Litchfield Care Limited

Beatrice Court and Citygate Lodge Home

Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

This inspection took place on the 6 and 7 October. It was an unannounced inspection.

Beatrice Court and Citygate Lodge are registered to provide personal and nursing care to 128 people. At the time of this inspection there were 81 people living at the home. Two units were closed and were being refurbished. Citygate Lodge accommodated people with residential care needs; Magnolia units provided care for people with both nursing and personal care needs. Ivy units were specifically for people with needs relating to mental ill-health and people living with dementia. The provider told us that when the home was fully open it would provide accommodation for 101 people.

The service has not had a registered manager since 2012. The current manager had recently applied to be registered with the commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

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.

When we completed an inspection in December 2013 we asked the provider to make improvements in safeguarding people from abuse. The provider had made the necessary improvements.

People we spoke with and their relatives were positive about the care provided at the home. Although we saw some very positive aspects of care we also saw some areas that needed improvement.

Systems were in place to keep people safe but we saw some improvement was needed to be taken to ensure people's ongoing safety. Some bedroom doors were wedged open and the provider did not have some equipment they had identified as necessary to support people to evacuate the home in the event of an emergency.

Some records of care were not completed or were not up to date. This meant that that there was a risk that people may receive inappropriate care and their preferences would not be taken account of.

Staff were not always following the principles of the Mental Capacity Act 2005. For example, people's capacity to make decisions was not assessed and there was inadequate information to show the actions that were needed to support people to make decisions. This meant that people's rights may not be upheld.

People living with dementia did not have enough to do. People spent periods with little stimulation and engagement with people and objects. When people were engaged and stimulated we saw positive benefits in their well-being.

Although people had noticed an improvement in the leadership and management of the home there remained areas that needed to be addressed to improve people's care.

Staff had the knowledge and understanding to identify and act when potential abuse of people was suspected. This helped to make sure people were kept safe.

People's health care needs were assessed and their individual needs were acted upon. People were supported to receive appropriate specialist health care support.

People were supported to have sufficient to eat and drink. There was a good choice of meals throughout the day. People could choose where to have their meals.

People told us and we observed that staff spoke with people in a caring and respectful manner. People felt that staff cared about them. Most people told us that the care staff took account of their individual needs and their wishes and choices were respected.

The home had an effective complaints procedure in place. People and relatives told us that the staff were responsive to their concerns. They said that when issues were raised these were acted upon promptly.

We found three breaches 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 this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were supported by staff that were aware of types of abuse and knew the action to take if they had concerns. People were supported by staff that had been subject to checks before they started work. This helped to keep people safe.

Systems were in place to assess and manage risks to people but some action was needed to make sure people were kept safe.

Records of care were not always accurate and up to date. This could lead to inappropriate care being provided to people.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People had their health care needs met and were supported to have sufficient to eat and drink. Where people needed specialist support this was provided.

The provider was not consistently acting in accordance with the provisions of the Mental Capacity Act 2005. This meant that people's rights may not be upheld.

Is the service caring?

Good

The service was caring.

People told us they were cared for and we observed that people were spoken with in a respectful and caring manner.

Relatives were welcomed to visit at any time. This meant that they could see their relative when they wanted and could help to provide their care.

People felt that their rights to privacy and dignity were promoted.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Records of care were in place but did not always reflect people's needs and preferences. This meant that people may not receive appropriate care.

People living with dementia did not have enough opportunities to engage with people and to be involved with hobbies and interests of their choice. This meant that their emotional well-being was not always well promoted.

People knew how to make a complaint and felt listened to. Concerns and complaints were acted upon promptly by the staff.

Summary of findings

Is the service well-led?

The service was not consistently well led.

There was no manager registered with the Care Quality Commission to manage the service and have the legal responsibility for meeting the requirements of the law.

People found the manager approachable and felt that care had improved since the manager had been appointed.

Systems were in place to monitor and review the quality of care people received. However there were areas of care that needed to be addressed to improve people's care.

Requires Improvement

Beatrice Court and Citygate Lodge Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We carried out this inspection on 6 and 7 October 2014 and the visit was unannounced.

The inspection team was made up of four inspectors, a specialist advisor who was a registered nurse specialising in tissue viability and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of supporting older people including people living with dementia.

Prior to the visit we looked at information we held about the home. This included notifications that the provider had sent us. Notifications inform us about incidents that have occurred within the home. We also had information from a staff member from the local authority that commissions services from the home.

During the visit we spent time talking with 19 people who used the service, three relatives and other visitors. We also spoke with 10 staff and the manager and provider. We reviewed 10 care records and looked at a range of documents relating to the running of the home and to monitoring and reviewing the quality of care.

We undertook some observations of staff supporting people and a short observational framework inspection (SOFI) over lunch in one of the units. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Following the inspection we spoke with four relatives, four health care and social care professionals and a representative the local authority that commissions care from the service to obtain their views about care people received.

Requires Improvement

Is the service safe?

Our findings

When we completed our inspection in December 2013 the home was not compliant with The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Regulation 11 - safeguarding. Our records, discussions with staff, people that lived at the home and with relatives showed that action had been taken and the necessary improvements had been made. One relative said; " I feel contented [relative name] is safe". Staff confirmed they were trained in safeguarding people. They told us about the different types of abuse and signs that may indicate someone had been abused. Staff were clear of their responsibility to act on any concerns and to report these to senior staff members. Discussion with senior staff and the provider confirmed they were aware of the need to refer allegations of abuse to the local authority. Information we held confirmed that the provider worked with the local authority to investigate and respond to issues of concern.

Risk to people were identified and acted upon to keep people safe. Individual risk assessments included the safe use of equipment, moving and handling assessments, fall risk assessments and nutritional and tissue viability assessments. In the sample we looked at we saw that some records were not accurate. For example one moving and handling assessment stated that the person could walk with the support of two staff. We observed this person being moved with the use of a hoist. We also saw that this person had had a fall and the risk assessment had not been updated to reflect any changes. In two plans relating to pressure ulcer prevention the pressure of the mattress did not correspond with the pressure recorded as required in the plan of care. This meant that the effectiveness of the mattress may have been compromised. Although staff could tell us about the care these people required the absence of accurate records could have led to people receiving inappropriate or unsafe care.

We checked the home's arrangements for managing people's medicines. Some people were prescribed topical medicines. These are creams and ointments and are applied to the body. We were told that these medicines were applied by the care staff when completing personal care. Staff and people we spoke with confirmed that they received this medication. There was no system in place to record when this medication had been given. This meant that the provider could not be sure that everyone had received this medication.

The absence of proper and accurate records meant that the provider was in breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had systems in place to make sure that the environment and equipment was safe for people to use. Equipment was regularly checked and serviced. A fire risk assessment had been completed. The fire officer had recently visited the home and identified some areas to be addressed. When we spoke with them they felt that the provider would make sure the areas identified would be acted upon. We observed that a small number of were cared for in bed and that their bedroom doors were wedged open. People had individual personal emergency evacuation plans completed by the care staff. They identified that some people would not be able to leave the home without the use of equipment and they had not yet provided the equipment. The home had a zoned evacuation programme so this equipment would only be needed if a full evacuation of the home was needed. The provider assured us that they would address these issues.

We saw that medicines were stored correctly. We observed two staff administering medicines and spoke with a third staff member about the administration process. Our observations and discussions showed that medicines were administered appropriately. We saw that people were asked if they were in pain and offered pain relief. Arrangements were in place for the consistent administration of 'when required' medication. One person self-administered their medicines and we confirmed that a risk assessment had been completed to make sure the person could do this safely.

The home had some controlled medicines. Controlled medicines are very strong medicines and must be stored, checked and administered very securely to ensure they are kept and used safely. We observed these were stored in a locked cupboard and a controlled medicine book was maintained. Our check on the records showed that these medicines were appropriately maintained with checks and administration confirmed by two staff.

Requires Improvement

Is the service safe?

People who could tell us about their experiences felt there were sufficient staff on duty. One person said: “I think there are enough staff on duty. They are quick to answer the call bell”. Relatives of people accommodated on the residential and general nursing units told us they felt that there were sufficient staff most times of the day to provide people’s support. Care staff and nursing staff on the more dependent units told us they sometimes found it difficult to provide the support people needed particularly in the mornings. One staff member said they had not had a break on the day of the inspection. We identified that the nurse with the responsibility for tissue viability within the home did not have any supernumerary time to undertake that role. We also saw that there was insufficient staff time to provide people living with dementia had enough to do and to engage in hobbies and interests.

The provider had a staffing dependency tool in place that was used to determine the correct level of staffing. Rosters we checked consistently showed that the level of staffing exceeded the identified levels on the staffing matrix. We were also told that the manager could put additional staff on duty if they were needed. This was confirmed when we spoke with the manager. The provider told us plans were in place to change the staffing arrangements to provide people with a better quality of care. They confirmed the tissue viability nurse was being given additional time to support other staff and were already reviewing the amount of time provided to support people to take part in hobbies and interests. This meant that the provider had identified that staffing levels needed to be addressed and had started this process.

Our checks on records and discussions with staff confirmed that there was a robust recruitment process in place. References were sought and a disclosure and barring scheme (DBS) check was completed. A DBS check includes a criminal record checks and confirmation that people were not on the list of people unsuitable to work with people needing care.

Requires Improvement

Is the service effective?

Our findings

The provisions of the Mental Capacity Act (2005) (MCA) were not being consistently followed. The MCA sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected. People's consent was not always gained before care was provided. We observed lunch time on one of the dementia care units. We saw protective aprons were put on people without talking with them or seeking their agreement. We saw that a protector was put on one person when they clearly said 'no'. For people with memory loss there was little information about people's capacity to make decisions or to show the support they needed to help them make decisions about their care. For example we did not see any use of symbols or pictures to help people to make choices and decisions. Care plans for people lacking the mental capacity to agree to their care should show evidence of best interest decisions that are based on decision-specific capacity assessments.

We saw that one person had been appropriately referred under the Deprivation of Liberty Safeguards (DoLs). The Deprivation of Liberty Safeguards (DoLS) ensures that when people have their liberty restricted this is done in a manner that protects their human rights. For other people with memory loss who were living in a unit with a locked door there were no capacity assessments completed and no information to show that there had been a consideration of whether they were being restricted and an application under the Deprivation of Liberty Safeguards should be applied for.

Some people had a 'Do Not Attempt Resuscitation' (DNAR) form in place. This form identifies that resuscitation should not completed if their heart stops. Of the three we checked two were not completed correctly. One identified that the person did not have capacity but there was no evidence of a best interest decision taking place. This meant that actions may not be taken in people's best interest or people's wishes may not be acted upon. This meant that the provider was not fully following the provisions of the Mental Capacity Act 2015 and was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider informed us that capacity assessments were due to be completed and that training in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguard provisions had been booked.

People that were able to speak with us told us that staff talked with them about their care needs and care was provided with their agreement. Staff also told us how they made sure that people were in agreement to their care. A relative we spoke with confirmed that care staff spoke with them about their family member's care.

People that could speak with us were complimentary about the quality of the care staff. Care staff told us and training records confirmed that staff received basic training covering such areas as fire safety, moving and handling, fire safety and health and safety. We observed several people being moved and this was done in a manner that kept people safe and promoted their dignity. Staff also told us they had the opportunity to complete further training. Some staff we spoke with told us they were completing training in end of life care. They told us they felt this helped them to provide more appropriate care to people. Records and discussions with staff confirmed that a large percentage of staff had completed training in managing behaviour that challenged. We did not observe any incidents during the inspection but staff were able to explain how they would try to and use diversion methods to reduce people's anxieties. The training matrix showed that less than half of the staff had completed training in dementia care. This meant that people living with dementia may not be supported by people who had the knowledge and understanding of their needs.

We spoke with two care workers who had recently started working at the home. They told us they received induction training and spent a week shadowing more experienced staff members. This had given them the basic knowledge of care practices and the opportunity to observe and work alongside experienced staff before providing care alone.

Care staff were supported to undertake their role. We saw that there was a programme of staff supervision in place. Records confirmed that nearly all of the staff had recently had a supervision meeting. Supervision provides staff with the opportunity to speak with a senior staff member about their role, their training and about people's care. We saw evidence that a staff meeting was planned.

Requires Improvement

Is the service effective?

People we spoke with told us that they liked the meals. One person told us; “They look after me. They give me choice”. Another person told us; “We get plenty of drinks and the food is OK."

People’s nutritional needs were assessed and evaluated most months. People were provided with specialist diets when needed. For example one person told us that following an assessment by a dietician they needed a soft diet and thickened fluids. They confirmed and we saw this was provided. Another person told us that they had lost weight recently and the staff were trying to build them up. They told us that the staff always offered them food they knew they liked. A health care professional told us that the staff referred people for specialist support when they lost weight

We observed that people had a wide choice of food for breakfast and tea and a choice of meals at lunchtime. We observed that drinks and snacks were available between meals. Lunch for people in Citygate Lodge was a relaxed and friendly experience – a social occasion. We completed a short observational framework inspection in one of the dementia care units over lunch. This showed that people were supported to eat their meals and were offered choices of food and drink.

People we spoke with told us their health care needs were responded to by the staff.” One person said; “They pick up on health issues and I have had an eye check here”. One relative described how the staff had identified that their family member had swollen ankles and had made sure they were seen by the GP. When there was no improvement the staff made sure the GP visited again. Another relative told us that the GP was always called when their family member was ill. We spoke with a local GP and they told us that they had no concerns over people’s care. They said that the staff referred people appropriately and acted upon recommendations.

We recommend that the provider considers the National Institute Clinical Excellence dementia care guidelines in relation to staff training.

Good

Is the service caring?

Our findings

People who were able to speak with us told us that they got on well with the staff. One person said: “They are very nice. They always have a smile”. Another person said: “They are very respectful, polite”.

People also told us that they were encouraged to be as independent as possible. One person said: “I do my wash in the morning; they help me when I need it”. Another person said: If I want help I can have it”. A third person told us they made their own breakfast.

We saw that there were positive and friendly relationships between staff and the people that lived within Citygate Lodge and in the downstairs unit in Beatrice Court. There was a relaxed atmosphere and people were spoken with in a respectful and caring manner. People confirmed that they were given choices about their lifestyle. For example one person told us they went out into the community regularly and that they always decided the things they wanted to do. Another person told us how they always decided where to spend their time and often requested and were provided with food that was not on the menu.

One person told us how the staff had made them feel special on their birthday. They said that the staff had taken them to visit a friend in another unit and they were provided with cakes.

We spent some time observing in the units where people living with dementia were accommodated. We saw some positive examples of people being treated kindly and with compassion, for example we observed one care worker talking with one person about the meal options in a patient manner. Another care worker was seen chatting with one person after lunch and it was evident that the care worker knew the person’s previous life history. A third staff member was seen sitting with one person holding their hand and talking in a quiet, gentle manner.

People told us that they were treated with dignity and respect. One person told us: “They put a towel across me when they wash me”. People also told us that staff 'always knock the door’. One person confirmed that staff waited outside when they use the toilet to give them some privacy. The home had a dignity champion system but we were told this scheme needed refreshing. A dignity champion is someone who is passionate about people’s dignity, acts as a role model, challenges poor practice and aims to educate and inform their colleagues. We spoke with one nurse who was passionate about ensuring people were treated with dignity. They were able to give us some examples where they had taken action to make sure people’s privacy was promoted. For example they made sure that people were covered up when they were hoisted. A social care professional we spoke with had been impressed with the way this nurse spoke about people and how they promoted their right to dignity. Our conversations with staff confirmed they were aware of the importance of promoting people’s privacy and dignity.

We saw some good examples of people’s privacy and dignity being promoted. For example we observed care staff ensuring that one person whose clothes had ridden up was covered up. We also saw staff on the residential and general nursing unit seeking consent before entering people’s bedrooms. A health care professional we spoke with told us that staff were always supportive towards people when they visited to provide foot care. They told us that this care was always completed in private. A relative told us that their family member was always clean and tidy and presentable.

We observed relatives and visitors throughout the inspection. Relatives we spoke with told us they visited regularly and they felt welcomed. We observed that staff were polite with visitors and that relatives were offered refreshments. There were no restrictions on visiting and some relatives visited to provide their family member with support. For example one person told us they visited every day and supported their family member to eat their meals. Other relatives told us that they had positive relationships with the staff and they were kept informed of their relative’s well-being.

Requires Improvement

Is the service responsive?

Our findings

Our checks on care records showed that these covered areas of health and social care. Of the ones we checked four were not fully completed or had gaps in them. For example three of the records we checked did not have a formal pain assessment completed. When we spoke with one of the nursing staff they were able to describe how one person living with dementia expressed pain. They said: "This person shouts when they are in pain. I will administer some pain relief. You get to know how people communicate through their body language." This meant that one nurse knew this person's needs. The lack of written information could mean that other staff did not have this information and that this people's pain may not be addressed. Another record of a person living with dementia said that the person's pain should be assessed daily. There was no information for staff to show how this assessment was to be completed. This meant that the person's pain may not be fully addressed.

Some care records contained information about people's social preferences and their previous lifestyle. Other plans did not. This meant that information was not available to support staff to provide people's care in the manner that reflected their previous lifestyle and preferences. The activity co-coordinator told us that they were in process of talking to everyone to ask them about their specific wishes and to gain better information about people's previous lifestyle.

This meant the provider was in breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spent time in the two dementia care units. One person said; "It does get a bit boring here. There is not much to do. I watch the TV or go to sleep'. Good practice guidelines identify that people living with dementia need to have meaningful occupation and stimulation to promote and maintain their well-being. We saw this was not consistently provided. During the inspection we observed periods when people were not taking part in any hobbies or interests and a lot of people were asleep or not engaged either with the environment or people around them. The television was on most of the time. At one point the television was on with the sound turned down and the radio on. We saw some attempts by staff to engage people but these were only for a few minutes and there was little suitable equipment available. We saw few sensory items around the units for people to touch that may stimulate their senses. We saw that when people were engaged and stimulated their wellbeing was markedly improved. For example we observed staff supporting people to take part in a movement to music session. People who were previously disengaged or sleeping became animated and involved. This demonstrated that people's wellbeing could be positively affected through engagement and taking part in hobbies and interests. We spoke with both the activity co-coordinator and the manager. Both said that they did not feel there were enough opportunities for people to take part in interests and hobbies. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also saw some examples where people were supported to maintain their previous hobbies and interests. For example one person was supported to spent time in the garden and another person was provided with holy communion by a visiting clergy. In the elderly residential units we saw evidence of people taking part in interests and hobbies. One person regularly went out for a walk. They said; "I go out when I like". Another person said; "They respect my wishes and give me choices". One person was reading a newspaper and another was doing a word search. We saw examples of arts and crafts that people had completed. We were told that the activity co-coordinator was trying to arrange for a clergy to regularly provide a spiritual service. A few people went to the library. We saw that a pet therapy dog visited every Monday and spent a short time in each unit. We saw that people enjoyed this contact.

We saw care that the staff responded to individual needs. For example we saw that people could personalise their bedrooms including bringing in their own furniture and having their room decorated the colour they wanted. We were also told about one person who liked birds and the staff had ensured pictures of birds were put in their bedroom. Relatives we spoke with said that they were satisfied with their family member's care. We noted that one person's bedroom lacked decoration and raised this with the manager, who told us they would address it.

Requires Improvement

Is the service responsive?

People told us that staff responded when they raised issues and they felt comfortable raising concerns and complaints. One person said; “I would feel confident to ask the staff about worries”. Another person said they would report any concerns said; “I don’t sit back and do nothing. I’d tell them”. A third person said; “They would do something about it. Staff will sort things”. Relatives we spoke also told us they would not hesitate to raise concerns.

We saw that there was a complaints procedure in place and this was available in different formats. This made the information available to people who had different methods of communication. We observed there was a suggestions box in the entrance area and complaints forms and feedback forms available on each unit. We saw that complaints received were acted upon. We saw that one referred to a loss of some clothing and the provider had arranged for the person to be reimbursed. The manager told us they were responsive to people wishes and concerns. He said that a bedroom had been decorated at the request of one person and when concerns were received about the quality of the food they had spent time tasting all the food to check the quality. This meant that when concerns were raised they were acted upon to improve the service.

Requires Improvement

Is the service well-led?

Our findings

The home has not had a registered manager since November 2012. The current manager started working at the home in February 2014 and applied to be registered with the commission in September 2014. We had prior to this contacted the manager several times and the provider to remind them of the requirement to register. The delay in applying to register meant that the home continues to be without a registered manager responsible for the care provided to people.

People that lived at the home told us there had been improvements since the manager had been in post. One person said: "[The manager] is a good manager. [The manager] works very hard. If there's a job [the manager] will do it". People and relatives felt that their views were listened to and acted upon. People told us that they saw the manager regularly as he spent time most days visiting the units. They also told us they saw the providers regularly. People told us that the management of the home were very approachable.

Staff we spoke with were positive about the management of the home. They told us they found the manager and the deputy manager very supportive and said they would have no hesitation in talking to them about any concerns. They were confident that issues would be acted upon.

The manager told us that although they had received no specific training they ensured they kept up to date with practice through journals and the internet. They told us they wanted people living at the home, relatives and staff to be more involved in developing the service. They particularly stated they wanted people to be involved in recruiting care staff.

The providers had recently sent satisfaction surveys out to residents and relatives. This was to gain their views of the service and to identify areas for improvement. We saw a sample of the replies and these were positive about the service. We were told that following comments in the surveys improvement had been made to the lighting in one unit and wall murals had been completed to improve the environment. Staff told us that they were not formally asked for their views about the service. The manager told us and we saw evidence that the first staff meeting since the manager was in post was arranged for October 2014. This meant that staff would have a formal opportunity to give their views about the care provided at the home and about any issues of concern.

The manager and the provider of the home told us that people had not always had their needs met previously. They told us they had implemented lots of changes and continued to take action to improve the service and to address shortfalls were they were identified. We were aware from the information we held about the service that the provider had made a number of improvements to the care people received. They told us, for example, of the action taken and they were continuing to take to improve the environment and to ensure care staff had the necessary training. They told us they were working hard to ensure people received appropriate care and knew that there were some areas that still needed to be addressed. They talked with us about plans that were in progress to change the staffing structure as one of the issues they were addressing to drive improvement in people's care. Following the inspection the manager sent us an action plan outlining the changes in structure.

The provider had a system in place to monitor the quality of care people received and to take action when there were shortfalls. We saw evidence that checks were completed on medication, accidents and incidents, pressure ulcer care as well as the environment and complaints management. Records confirmed that care plans were audited and omission and errors were acted upon. This was an area we had seen that still required improvement. We also saw that some risks to people were not acted upon promptly and some aspects of training needed to be addressed. The manager and provider told us they were aware of some of the shortfalls we had identified but did not have a written improvement plan in place.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Person-centred care** The care and treatment of service users must- be appropriate,meet their needs, and reflect their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Need for consent-** Care and treatment of service users must only be provided with the consent of the relevant person.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Good governance Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.