Fearnhead Residential Limited

Pembroke Residential Home

Inspection report

81 Marine Parade
Saltburn By The Sea
Cleveland
TS12 1EL

Tel: 01287677106

Date of inspection visit:
01 March 2016

Date of publication:
12 May 2016

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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 1 March 2016 and was unannounced. This meant that the provider did not know we would be visiting. The service was last inspected on 23 March 2015.

Pembroke Residential Home is situated in Saltburn-by-the-Sea. It is a converted house, and has a private garden. The service can accommodate a maximum of 12 people. At the time of the inspection 10 people were using the service, some of whom were living with a dementia.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were safely supported with their medicines, but effective processes were not in place for monitoring medicine stocks. This led to large stocks of unused medicines building up, including controlled drugs. Personal emergency plans were in place but these were not readily accessible to the emergency services.

Care records contained evidence of mental capacity tests and best interest decisions being undertaken, but these were limited to personal hygiene decisions. Following our inspection in March 2015 the registered manager said that best interest decisions and care plans would be updated. Our judgment was that this had not yet been done.

The registered manager carried out quality assurance checks, but there was not always a record of these and they had not identified the issues we found in relation to medicines or best interest decisions. Care plans were reviewed, but it was not clear how this was done. There was no evidence that audits of care plans took place.

The registered manager and staff asked people for their feedback on the service, but a questionnaire planned for 2015 had still not been sent to people.

Risks to people arising from their health and support needs or the premises were assessed, and plans were in place to minimise them. These plans sought to minimise risks whilst allowing people the independence to do what they wanted to. Checks were carried out to monitor the safety of the premises.

Staff understood safeguarding issues and could describe the types of abuse they looked out for. Staff said they would be confident to raise any issue they had, including whistleblowing.

Robust recruitment procedures were in place to ensure that only suitable staff were employed.

There was a low turnover of staff at the service, and the registered manager periodically reviewed people's

support needs to ensure that staffing levels were sufficient to support them safely.

Staff received training to ensure that they could appropriately support people, and felt confident to raise any additional training needs they might have.

Staff received support through supervisions and appraisals, and staff felt these were useful in monitoring their support needs.

People were supported to maintain a healthy diet, and people's dietary needs and preferences were catered for. People spoke positively about the quality of the food provided.

Care plans contained evidence of regular involvement in delivering people's care by external professionals.

Staff treated people with dignity, respect and kindness. People and their relatives spoke highly of the care they received. There was a friendly, homely atmosphere at the service.

The service provided people with information on advocacy services. Procedures were in place to provide end of life care to people that needed it.

The care people received was based upon their assessed needs and preferences. Care plans were regularly reviewed and daily notes kept to ensure staff were aware of people's current needs.

People were supported to access activities, and were seen to be engaged in these during the inspection.

The service had a clear complaints policy that was applied when issues arose, and this was prominently displayed in a communal area.

Staff were able to describe the culture and values of the service, and felt supported by the manager in delivering them.

The registered manager understood their responsibilities in making notifications to the Commission.

We found two breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 in relation to monitoring medicine stocks, recording best interest decisions, audits of the service and seeking feedback from people. You can see what action we took at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were safely supported with their medicines, but effective processes were not in place for monitoring medicine stocks. Personal emergency plans were not readily accessible to the emergency services.

Risks to people were assessed, and assessments were used to plan and deliver care that minimised them.

Staff understood safeguarding issues and felt confident to raise any concerns they had.

Pre-employment checks were carried out to minimise the risk of unsuitable staff being employed.

Is the service effective?

Requires Improvement

The service was not always effective.

Best interest decisions were not always recorded, though staff understood and applied the principles of the Mental Capacity Act and the Deprivation of Liberty Safeguards.

Staff received training to ensure that they could appropriately support people. Staff received support through regular supervisions and appraisals.

People were supported to maintain a healthy diet, and spoke positively about food at the service.

People had access to external professionals to support and maintain their health.

Is the service caring?

Good

The service was caring.

People were treated with dignity, respect and kindness.

People and their relatives spoke highly of the care they received.

The service provided people with information on advocacy services and had procedures in place to provide End of Life care.

Is the service responsive?

Good

The service was responsive.

The care people received was based upon their assessed needs and preferences.

People were supported to access activities, and looked engaged in these during the inspection.

The service had a clear complaints policy that was applied when issues arose.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality assurance checks took place but there was not always a record of these and they were not always effective.

There was no system in place for formally seeking and recording feedback from people using the service.

Staff felt supported and involved in the running of the service by the registered manager.

Pembroke Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 1 March 2016 and was unannounced. This meant that the provider did not know we would be visiting. The service was last inspected on 23 March 2015. At the time of the inspection 10 people were using the service, some of whom were living with a dementia.

The inspection team consisted of one adult social care inspector, one specialist advisor (on this inspection, a nurse with experience of caring for older people) 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.

We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

The provider was not asked to complete 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 contacted the commissioners of the relevant local authorities, the local authority safeguarding team and health and social care professionals to gain their views of the service provided at this home.

During the inspection we spoke with five people who lived at the service and one relative. We looked at five care plans, Medicine Administration Records (MARs) and handover records. We spoke with five members of

staff, including the registered manager, senior carers, carers and the cook. We looked at two staff files, including recruitment records. We also looked at records associated with the day to day running of the service.

We also completed observations around the service, in communal areas and in people's rooms with their permission.

Requires Improvement

Is the service safe?

Our findings

People were safely supported with their medicines, but an effective process was not in place for monitoring medicine stocks.

Medicines were stored safely and securely in a locked medicine trolley. Medicines requiring refrigeration were stored in a medicines fridge, and the temperature of this was regularly checked and recorded to ensure it was in the appropriate range. We observed a medicines administration round, and saw that the staff involved demonstrated safe practice.

We looked at five people's medicine administration records (MARs). A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered. There were no errors or omissions in the MARs we reviewed. Where medication had been withheld or refused there were clear entries on the back of the individual MAR. Any medicines not given were disposed of in a plastic drum and signed for in a record book. These are returned to the pharmacy. Each person had a photograph with their medicine record for identification purposes, apart from one person who was receiving respite care. Body maps for use with prescribed topical creams were located in the MAR folder and in care records

In reviewing the MAR folder we noted there was no sample signature sheet in place. Sample signature sheets are used to identify who has administered medicine. The registered manager said there was usually one in place, and undertook to replace this as soon as possible. There were clear 'as and when required' (PRN) protocols in place for people requiring them.

One person at the service was receiving controlled drugs. Controlled drugs are medicines that are liable to misuse. Controlled drugs were stored appropriately in a secure cupboard. However, there were stocks of controlled drugs at the service that were no longer being used. Some of these had been prescribed for two people who died in 2015. Another person was prescribed controlled drugs for use on an 'as and when required' basis. This had last been given in 2015, but the service retained stock with an expiry date of June 2015. We also noted that three people had large stocks of non-controlled drugs at the service that did not appear to be in use, and there was no evidence that reviews of medicines were taking place when stocks were accumulating.

Personal emergency evacuation plans (PEEPs) were in place. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. PEEPs contained information on people's support needs, and guidance to staff on how they could best be supported in emergency situations. PEEPs were stored in people's care plans, and we asked the registered manager how the fire brigade could access these quickly in an emergency situation. They said, "They're kept in people's care plans. The fire brigade did suggest that I photocopy them and put them in a file at the front, but I haven't gotten around to doing that yet."

These were breaches of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014

Risk to people using the service were assessed, and plans were in place to minimise them. Risk assessments were carried out in a number of areas, including manual handling, bathing, mobility, going out alone and using the stair lift. A risk assessment was also undertaken where risks specific to a person arose. For example, one person had a risk assessment in place for use of a hot water bottle as they liked to take one to bed. Risk assessments sought to protect people from harm without limiting their freedom of choice. For example, one person's mobility risk assessment read, 'The benefit of [the person] walking up and down the stairs is to enable them to keep their independence for as long as possible without relying on aids or assistance. It also enables [the person] to come and go as they wish.' Risk assessments were reviewed annually, but staff said they would be updated if people's circumstances changed.

Risks to people arising from the premises were also assessed and reviewed. An electrical safety inspection in May 2015 identified issues that needed remedial action, and the registered manager explained that this had been completed. Required certificates in areas such as electrical testing, firefighting equipment and gas safety were up to date. There was a detailed fire emergency plan in place which detailed how staff could safely support people in the event of a fire.

Accidents were recorded and investigated. Accidents were analysed by the registered manager to see if any trends were emerging which meant that action could be taken to reduce any identified risks.

Staff understood safeguarding issues and could describe the types of abuse that might occur in care settings. Procedures were in place to reduce the risk of abuse occurring. There was a safeguarding policy in place, based on guidance from the local authority, which contained advice to staff about how concerns could be reported. Where issues had arisen, records confirmed that they had been investigated and advice sought from the local authority. Staff said they would be confident to raise any concerns they had. Staff knew how to whistle blow. Whistleblowing is where an employee reports misconduct by another employee or their employer. One member of staff said, "If I had concerns I would go to a senior carer, but if it was about any of them here I would go higher up. I have read the whistleblowing policy."

We asked the registered manager how they ensured staffing levels were sufficient to support people safely. They said, "We don't have a high turnover of staff. It has always been a ratio of five people to one staff. I help out sometimes if we are busy. I have very good staff. If we are short I just phone around and it gets covered." At the time of the inspection, staffing levels between 8am and 4pm were three care staff. Staffing levels between 4pm and 9pm were two care staff. Staffing levels between 9pm and 8am were one care staff, with a senior carer who lived on site being available if needed. Staff thought that staffing levels were sufficient to support people safely. One said, "We're a team" and "If any of us need anything we always help." Another said, "I think there are enough staff. I never feel rushed. We all work as a team. There are busy times but we help each other." During the inspection we observed that staff responded to call bells promptly and that people requesting support got it quickly.

No new staff had been recruited since the time of the last inspection in March 2015. The registered manager described the pre-employment checks that would be carried out, which included details of an applicant's employment history, references from previous employers and a disclosure and barring service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to minimise the risk of unsuitable people from working with children and vulnerable adults. Staff files we reviewed confirmed these checks had taken place on staff working at the service. Staff completed an annual declaration that there were no changes in their DBS status and that they would notify the registered manager of any changes, which helped ensure the service had the latest information on them. A member of staff we spoke with said before they were employed, "My DBS was checked and references (were taken)."

The service was clean and tidy. Three people let us look around their rooms, and their carpets and bedding were clean and fresh. Throughout the day we observed staff moving items to keep areas clear of clutter and potential tripping hazards. Staff were observed to wash their hands appropriately in between episodes of care. Staff had easy access to supplies of personal protective equipment (PPE) such as aprons and gloves, and understood the principles of infection control.

Requires Improvement

Is the service effective?

Our findings

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. At the time of the inspection two people were subject to DoLS authorisation, and appropriate process had been followed to obtain these. Another person's DoLS application had recently lapsed, and an application to renew this had been submitted. Staff understood the principles of the MCA, and were able to describe how they applied to the provision of care at the service. One member of staff, in discussing how they thought about people's capacity, said, "They (people) might have capacity for one thing but not another." People who were not subject to DoLS authorisations were free to enter and leave the service whenever they wanted.

Care records contained evidence of capacity tests and best interest decisions being undertaken. However, best interest decisions were only in place in relation to personal hygiene decisions. During our inspection in March 2015 we had identified that best interest decisions did not clearly state what the best interest decision was, and at that time the registered manager said that best interests decisions and care plans would be updated. Our judgment was that this had not yet been done.

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

Staff received mandatory training in areas including medicines, fire safety, first aid, health and safety, moving and handling, infection control, food hygiene, safeguarding, dementia, nutrition and the Mental Capacity Act. Mandatory training is training that the provider thinks is necessary to support people safely. Training was regularly refreshed, and the registered manager kept a record to monitor staff completion of training. Staff files contained certificates confirming that training had taken place. The registered manager was waiting for the certifications of completion of safeguarding training that had taken place in February 2016.

Staff said they would be confident to request any additional training they felt they needed. One said, "Everyone does it (training) together and we get a certificate at the end." Another member of staff joked, "We get too much training! It is organised by the [registered provider]."

New staff were required to complete induction training before they were allowed to support people unsupervised. This included an introduction to the service's policies and procedures and meeting people

who used the service. One member of staff told us, "I did a week long induction with [the registered manager]. We ticked off a sheet to say it was done. This covered policies, PPE and safety. I met [the registered provider] as well."

Staff received support through regular supervisions and appraisals. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. Supervisions took place every three months, and appraisals annually. Records on staff files confirmed that staff were able to discuss their support needs and any other issues they thought relevant at these meetings. Where issues had been raised by staff we saw that the registered manager had taken action to address them. Staff performance was reviewed at appraisals, including knowledge of policies and procedures. One member of staff said, "We get supervisions and appraisals. They're fine. Supervision goes through achievements, and what we need to work on if any areas of concern."

People were supported to maintain a healthy diet. People's dietary needs and preferences were recorded on their care plans, and the cook was knowledgeable about the food people liked to eat. They said, "We have set menus and people tend to like what is on that. It's all traditional food that they like. I tend to go around on a morning and ask what people would like." Most people chose to eat in the dining room, which had a pleasant and homely atmosphere during the lunchtime we observed. People were regularly offered drinks, and said they enjoyed the food. One person said, "The food is very good here." Another person said there was always plenty of choice at mealtime. They added, "There always is fresh fruit in the lounge and we help ourselves at any time." Drinks and snacks were available throughout the day, and people also had these in their rooms.

People were regularly weighed, with the results recorded on malnutrition universal screening tool (MUST) sheets. MUST is a screening tool to identify adults, who are malnourished, at risk of malnutrition (under nutrition), or obese. However, there was no evidence that this weight information was being used to complete a MUST assessment. We reviewed five people's individual's weights and noted they had either maintained weight or increased weight over the previous three months. We asked the registered manager why weight information was not being used to complete MUST assessments, and they said this would be reviewed.

People were supported to access external professionals to maintain and promote their health. Care records contained evidence of visits by GPs, district nurses and psychiatric nurses. The registered manager said a chiropodist visited the service every eight weeks. A senior carer told us, "We have a good relationship with the chiropodist. You can sit down and talk with them. With district nurses, we have a good rapport with them and with GPs."

Good

Is the service caring?

Our findings

People described the service and staff as kind and caring. One person said they, "Couldn't be at a better place" and "All the staff are very good. It's like a family here." Another person said, "I like this place. The food is good here and all of the staff are good." A third person told us, "They (staff) will always come and knock at my door and ask if I need a hot drink and if I am alright."

A relative we spoke with said the service had been "instrumental" in improvements in a person's condition, and when they visited it felt like they were at the person's home with their extended family.

Staff clearly knew the people they supported well. Throughout the inspection we saw staff and people enjoying friendly conversations and jokes, and saw that this contributed to a homely atmosphere. When relatives visited they were also quickly involved in general conversation between staff and people. One member of staff told us, "We talk with people, get to know them and their preferences. It's brilliant to talk with them. It's really nice to talk about people's pasts. I love doing it." Another member of staff said, "I like to ask about families and (people's) lives during one to one time. It's great to know what they like" and "I like to have a joke and laugh with people. You have to be serious sometimes, but have to make it as pleasant as possible."

Throughout the inspection we observed staff treating people with dignity and respect. Staff were always polite and courteous when speaking with people, and asked for permission before assisting them. Where people requested assistance, staff approached them and asked discreetly how they could help, or moved people away from communal areas if they had something private to discuss. Staff knocked on people's doors and waited for permission before entering. One person told us that all staff were, "very polite." Staff told us how they protected people's dignity. One said, "We close doors and curtains and cover people with a towel to protect their dignity."

Staff understood the importance of protecting and encouraging people's independence. Throughout the inspection we saw staff encouraging people to do things for themselves, while always being available to provide support where needed. One member of staff told us, "We give people independence by letting them do what they can, like washing their hands and face or leaving clothes out but letting them choose. If they feel they can do it themselves we encourage that as we like people to be independent for as long as possible." Another member of staff said, "We try to keep (people's) independence by giving people things to do that they can do, and assist them if they can't do it."

At the time of the inspection no one at the service was using an advocate. Advocates help to ensure that people's views and preferences are heard. There were procedures in place to assist people with accessing advocacy services should they be needed.

No one at the service was receiving end of life care. The registered manager was able to describe the procedures in place for providing this.

Good

Is the service responsive?

Our findings

The care people received was based upon their assessed needs and preferences. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to the person.

People's care plans began with a detailed life history, including details on their personal and family history, their hobbies and activities they enjoyed. This meant staff who had not previously supported the person would know something about them before they did.

Care plans were in place covering a number of different areas, including communication, decision making, mobility, behaviours that challenge, continence, skin integrity, oral health and personal care. People told us they were involved in planning the kind of care they wanted. Care plans were detailed and person-centred. For example, one person's morning routine was recorded as, 'I rise when I wish to, I take care of all of my own hygiene. I choose the clothes I wear and I choose what time I like to go down for breakfast. On occasion some staff will knock on my door and pop their head in just to enquire if I am okay and if I require anything.' Care plans were reviewed by care staff on a monthly basis and annual reviews involving people's social workers also took place.

Daily logs were used to record any changes in people's current support needs. Staff coming on shift consulted these as part of the handover process to ensure they had the latest information on people's needs. We reviewed the daily notes and saw they were up-to-date. One member of staff said, "Everything gets passed over in handover. We get updates on people, for example if they are up, if the district nurse has been in. That's also documented in the communication sheet."

Staff said care plans contained enough information to allow them to deliver personalised care. One said, "I think care plans are relevant and have enough detail. They have everything we need. If needs change we update the care plan." Another said, "I think the care plans are a lot better. You can see they are reviewed on a regular basis. Seniors (carers) do the changes. Carers leave notes if they've noticed something, for example if someone's mobility deteriorates."

We asked the registered manager how people were supported to access activities. They said, "Usually the girls (staff) are busy on the morning but we have one who plays cards with people, and plays games. We have a gentleman who comes in and plays the keyboard. Every now and then we get an entertainer in to play the keyboard, but that can be expensive." Staff told us they raised funds through raffles and through a staff lottery to help provide birthday cakes and presents for people who used the service, and that they enjoyed doing so.

During the inspection staff were preparing a raffle for an upcoming party, and we saw that people and staff enjoyed talking about what this would involve. None of the people we spoke with said they wanted more activities to be provided. One person said they liked spending time talking with other people in the lounge, and watching TV. Staff told us they thought people had enough to do at the service. One said, "There are enough activities but sometimes we need to encourage people" and "In better weather we take them out to

the beach or for tea." Another member of staff said, "I think people have enough to do. They like to do arts and crafts. Quite often they like to sit and watch TV. Every afternoon we try to do something. Those that want to, we get into a little group to do it."

There was a complaints policy in place, which was prominently displayed in the reception area. This set out how complaints would be investigated, relevant time frames for doing so and details of external bodies for people who weren't content with the outcomes. The registered manager told us there had been no complaints in the last 12 months, and was able to describe the steps that would be taken if an issue was raised.

Requires Improvement

Is the service well-led?

Our findings

The registered manager told us about the quality assurance checks they carried out to monitor and improve standards at the service. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations.

The registered manager carried out weekly checks of areas including door guards, fire alarms, water temperatures and call alarms. Records confirmed that the checks were up-to-date.

The registered manager said, "Senior carers do care plan reviews and I review each month. They do the care plans and notes. I check by looking through." Care plans had records at the front that had the date of review logged, but these were largely date entries followed by 'no change to plan.' There was no record of what had been examined during the review, or of any comprehensive audit.

The registered manager also said, "Once a month I do medicine checks. I check all the carrying forward sheets myself, or I do the returns. Night staff are responsible for night checks, which I randomly check. I check the creams and the medicines. I don't do MAR checks. There's a missing signature sheet." There was no record of what had been examined during these audits, and we noted they had not identified the issues we found with management of medicine stocks and controlled drugs.

We asked about the quality assurance checks the registered provider carried out. The registered manager said, "[The registered provider] does checks of the external premises. (They) come in once a week at least, sometimes three times a week. Might check paperwork. [The registered provider] does the checks when they come in, and always checks the safeguarding logs off." We did not see any records of the checks carried out by the registered provider.

During our inspection in March 2015 we identified that audits did not always record what had taken place during the audit, and at that time the registered manager said they were aware of the need to develop audits further. Our judgment was that this had not yet been done.

The registered manager planned to obtain feedback from people by sending them questionnaires. They said, "We do have questionnaires but I haven't sent any out yet. There have been lots of changes in our clients. We are only a small home so we do have time to spend with people and families and they give us a lot of information." During our inspection in March 2015 we identified that records of feedback from people were not kept, and the registered manager said they were planning on sending questionnaires out to people in the middle of 2015. At the March 2015 inspection we also identified that improvements were needed in how best interest decisions were recorded. Our judgment was that these had not yet been done.

These were breaches of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We asked staff to describe the culture and values of the service. One said, "Lively, bubbly staff who are good. A home away from home. Lovely food, clean and well kept. People have their own freedom." Another said, "We don't have a high turnover of staff for a reason."

People and staff spoke positively about the registered manager. Staff said they were supported by the registered manager, and felt involved in the running of the service. One said, "[The registered manager] is lovely. We get on well inside and outside (of work) and the place wouldn't be the same without them. [The registered manager] helps me at work and I can always ask for help. I feel involved in the running of the service. We (staff) aren't pushed out to the side" and "If I had any problems I would go straight to the registered manager." Another member of staff said, "[The registered manager] is lovely. You can tell [the registered manager] if you have any problems and they will do anything for the residents" and "I feel supported by [the registered manager], who backs you up."

Staff confirmed that staff meetings took place, and that they were free to raise any issues they had at these. Records were kept of these meetings, which confirmed that a wide range of topics were discussed and that staff could raise any issues they had.

The registered manager was able to discuss the roles and responsibilities of a registered manager, and understood the types of notifications that should be made to the Commission.

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 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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Personal emergency plans were in place but were not readily accessible to the emergency services. Medicines were not always safely disposed of, and systems were not in place to review medicine supply and stock. Regulation 12(2)(b) and (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Best interest decisions were not always recorded. Audits did not always record the checks that been carried out. There was no system in place for formally seeking and recording feedback from people using the service. Regulation 17(2)(a), 17(2)(c) and 17(2)(e)