United Response

United Response - 2 William Street

Inspection report

2 William Street
Calne
Wiltshire
SN11 9BD

Tel: 01249817215
Website: www.unitedresponse.org.uk

Date of inspection visit:
07 February 2019
14 February 2019

Date of publication:
12 April 2019

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service:

2 William Street is one of a number of small care homes provided by the organisation in and around the Chippenham area for four people with learning disabilities. At the time of the inspection there were three people accommodated.

People's experience of using this service:

•There were a range of quality audits undertaken by the area manager and registered managers from other locations. However, internal audits were not consistent with all the findings from the inspection.

•People told us senior managers were approachable. Staff told us the team worked well together. The team was stable and long standing. They said the registered manager was approachable but there was a lack of management presence.

•People were not able to recall that support plans were in place to meet their need. Where people had attended the review meeting their names were included in the minutes. The recently introduced support plan format ensured staff identified future learning and goals. However, how to achieve outcomes identified were not made clear in the care plans. Some care plans were conflicting and lacked detail about how staff were to meet people's identified needs.

•Risks were not clearly identified and detailed in care plans. Information gained about people that had identified risk was not used appropriately in the care planning. For example, risk assessments needed clarity on how they were to be reviewed.

•People told us the day to day decisions they made and who helped them with more difficult decisions. Staff were knowledgeable about the principles of Mental Capacity Act 2005 in relation to daily living decisions.

•Mental capacity assessments were not in place for all specific decisions. Where mental capacity assessments were in place, there was no evidence to show how the person was supported to make specific decisions. Best interest decisions were made before assessments of capacity were undertaken. Where relatives had power to make decisions, documentation about this was not checked.

•There were areas of the home that would benefit from better cleaning routines. Cleaning schedules were not in place.

•There were systems to support staff with developing their skills and discuss performance. Staff said one to

one supervision with their line manager was "sporadic " but the training matrix provided showed one to one supervision had occurred at the set intervals. Staff told us more specific training was needed to create an insight into how best to care for people with particular conditions.

•□Medicine systems were managed safely. Medicine administration records (MAR) charts were signed to show medicines administered. Where medicines were not administered codes were used to detail the reasons. A record of medicines no longer required was maintained and signed by the pharmacist to evidence receipt of the medicines for disposal. However, the protocol for one person needed to be reviewed to reduce confusion on when to administer remedies and pain relief. We recommend that you seek guidance on how to develop PRN protocols for people that have over the counter medicines.

•□The views of people, friends and families as well as professionals were gathered. People gave positive feedback about the service.

•□People told us they felt safe with the staff. The staff we spoke with knew the types of abuse and to report their concerns.

•□People told us the staff responded to their request for support and assistance. We saw adequate numbers of staff available to support people.

•□People participated in menu planning and food preparation. People's dietary requirements were catered for.

•□People had access to healthcare services as required. The hospital passports were up to date.

•□People we spoke told us they were able to maintain relationships with relatives and friends. We saw some good interactions between people and staff. .

•□Activities were taking place. People arranged their daily activities using a white board with staff support.

•□People knew who they would approach with complaints.

•□The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen." Registering the Right Support CQC policy. The home was located close to shops and people were recognised as part of the local community.

Rating at last inspection:

This service was rated good at the inspection dated October 2015.

The Action we told the provider to take:

We found breaches of Regulation of the Health and Social Care Act 2008 (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

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our Well-Led findings below.

United Response - 2 William Street

Detailed findings

Background to this inspection

The inspection:

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

Inspection team:

This inspection was undertaken by two inspectors.

Service and service type:

A registered manager was in post. The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:

Inspection site visit activity that took place on the 7 February was unannounced and we announced the visit that took place 14 of February 2019.

What we did:

Before the inspection we reviewed other information, we held about the service including notifications sent

to us by the provider. Notifications are information about specific important events the service is legally required to send to us. We also looked at information in the 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.

During the inspection we spoke with three people. We spoke with the area manager, registered manager and three members of staff. We looked around the premises and observed care practices for part of the day.

We reviewed the care plans and risk assessments for three people, copies of minutes and medicine systems. We also reviewed daily notes and healthcare documentation.

After the inspection we were provided copies of complaints log, quality assurance systems improvement plan and surveys. Training matrix, supervision matrix and copies of commissioning visits were also provided after the inspection.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

•□Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management:

•□Risks were not always well managed. There were a range of risk assessments which included independent living, staying at the home without staff support, leaving the home independently and accessing money. The staff told us that risks were assessed and clear guidance was provided on the actions to take.

•□For one person the staff had recorded that "taking positive risk" (abilities to weigh up the benefits and exercising one's choice of action over another) was important in relation to their finances. However, staff were managing all aspects of this person's finances.

•□Support plans were in place for people to manage their finances. People withdrew weekly amounts from the bank which they handed to the staff for safekeeping. The staff then gave people a daily budget which depended on the range of activities they were to join that day.

•□The learning outcomes within the support plans were for people to either manage larger amounts or to use the cashpoint independently. However, the actions to help people achieve these outcomes were not listed in the action plans.

•□Where risks had been identified in feedback during team meetings, or through concerns raised, these had not been incorporated into the support plans. Action plans had not been reviewed.

•□Where action was taken to address individual risks, documentation was not clear or coordinated. When risks in support plans were reviewed, this was done through a check of the written information, rather than assessing if the steps to be followed remained safe for that person.

•□Where changes of people's behaviours had been triggered by brain injury the support plans lacked guidance. Staff were not provided with guidance on how to support people when they presented with behaviours difficult to manage. We saw two documented incidents where staff had interpreted the actions to take when managing difficult behaviour. These actions were not part of the support plans or discussed with the person as part of a planned strategy.

•□There were people who at times expressed frustration and anxiety using behaviours the staff found difficult to manage. Positive behaviour plans for one person gave staff guidance on the triggers of behaviours, the actions to take and that a debrief was to take place following incidents.

•□Staff told us they had a consistent approach towards behaviours they found difficult to manage. A member of staff said, "we talk among ourselves and make sure we work the same ways."

•□One person told us at times they expressed their feeling with behaviours that could escalate. This person said the staff checked with them the reasons for their behaviour. This person told us the staff would say "what is this about" and advised him to "go back to sleep".

Preventing and controlling infection

•□Cleaning scheduled were not in place and better cleaning regimes were needed as areas of the home were not clean.

•□The oven had been identified in a team meeting as needing to be deep cleaned. There was a build-up of food debris on kitchen cupboards and handles, as well as on top of the dishwasher. The downstairs bathroom had a build-up of dust around the doorway, as well as cobwebs and limescale around the taps and sink. The stairway had cobwebs and splash marks on the walls.

•□Staff were not pro-active or taking accountability in ensuring the home stayed clean. We were told that people cleaned the home and there was no schedule in place for staff to be involved in regular cleaning. We discussed the cleanliness with the registered manager. They said, "A staff member could do that on a weekend or something", regarding the build-up of food debris on food cupboards and handles.

Learning lessons when things go wrong:

•□There was little evidence from reports of lessons learnt. Comments from staff did not indicate that actions were taken to prevent further re-occurrences. The staff had left medicines unattended which another person had taken. The National Institute for Health and Care Excellence (NICE) states: "Doses must only be left out for a person to take later, if it has been agreed with them, and a risk assessment has taken place. This information should be recorded in the care plan and an appropriate record should be made on a medication administration record." However, the care plan was not updated.

•□While records confirmed the staff had reported three incidents in 2018. Reports did not include the actions taken by staff when people became injured. Where one person had sustained an injury, the reports did not include the extent of the injury, if medical attention was needed and if pain relief was offered.

•□Incidents were not always reported to CQC and safeguarding. One incident that related to medicines was assigned incorrectly as an error instead of an omission. The incident related to avoidable harm and reportable under neglect to CQC and to the safeguarding team.

The above concerns demonstrated a failure to ensure the staff providing care or treatment to people. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment:

•□People told us there were staff on duty and they were available as required. The staff told us two staff were on duty when there were three people at home and one staff when less than three people were at the

home. At the team meeting dated September 2018 a decision was taken for one member of staff to be on duty when there were no evening activities.

Systems and processes to safeguard people from the risk of abuse:

•□People told us they felt safe living at the home. One person said the staff and other people living at the home gave them a sense of security. Another person said, "Feels safe living at the house. It is secure and we all know each other".

•□The staff we spoke with told us they had attended safeguarding adults training. These staff were aware of the types of abuse and their responsibility to report abuse.

•□Safeguarding procedures were in place for staff's reference. We saw flow charts were available for staff to follow as needed.

Using medicines safely:

•□People told us that the staff administered their medicines. Medicine support plans listed people's prescribed medicines, their purpose and side effects.

•□The medicine file included individual medicine administration records (MAR), information on the person's prescribed medicines and how they preferred to take their medicines. MAR were signed by staff to indicate the medicines administered. Where medicines were not administered staff recorded the reasons for this using codes.

•□Protocols were in place for medicines prescribed to be taken "when required" (PRN). However, for one person the PRN protocol was for paracetamol/lensip and Benilyn Cough mixture. As, over the counter medicines were grouped together, there was a risk this could be confusing and may lead to all medicines being administered at the same time.

We recommend that you seek guidance on how to develop PRN protocols for people that have over the counter medicines.

•□A record of medicines no longer required was maintained. The records showed that since October 2018 there were no medicines to be returned to the pharmacist for disposal.

I

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

Ensuring consent to care and treatment in line with law and guidance

•People told us the decisions they made and who helped them with decision making. People said they made decisions about what to wear, activities and menus. One person told us decision making was joint with the staff. The staff were knowledgeable about the principles of MCA when consent related to daily living. Records confirmed that staff had attended MCA training.

•Information showed mental capacity assessments were needed but these were not in place despite people being subject to continuous supervision.

•There was a generalised approach to assessing people's mental capacity to consent to care and treatment and the best interest decision making process. Where some people had capacity for some decisions and not for others, there were no specific mental capacity assessments for this. This meant staff were documenting best interest decisions for some specific decisions before undertaking mental capacity assessments.

•Where mental capacity assessments were in place they did not provide specific information to evidence how people were involved. One person's care plan stated that they benefitted from receiving information to make decisions, while in a calm and non-distractive environment. Their assessment did not evidence that this had been ensured, as no information was recorded.

•Staff had documented they managed all aspects of a person's finance. A mental capacity assessment

was not in place for managing this person's finance. This person contributed to the home's vehicle and annual entry passes to theme parks but a mental capacity assessment and best interest decisions were not completed for these specific decisions.

•□Records showed relatives managed another person's finances. There was some confusion on whether the relatives had deputyship or lasting power of attorney. The registered manager showed us a document dated 2013 that a close relative had lasting power of attorney for care and treatment. However, the staff had not ensured these documents had been activated.

•□In the best interest decision for one person, it was recorded their family were happy with the decision made. The family members consulted with had not been recorded as being involved in the discussion about the decision or hold any legal powers to do so.

•□There were no DoLS applications in place, despite people being assessed as lacking capacity to consent to their care placement. Some people were subject to continuous supervision yet they were able to leave the home without staff support. There was no evidence that a mental capacity assessment had taken place to establish the most appropriate and least restrictive action had been taken. The support plans were not clear on how people were to be supported with positive risk taking.

The above concerns demonstrated a failure to ensure consent. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

•□Records showed that staff had attended fire safety, Health and Safety, dementia and positive behaviour management training. The records also showed three staff had achieved vocational qualifications to level two and three.

•□The staff we spoke with told us additional training was needed to increase their insight into the needs of people with brain injury. The care records of people with brain injury showed a lack of insight into their needs. Some staff thought some "behaviours were learnt" but support plans were not in place on what these were.

•□Staff said there was an expectation that one to one supervision was every eight weeks with their line manager. However, they told us one to one supervision with their line manager was "sporadic" due to cancellations because of staff vacancies. The supervisions matrix provided after the inspection showed the staff in 2018 did not have one to one supervision at the required eight weekly timescale.

•□Staff said that at one to one meetings they discussed team working, performance and training completed.

Supporting people to eat and drink enough to maintain a balanced diet

•□People told us they were involved in preparing meals. One person told us they liked to make curries and another person said they always enjoyed these. Another person said that they took turns with the staff to cook.

•□People were independent in accessing snacks and drinks. People often chose to walk to the nearby shop

to choose what snacks they would like for the day. There wasn't a range of snacks available in the home.

•□People went shopping with staff and helped to choose what meals they would like to prepare

Adapting service, design, decoration to meet people's needs

•□Some areas of the home needed better maintence including repairs and replacements. . For example, the kitchen cupboard doors were not secured to the cabinets.

•□There was a leak from the hand washing sink. This had caused a build-up of dirty, old water to collect in the stack of dishes and bowls in the cabinet below. One staff member said, "That was fixed but it has broken again."

•□There were some adjustments to help people feel more secure when moving around the home, such as different angled grab-rails on the steep staircase.

Supporting people to live healthier lives, access healthcare services and support

•□People told us they were accompanied by staff to their healthcare appointments. People had access to NHS community facilities such as opticians and dentists. The outcomes of healthcare appointments were documented by staff in the healthcare appointment notes. Staff told us people had annual health checks with their GP.

•□Information from healthcare appointments and reviews was not transferred into people's support plans. We found more information about a person's condition by reading their appointment feedback from the GP.

•□Where people had declined certain healthcare checks, there was no evidence to explain how the person had been supported to understand what the check was for. Where people had been assessed as lacking mental capacity to consent to care and treatment, there were no specific assessments regarding the healthcare check. There was also no evidence of what had been tried previously, or when the person had last had the decision discussed with them. This meant that some people were at risk of not receiving health checks or interventions that may be in their best interests.

•□Hospital passports intended for medical staff, in the event of an admission, detailed people's medical history and current medicines. "Things you must know about me", "Things that are important to me" and "Likes and dislikes" were also included in the Hospital passports.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in some of their care.

Ensuring people are well treated and supported; equality and diversity:

•People told us the staff were caring. One person said, "The staff are caring. They look after me. I am impendent and good at looking after myself." Another person said the "staff help me make the right decision."

•The staff told us how they ensured people were made to feel they mattered. A member of staff said, "I am sympathetic, willing to listen and help. Getting to know their likes." This member of staff said spending time and sharing a "common ground" with activities helped developed relationships with people.

•Positive feedback was documented by the GP for one person. The GP related these improvements to the care provided by staff at the home. We also saw that the person had been able to reduce their antipsychotic medicines.

•We saw staff and people having conversations about their day. People sought staff attention for reassurance on their daily activities. One person discussed with the registered manager the plans for the rest of their day.

Supporting people to express their views and be involved in making decisions about their care:

•The registered manager and staff said house meetings only took place when there were specific issues. For example, when one person moved from the home.

Respecting and promoting people's privacy, dignity and independence

•While people said the staff knocked on their bedroom doors before entering, we noted that bedrooms were not lockable. One person told us, "I am treated as an adult because I am".

•Staff told us how they ensured people's rights were respected. [Staff explained how they respected people's privacy and dignity.] They said they ensured people were "covered up" and they locked bathroom doors when personal care was taking place. Staff also told us they asked people before undertaking tasks.

•Training records showed staff had attended equalities and diversity training.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:

•The people we spoke with were not able to recall whether support plans were in place on how their care needs were to be met. One person said staff recorded information about them. This person said if they asked the staff then an explanation would be given on what was documented. Another person was aware they had a care file but were unaware of its content.

•People's support plans did not fully reflect their needs. Information was held about people in staff member's personal knowledge, as well as in records of team meetings, and health care appointments. This had not been collated and brought together to produce a comprehensive support plan for each person.

•Life stories that gave staff an insight into the person's background, education, family networks and interest were not documented. Some people had lived at the home for many years and were supported by staff who had been employed for an equal amount of time. However, there was a lack of evidence of personal goals for people to achieve as a positive outcome over time.

•Where outcomes had been identified as goals for people to work towards, there were no support plans in place to achieve them. The outcomes for one person was that they would be able to use their debit card to make cash withdrawals. However, staff continued to make these with the person. There were no steps in place for staff to support the person to achieve this.

•People's mental health and wellbeing needs were not incorporated into their support plans. There were no clear directions for how staff were to support one person who had been assessed by their GP as being anxious and depressed. There was limited guidance on how staff were to support people with a deteriorating mental health. A support plan regarding one person's wellbeing, related solely to when they chose not to get out of bed and the positive behaviour support plan stated the person "may have low mood with depression."

•Care plans were evaluated monthly and where people attended their names were included in the minutes. The evaluation meetings for one person were almost identical each month. Although the evaluation of the behaviour care plan stated this person had not experienced, any behaviours deemed to be difficult, a positive behaviour support plan was still required

•The staff told us they were struggling to develop the new care plan formats. Staff told us "the new care plans were given to us. We had to do them without guidance. We had to carry on and do them." Another member of staff said the care plans needed to be clearer. The registered manager told us they had

"facilitated coaching" on the new care plan formats.

•□People were encouraged to maintain relationships with people of importance to them, such as relatives and friends.

•□People told us they participated in household chores. There was an expectation that people participated in household chores such as laundry, cleaning their bedroom, meal preparation and shopping. The staff told us the allocated chores depended on people's abilities. There were individual pictorial boards in the dining area which people used to show their daily activities including chores.

•□People told us about their hobbies and how they spent their days. One person said their hobbies included knitting, swimming and watching television. Another person told us they went out independently within the local community.

Improving care quality in response to complaints or concerns:

•□People told us they would approach staff with concerns. In people's care plans there was a summarised version of the complaints policy. This explained that people could raise complaints by various methods, including making a video or sending an email. In the contact details provided in that summary, there was no email address included. There were no complaints received since the last inspection.

End of life care and support:

•□Support and health plans did not include any evidence of conversations that had taken place to consider people's end of life wishes.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Continuous learning and improving care:

•There were inconsistent systems in relations to how the registered manager audits and monitors the service, the quarterly audits undertaken by other registered managers within the organisation and six monthly audits by the area manager.

•Copies of the quarterly audit dated 18 January 2019 showed shortfalls identified were in included in the service report and continuous improvement plan. However, not all areas identified at this inspection, were recognised.. These included mental capacity assessments, best interest decisions and updating care plans as people's needs changed.

•Where shortfalls were identified action plans had been developed. The registered manager provided us with a service visit report which listed the actions identified in the quarterly and six- monthly audits. Also included were the recommendations made from commissioner's visits. For example, to update fire procedures and support plans.

•We saw there were three recorded incidents and accidents. The record of a medicines error was reportable to CQC. However, a notification was not received under neglect.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility:

•A registered manager was in post. The registered manager told us their style of leadership included "supportive, I listen and help staff to sort things for themselves. [I] facilitate team meetings and coaching with new care plan formats. As staff give feedback about the care plans these are updated. [I am] approachable and share information as it arrives. Monthly staff updates are discussed at team meetings."

•The staff said that while the registered manager was approachable there was a lack of management presence at the home.

•□The registered manager told us the challenges were mainly "time" related. This meant "not being present as much as [I] would like. Staffing levels which included absences." The registered manager said there were times when they participated in sleeping-in shifts at the home.

•□The registered manager told us how sustainability was promoted. This registered manager said "people are happy and have good relationships with the staff team. Good relationships with staff including senior managers."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:

•□Staff told us the team worked well together. The staff we spoke with said the benefits included having a mixed aged group. Another member of staff said, "Everybody gets on. All disagreements are resolved promptly."

•□The registered manager told us team meetings were monthly and took place at the United Response office. The staff told us the most recent team meeting took place in November 2018. The copy of minutes of the most recent meeting available was dated 24 September 2018. At this meeting the decision was taken to reduce staffing levels to one staff when there were no evening activities.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:

•□The views of people were gathered through questionnaires. However, there was no system in place to discuss survey results. The area manager told us people had to request survey results. The area manager explained the analysis was based on feedback from all services in the south west division. The registered manager said annual surveys results were kept at the United Response office. We received copies of the individual surveys and the analysis of the United Response south west region. The survey result overall were positive. The results did not include an action plan on how the results were to be improved.

•□A social healthcare professional told us there were good working partnerships with the service. The social healthcare professional said the registered manager had joined Wiltshire Council forums. They said the staff had engaged with them and where recommendations were made the staff actioned them.

●Working in partnership with others:

•□The registered manager told us about partnership working. The registered manager told us there were commissioning visits to assess the placements funded by the Wilshire Local Authority. This registered manager said there were good working relationships with GPs.

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 11 HSCA RA Regulations 2014 Need for consent Where people lacked capacity their mental capacity was not assessed for all specific decisions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks were not well managed. Risk assessments lacked actions on how outcomes identified were to be met. Areas of the home were not clean and cleaning schedules were not in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Audits were not consistent with the inspection findings. There were areas for improvement identified within the inspection.