of people's views, changes had been made to the menu and people's feedback was sought after each meal. People told us they would speak with the manager if they had any concerns. They felt time was needed for them to be confident that their concerns would always be listened to and used to drive improvements to the service.

The service had sent out quality assurance surveys to people's relatives in May 2016 and they were still receiving their responses and therefore had not yet been able to complete any analysis of the feedback. We saw the questionnaires that had been returned were generally positive and relatives noted improvements had been made. The acting home manager told us they would be using the relatives meeting on 29 June 2016 to invite relatives who had identified specific concerns to meet with them to discuss these in more detail.

The service had received two complaints since our inspection in January 2016. Records showed the provider had responded to these promptly. The acting home manager could explain how these complaints had been investigated and the record relating to each investigation, showed that the provider had put things right for people. However, there was not sufficient detail to evidence that the root cause of the complaints had been investigated, which in all three cases related to staff conduct. The acting home manager could not explain how learning from these investigations were going to be used to address the emerging pattern of concerns relating to staff conduct to prevent similar complaints from being made. Time was needed to ensure these improvements had become sustained in the service so that complaints investigations would always be

comprehensive and complaints monitored over time so that trends could be identified and investigated.

Requires Improvement

Is the service well-led?

Our findings

At our inspection in January 2016 we found there was a lack of effective quality monitoring in the service and the provider had not effectively identified the shortfalls we found at our inspection. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities). At this inspection we found the provider had made some improvements in this area, however further improvement was needed before the service would meet the requirements of this regulation.

The audits and checks the provider had in place to monitor the medicine management, catering and infection control arrangements had been effective in driving improvements in these three areas. The service had effectively implemented an infection control improvement plan with the support of the West Hampshire Clinical Commissioning Group (WHCCG) and continued to monitor the improvements to ensure they were sustained and all areas of concern addressed. The medicine audits had improved the safety of the service's medicine management and we found the number of medicine errors had significantly decreased. The service's medicine checks had effectively identified these errors and action had been taken promptly to reduce the risk of harm to people from not receiving their medicine as prescribed. The provider had sourced a new community pharmacist to support the service from 18 July 2016 to further improve their medicine practices. The provider had, with the support of the new community pharmacist, identified the temperature needed to be controlled more effectively in the medicine room and one of the drugs cupboards needed to be replaced. Action was being taken to rectify this. The new community pharmacist was also planning to undertake an external audit of the service's medicine to ensure the service's internal medicine audits would always be implemented effectively.

The provider was taking action to improve the quality of people's care plans. Regular care plan audits had been completed and these identified similar concerns to those we found. Nurses were reviewing people's care plans and were making the improvements as identified in the audits and the WHCCG action plan. Time was needed to ensure consistent quality and comprehensive information within all care plans, especially in relation to people's health needs. A process had been put in place to ensure a monthly audit took place of all incidents, safeguarding, accidents, falls and complaints, in order to identify the numbers of each. Time was needed to ensure the audit would investigate the causes of each and any trends that could be used to identify potential risks to people or concerns in staff practice.

Although we found some governance systems had enabled the provider to make improvements, other systems had not been effective or developed to drive improvement across all areas of the service. For example, senior care staff were completing checks three times a day to identify any shortfalls in people's daily records including their repositioning charts. We found despite senior care staff completing these checks they had not identified the gaps in people's records we found. This meant staff could not promptly determine whether people had received their care or not, so that remedial action could be taken to minimise the risk to people's skin if they had not been repositioned as required. Systems in place to monitor people's health and identify when they were becoming unwell had not always been implemented effectively. For example, people's weekly weight and fluid intake had not always been monitored as required to identify any concerns that might require closer monitoring. Systems were not effective in ensuring

changes in people's care arrangements were recorded in their care plans promptly so that all staff would know for example, what support people required to manage their diabetes. The provider did not systematically review the number of staff and range of skills required, to ensure sufficient and suitably skilled staff would always be available if people's needs changed or more people were to be admitted to the service. The provider had had technical difficulties accessing their call bell system and call bell response times had not been monitored routinely to assess whether people had been responded to promptly. These systems in place to support the provider to identify and monitor risks to people had not always been operated effectively so that action could be taken to reduce the likelihood of people coming to harm.

Systems had not been effective in always addressing risks relating to staff. For example, feedback about staff that could indicate possible risks to people had not always been investigated to ensure action would be taken to protect people. The provider had been alerted to possible concerns about staff conduct through the three complaints received since January 2016. People had raised concerns about staff at the resident meeting on 28 January 2016. We also noted in our report from our inspection in January 2016 that people had not always experienced respect and consideration from night staff. People told us at this inspection that these concerns were still ongoing. We asked the acting home manager, what action had been taken to address these concerns. They told us these were historical concerns and ''Staff who had been a problem had left and all staff now know how they must behave towards people''. The acting home manager could not evidence how these concerns had been explored or addressed for example, through individual supervision, night staff meetings or observation and other staff disciplinary action. The acting home manager had made the decision that staff posed no risk to people, based on their personal judgement. There had not been a thorough investigation and evaluation of this information. This had left people at risk as opportunities to identify and understand trends in concerns relating to staff conduct had been missed.

Improvements were needed to ensure all governance systems across the service became and remained effective if the number of people using this service increased. The provider did not operate effective quality assurance systems to assess, monitor and improve the quality and risks related to the service. Although some improvements had been made further improvement was needed to ensure the effectiveness of the service's governance system. This was an ongoing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no registered manager in post. An acting home manager had been appointed in January 2016 following the resignation of the previous acting home manager. The provider explained that there had been some delay in addressing the required improvements and implementing the inspection action plan due to the change in management of the service. The acting home manager was planning to submit their application to be registered with the CQC to ensure the provider would meet their registration requirements.

People told us they felt the service was being well led. One person said ''The manager is good and the staff are very accessible''. Relatives told us they had seen improvements in the service over the past six months. One relative noted the provision and monitoring of fluids had improved. Another relative said ''The staff are very caring, the majority. The old staff were a bit rough. But now it's a smooth and well-run place''. Staff also told us they felt the culture of the service was beginning to change. They described improved communications, more empathy for roles and increased transparency with the providers visiting twice a week to keep staff up to date. Staff felt the team was functioning better together. They told us nurses had taken stronger leadership and they provided support and guidance. The senior care staff were also developing a better understanding of the roles and responsibilities of the care staff on each shift.

All staff were complimentary about the acting home manager's approachability and openness to ideas and feedback. Care staff told us their suggestions to review the care record format to create more space for the

afternoon recording had been supported. We found however, that the acting home manager did not have a good understanding of the current good practice guidance in relation to the induction of new care staff. They had not always used concerns raised about staff to determine if they indicated a trend or culture that could put people at risk. The acting home manager told us they were still developing an understanding of the service's audits and action plan. They did not always have a good understanding of their responsibility for ensuring progress against the action plan was monitored and evaluated; that would have been reasonable for them to have known. There was a risk that progress with the plan might be delayed or fragmented without strong leadership.

Following the implementation of the inspection rating system, providers are required to display their most recent rating conspicuously and in a place which is accessible to people using the service. At our previous inspection in January 2016 we found a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had not displayed their CQC performance assessment as required. At this inspection we found improvements had been made in this area and this regulation had been complied with. The provider had printed a copy of their inspection report from January 2016 which clearly showed the rating for each domain. This was displayed in clear view in the service's entrance. People and their relatives told us they were aware of the outcome of the previous inspection.

At our previous inspection in January 2016 we found the provider had failed to report abuse or allegation of abuse to CQC as required; this was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. At this inspection we found improvements had been made in this area and this regulation had been complied with. The provider had notified us as required of any allegations of abuse as well as any medicine incidents as agreed after the inspection in January 2016. We have also received notifications of the outcome of all DoLS applications as required. However, the last three DoLS notifications had been submitted two to three months after the outcome was known. The acting home manager could not explain the reason for this delay. Time was needed to ensure these notifications would be submitted as soon as reasonably possible so that swift action could be taken to review whether people's rights had been protected appropriately in accordance with the MCA.

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 Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment was not always provided with the consent of the relevant person. Where people were unable to give such consent because they lacked capacity to do so, the provider did not always act in accordance with the 2005 Act. Regulation 11 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Persons employed by the provider did not always receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2) (a)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not operate effective systems or processes to assess, monitor and improve the quality and safety of the service and to mitigate the risks to people. The provider had not always maintained an accurate, complete and contemporaneous record in respect of each person, including a record of the care and treatment provided to each person and of decisions taken in relation to the care and treatment provided. This was a breach of Regulation 17(1)(2)(a)(b)(c).

The enforcement action we took:

Warning Notice