Heritage Care Limited

The Croft

Inspection report

The Croft
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Date of inspection visit: 8 and 9 December 2015
Date of publication: 27/04/2016

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Inadequate
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

The inspection took place on 8 and 9 December 2015 and was unannounced. We previously inspected the service on 11and 13 May 2015 and found that the service's medicines procedures and recording practice needed improvement in order to maintain people's safety consistently.

The service provides accommodation and personal care for up to 60 older people. This service does not provide nursing care. At the time of our inspection there were 55 people using the service. The service has a registered manager supported by a deputy manager.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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's feedback regarding The Croft was critical. They told us that too many agency staff work at the home and this had an impact on the quality of care. Several members of staff had told us they had provided feedback to management about the lack of support they receive in carrying out their duties, however they felt nothing had changed.

Staff had received training in topics such as fire safety, manual handling, and mental capacity. However, staff supervision were not being held on a regular basis.

People's privacy was not maintained as there were large white notice boards displayed throughout the home with personal information of people on display.

People were not protected by The Deprivation of Liberty Safeguards and had restrictions placed upon them without staff having the authorisation to do so.

Complaints were not listened to or acted on and this led to a failure to use this information to improve the quality of care received. Staff were kind and caring in their approach to the people who lived in the home.

The risk assessment process to identify risks to people and how they were to be eliminated or managed were not always being carried out or recorded. This meant people were not always being protected from identifiable risks to their health and safety.

Policies and procedures in relation to safeguarding of adults accurately reflected local procedures and included relevant contact information. All of the staff we spoke with were able to explain the procedures in relation to the safeguarding of adults.

People's care plans did not always reflect the care that had been carried out. Accidents and incidents were not recorded accurately and had not been investigated appropriately.

We found where people sustained unexplained bruises, no action was taken to investigate or escalate them to the appropriate agencies. This placed people at risk of unsafe care and inappropriate care.

The décor of the home was in need of updating, some of the ceilings had large damp patches where water had leaked from one of the rooms.

We observed staff to be rushed and task focused and had little time to interact with people. We found that there were not sufficient numbers of staff to meet the needs of the people in the home.

We found that there were 11 staff in the building for 55 residents. Most of the residents were living with dementia and had a high level of need. Additional staff were a deputy and a shift leader however they did not work directly on the units and were in the office on both days of our visit.

The home has largely agency staff who work in the home due to difficulty in recruiting permanent staff. However the home tries to ensure the same staff are requested from the agency.

Medicines were not administered safely and in a timely manner. We saw the morning medicine round still being carried out at 11.a.m this meant that the people who required a lunch time dose of medicine would be at risk of receiving it too close to the morning dose. The medicine cupboard was observed to be left open and unattended on the second day of our visit. We were also aware that controlled medicine had not been correctly booked in in the appropriate book. Some stock of medicine did not reflect what was left in the medicine box. On the first day of our visit we were aware that two medicine errors had occurred.

Staff had received training in the administration of medicine. Quality assurance systems did not effectively assess or monitor the quality and safety of services provided. Activities were not planned in accordance to the people who were able to participate.

The provider was not meeting the requirements of the law. You can see what action we told the provider to take at the back of the full version of the 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?

Inadequate 

The service was not safe.

People were not being consistently protected from the risks associated with the management of their medicines.

Risks to people were not being consistently assessed or recorded. Plans to eliminate or manage risks to people were not being consistently recorded.

Although there was a high use of agency workers, the home tried to ensure consistency of people's care by booking the same personnel to cover the home.

There was insufficient numbers of staff to ensure the safety of people.

Is the service effective?

Requires improvement 

The service was not always effective.

People did not receive safe and effective care because staff were not always supported through, for example regular supervision and support within their role.

People's rights were not always protected because decisions made on their behalf were not in accordance with the Mental Capacity Act 2005 where they lacked capacity.

People received support to attend healthcare appointments. However, weight loss and the risk of malnutrition had not been managed well.

Is the service caring?

Requires improvement 

The service was not consistently caring.

The service did not capture people's preferences in regards to end of life care.

Staff treated people with respect and showed kindness.

People did not have any formal opportunities, such as residents meetings, to share their views and receive updates about events affecting their care.

Is the service responsive?

Requires improvement 

The service was not always responsive.

People were not supported to take part in social activities that were tailored to their abilities.

Reviews of care were not consistently undertaken due to lack of permanent staff.

Summary of findings

Is the service well-led?

The service was not consistently well led.

People were at risk of receiving inconsistent care as records had not always been appropriately maintained.

Quality assurance systems in place were not effective in assessing, monitoring and improving the quality and safety of services provided.

People were protected from the risk of harm because the registered manager knew how to report any serious occurrences or incidents to the Care Quality Commission. This meant that we could see what action they had taken in response to these events.

Requires improvement 

The Croft

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.

The inspection took place on 8 and 9 December and was unannounced.

The inspection team consisted of an inspector and a specialist advisor. The specialist advisor was experienced in dementia care.

The service was previously inspected as a responsive inspection in May 2015. The responsive inspection was carried out due to concerns relating to medicine administration. The service was found to be, requires improvement at that time.

Prior to the inspection we reviewed notifications about the service. Notifications are important events that the service is required to tell us by law. A Provider Information Record (PIR) was not requested prior to our visit. A PIR is a form that asks the service what the service does well and any improvements they plan to make.

We looked at five people's care plans and case tracked two respite admissions. Case tracking a care plan involves looking in depth at how care is planned and delivered that reflects current needs.

We looked at a variety of documents, administration records, and policies and procedures relating to how the service was managed. These included people's care plans, medicine records, staff files, staff rotas, accident reports, meetings, maintenance records and quality assurance records.

During our inspection we spoke with the registered manager, deputy manager the responsible individual, the local authority and professionals who visit the service. We also spoke with three people who use the service, six care staff, a visiting relative and six agency staff.

We looked around the premises and observed care practices and spent time on three units within the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us. In addition we observed staff supporting people during the lunchtime meal.

Inadequate

Is the service safe?

Our findings

People were not always protected against the risks of potential abuse.

We noted one person had multiple bruises on their arms and legs, staff were unable to clarify how this bruising occurred. We found no evidence of any investigation being carried out to find the cause of the bruising. This was not in line with the service's safeguarding policy which stated that investigations should be carried out in the event of unexplained injuries. This placed people at risk of harm or unsafe care because no preventative action was taken by the service when unexplained injuries were found. We informed the registered manager about the person's bruising. They told us they were not aware of the bruising. We alerted the local authority to our findings following our visit.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the provider's policy for safeguarding and found this to be satisfactory. Staff were able to describe what they would do in the event of abuse or neglect, most said they would report any concerns to the management. However, this did not happen with regard to the person with bruising, this had not been reported to the manager.

Staff were aware of the home's whistle blowing policy and procedure. Accidents and incidents were reported, however one of the accidents relating to a person, was documented in such a way that it was difficult to understand how the accident occurred. The written account documented in the computerised care plan was unclear and ambiguous. This was brought to the attention of the registered manager who confirmed they would look into this. We were not aware that any impact to the person had occurred because of this.

Occasionally people became upset, anxious or emotional. We saw one person who's behaviour presented as challenging, they were reluctant to accept assistance and were verbally aggressive towards staff and on occasion 'lashed out' at staff. Staff were able to give clear examples of positive de-escalation techniques used to support the person. However, the person's care plan and risk assessment did not identify potential triggers or guide staff how to support the person appropriately. This meant that staff who had not received training in managing challenging behaviour increased the risk of inappropriate care interventions thereby causing potential injury to the person or others. The home did not follow the service's policy on behaviours that challenge. Care plans did not detail how individuals were to be supported if they became upset or distressed.

There were arrangements in place to keep people safe in an emergency and staff had received fire training. However, during the second day of our inspection the fire alarms went off, staff did not respond to the possibility that a fire had broken out. We confirmed with staff that this was not a fire alarm test, however, staff continued to serve lunch and did not follow the evacuation procedure. Staff did not respond to what could have been an emergency situation. The service's training in relation to, in the event of fire, was not adequate.

The registered manager commented that the maintenance person who was carrying out redecoration had caused the fire alarms to go off, as dust particles had set the alarms off.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service used agency staff on a regular basis however we found that agencies who supplied temporary staff had not always provided confirmation of the recruitment checks and training for each worker. We spoke with six agency staff and only three confirmed they had received dementia training. This means the service does not ensure staff have the relevant skills to meet the needs of people in their care. Furthermore, this does not correlate with the information in the handbook given to people and their relatives on admission to the home which states that 'our staff are trained and consider the person with dementia as a unique individual'.

Staff reported that sometimes the home was left without sufficient members of staff to ensure the service was safe. For example, when the agency staff leave at 21.00 one member of staff was left on the unit until night staff arrived at 21.30. This issue was raised in the staff communication book which we looked at, we also saw evidence from the rota to confirm this was common practice.

Inadequate

Is the service safe?

We reported this to the registered manager and they disagreed with the comment that the member of staff made and assured us that this does not happen. However, this did not correspond with the rota and communication book we looked at.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were not managed and administered safely. We were informed by the registered manager that two medicine errors had occurred previous to our visit. We also observed the medicine cupboard to be left open and unattended during our visit. We were also aware that the morning medicine round was still being carried out at 11.a.m. This meant that the lunch time medicine could not be given as it would be too close to the morning dose. Staff reported feeling unsupported by the senior members of staff in relation to administration of medicine. We observed medicine administration on three units of the home and each member of staff who was administering medicine had several interruptions from other members of staff and the people living in the home. This put the member of staff under pressure and was also a distraction which could lead to medicine errors.

There was not always a balance of medicines in stock recorded on the medicine chart which made it difficult to check whether medicines were being administered as prescribed. Stock levels were not recorded in the medicine audits. There was a concern that at weekends there was a lack of staff who were trained to administer medicines. This put the staff who are trained to administer medicines under additional pressure to cover several units.

This was a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted that the cleaning trolley with materials for the cleaning of the home was kept in the sluice. This meant they may come into contact with items such as bed pans, thereby causing potential cross contamination. Staff reported that the home often run out of essential cleaning products like cleansing wipes and tissues which were used to carry out personal care for people. We reported this to the deputy manager and they said "well they (staff) can always go to the shop and buy some." We were not aware of 'petty cash' available for staff to buy such items.

We could not find a cleaning schedule that showed what cleaning has been carried out. People were not protected from acquired infections as domestic staff did not follow a cleaning routine or follow a schedule to show what had or had not been cleaned.

This is a breach of regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because systems for preventing, detecting and controlling the spread of infection were insufficient.

Requires improvement

Is the service effective?

Our findings

We looked at the recruitment procedures used at the service. The files we looked at contained all required documents such as a Disclosure and Barring Service (DBS) check and written references from previous employment. An induction for newly appointed staff was completed and a competency assessment was carried out by senior members of staff following the induction.

Staff had received the services training which included safeguarding, fire safety and moving and handling. However the training records were difficult to follow and did not provide a good overview of the training completed.

The Mental Capacity Act (MCA) 2005 is legislation which protects and promotes the rights of people who are unable to make all or some decisions about their lives for themselves. It promotes and safeguards decision making within a legal framework. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom.

The service was not fully meeting the requirements of the Mental Capacity Act 2005 (MCA). Staff we talked with did not have a good understanding of Deprivation of Liberty Safeguards (DoLS) or the MCA . Whilst we saw 14 applications had been made to the local authority for DoLS the information was not embedded in care plans. Copies of the applications were kept in the main office where any visiting professionals and staff would not be able to access. This would then make it difficult for staff and visiting professionals to be aware that the person was being deprived of their liberty and for what reason. People living in the home were under continuous supervision and control thereby being deprived of their liberty. The service had not always followed the legal requirements to ensure this was done in the person's best interest .We observed restrictions on people that had been imposed without evidence that the MCA and DoLS had been followed in accordance with regulations/Act. For example, during our visit we had to exit one unit via a coded door. People living in the home had to be escorted away by staff from the open door in order for us to leave the unit.

People did not have their capacity assessed in accordance with best practice. For example, there was no explanation of how the decision was made to move the person to the home.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the service did not seek consent from people before providing care and did not follow the Mental Capacity Act 2005 (MCA) code of practice. Photographs were used in care plans and medicine charts with no evidence of consent. We found people had not had their capacity assessed in relation to these decisions and the relevant people such as family members had not always been consulted to ensure these decisions were in the person's best interest.

Staff reported that they had received training in relation to the MCA but was not clear who was responsible for undertaking the capacity assessments. The provider's consent to treatment policy guidelines provided information and key points in law to assist staff on this subject and gave good practice guidelines . It clearly stated staff must be aware that it is illegal under the MCA to consent on behalf of a person. People's records we looked at confirmed that capacity assessments had not been completed.

Supervisions were carried out by senior staff however this was sporadic and one member of staff had not had any supervision since May 2015. All the staff we spoke with reported that they did not feel supported by the senior members of staff. One member of staff commented, "It is a nightmare and not safe, people come in on their days off to administer medication". The staff we spoke with commented the deputy managers are the key people in medicine training. However, when staff have asked for help and support they were told that they (the senior staff) do not know the people well enough to administer medicine. Staff confirmed that they had attended medicine training but were reluctant to attend any further training.

Staff who we spoke with all reported that when they had asked senior members of the team for help, due to staff shortages, they were told to 'deal with it'. There was no senior member of staff on the units on both days of our inspection. It was clear from speaking to staff that they were unhappy and felt unsupported in their role.

Requires improvement

Is the service effective?

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service offers respite care, however this was not always communicated to staff if a person was due for admission. The communication between staff was inadequate and this presented a risk to people in relation to what level of monitoring and support they were given. For example, a member of staff was asked about a person's care plan and its content. They reported "I don't know that person I have been on annual leave". This confirmed our observations during our visit that the lack of communication between senior members of staff and staff working in the units put people at risk of receiving inadequate or inappropriate care.

The service used computerised care plans. However, the care plans we looked at did not contain sufficient information to enable staff to carry out care that was individualised. For example, one person who had a particularly low weight of 45.3kg had no active care plan in place to monitor their nutritional needs. There was no information about their dietary preferences or any information to address how the person's weight was to be managed. We could see no input from a dietician or evidence that the food should be high in calories to ensure an acceptable weight is obtained. We asked the deputy manager if the person had had a referral made to the dietician. They confirmed that they had not made a referral or had arranged with the chef to have the person's food fortified by way of adding full fat milk and cream to some foods.

People were supported to have access to healthcare services. During our visit we saw a district nurse attend the home to meet people's health needs. The G.P visited the service when a request was made.

We were told that choices were available at meal times and special diets catered for by catering staff. However, there was no evidence that people had any choice in what they had for their meal.

We observed staff giving out meals without any interaction with people. We noted one member of staff assisting a person with their meal with no interaction throughout the process. We observed staff routinely walking past people carrying out tasks without speaking at any time.

We found that care plans did not always reflect the current care provided. In one person's care plan a food and fluid chart was in place due to weight loss, we found no entries for two days, this meant that the nutritional intake could not be monitored to ensure the person had sufficient nutrients to meet their assessed needs.

We were aware that some practices showed lack of respect and did not promote dignity and well-being. For example people being left sitting in the dining room whilst staff carried out duties such as loading the dishwasher and undertaking domestic tasks. This meant that the dining room experience for people was interrupted and noisy. However, people who remained in the dining room whilst staff attended to their duties appeared content to observe staff carrying out their duties. The building in general was in need of redecoration as parts of the ceilings had large damp areas where water had leaked from bathrooms. The registered manager informed us a redecoration plan was in progress.

We recommend the service finds out more about obtaining consent, based upon current practice, in relation to the MCA.

Requires improvement

Is the service caring?

Our findings

People's privacy and dignity was not always respected at the service. For example there were large white boards on each of the units displaying people's names. Some of the boards had specific details in relation to care needs for example 'needs assistance' and 'walks with frame'.

This did not respect people's confidentiality and privacy. This was brought to the attention of the registered manager and they confirmed that they would review the use of the boards.

Staff were not able to tell us about people's life history and personal preferences, and the importance of needing to know about people as individuals. Knowledge about care needs were limited and care was task led rather than person centred. This meant that people did not receive person centred care that identifies choice and preferences.

The service uses an annual survey to ask all people living in the home and their family members what they think of the service and what could be improved. However, we were not able to access the results of surveys carried out by the provider. Care plans we looked at did not demonstrate how people or their relatives were involved in decisions about care and treatment.

Comments from a visitor said that the permanent staff were really caring and that they are always contacted if there have been any incidents or changes to their family members well-being.

However, they said that staff are always rushed and the level of agency staff used has a direct impact on the home. We observed that staff did not smile or position themselves at the same level when talking to people, this inhibited positive engagement and did not initiate interaction from the people living in the home.

People were treated with kindness and compassion in their day to day care. Staff knew they needed to spend time with people to be caring and have concern for their well being however there were insufficient staff to enable staff to spend quality time with people.

People could move freely around the home and could choose were to spend their time. People had keys to their rooms affording them further privacy and security. People had been able to personalise their bedrooms to make them look homely and to suit their tastes. We saw people had brought in photographs, ornaments and other items to make their room individual.

Requires improvement

Is the service responsive?

Our findings

We observed that staff were task driven often without regard to people as individuals. The care plans reflected this with no acknowledgement of person centred care. We looked at the care plans for carrying out personal care and it did not contain detail of how the person prefers to be cared for. For example, a tick box was used for personal care and any daily tasks carried out such as washing and oral care.

Staff were not able to tell us about people's life history and personal preferences and the importance of needing to know about people as individuals. Knowledge about people's care needs was limited, for example, some staff were not aware that a person was at risk of malnutrition and had a food and fluid chart in place.

We observed that staff were rushed this meant that staff were unable to spend any quality time with people, people did not receive person centred care that considers people's preferences and choice.

People had care plans in place to direct staff but not all of these plans reflected people's current needs. The plans were divided into sections according to area of need this included life history, these were frequently incomplete. The information is important for staff to facilitate meaningful conversation, and deliver person centred care. None of the care plans we looked at had been cross referenced with the risk assessment . It is important to plan care from the risks identified for example, if a person had a risk of pressure sores then specific care was based on this information.

The care plans had no evidence of being regularly reviewed with people or if appropriate their relatives. We found that due to the electronic system used in care planning some members of staff had difficulty in accessing information. For example, a person who was assessed as being at risk of malnutrition, and had a weight recorded as 39.9kg. The person had a food and fluid chart in place, however, the food and fluid chart was difficult for the member of staff to access. When the chart was eventually found it showed that the person only had one bowl of cornflakes throughout the day of 8/12/2015. The same amount of food was documented on 1/12/2015. Furthermore, there was no reference to the person's meals being fortified or any evidence that there was involvement with a dietician for advice and support to ensure the person does not become malnourished.

We were told people's needs had been assessed before they moved into the home. However the home was unable to provide pre assessment information for two people who had recently been admitted to the home. We were informed that the information was often obtained from professionals' assessments and transferred to the home's admission forms. The forms listed people's assessment, care and support preferences. However, without a pre admission assessment from the service, it may not always be possible to capture important information such as how the person communicates or their cognitive ability. The two people without a pre assessment were admitted for respite care we were not told why the home did not carry out a pre assessment. However, an assessment was carried out on admission.

The home had two activity co coordinators providing 31 hours per week of activities. Staff told us activities were open to all people living in the home regardless of what unit they lived in. We observed a church service being held on the day of our visit, a staff member told us that the people living with dementia would not be invited as they could sometimes be disruptive and wander off. This did not reflect on the information we were given with regard to activities being open to all people living in the home. Furthermore, this did not uphold the home's aims and objectives to support each individual equally with regard to their social and emotional desires. We were informed that there were no formal activities planned for people and no planned activity programme available. We noted that posters were displayed with information for residents of events and activities. However, some people had a diagnosis of dementia and the information would not be clearly understood. Furthermore some people would not have been aware of the posters displayed within the units.

During the two days of our visit we were aware of the lack of any stimulus for people. We did not observe any specific activities for people living with dementia and staff were unable to give any examples of appropriate activities. This meant that people living with dementia were not offered opportunities for stimulation.

During the morning we found people sitting in the lounge area with the television on but no other stimulation. Most

Requires improvement

Is the service responsive?

people were asleep in their chairs. One member of staff told us "there is nothing going on most of the time" another member of staff commented that activities were not provided daily and care staff had little time to engage positively with people. The provider had not ensured there were activities to meet most people's social and emotional needs on an individual basis.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had systems in place to capture complaints received however; it was not clearly recorded if the actions taken was to the complainant's satisfaction.

We looked at how the provider investigated and responded to complaints. We noted an absence of signs around the building which informed people and relatives how they could make a complaint if they needed to. A copy of the comments and complaints procedure was included in the initial folder that is given to each person on their arrival in the home. We looked at the most recent complaint which was dated March 2015. The complaint was about poor communication between staff. There was no clear evidence whether the complaint had been addressed or what the outcome was.

We recommend that comments and complaints are investigated thoroughly and people and their relatives are satisfied with the responses.

Requires improvement

Is the service well-led?

Our findings

People were cared for in a home which was ineffectively managed.

The registered manager had recognised the challenges of the service and was committed to drive improvements to ensure the home had a positive culture that is person-centred, open, inclusive and empowering. The registered manager had not developed the staff team to consistently display appropriate values and behaviours. For example we asked a senior member of the care team about the needs of a person who had recently been admitted for respite care. They informed us that they could not give us any information about the person as they had recently returned from annual leave We were not aware how information is shared when staff have returned to work following annual leave. This may put people at risk of receiving care that does not meet their needs.

The provider did not have effective systems in place to monitor the quality of care and support that people received. Although audits had been completed, there was limited examples of how subsequent action plans to address the shortfalls were in place. For example, a care plan audit showed that some care plans had not been updated and reviewed on a regular basis. There was no information or a time frame of when the care plan reviews needed to be completed by. The registered manager was aware that the shortfalls identified in the audits needed to be followed up.

They reported that the deputy manager assists with this. However, we did not see any evidence of shortfalls being acted upon.

We did not see audits carried out to ensure the home is clean and free from infection. For example, we observed that the cleaning schedule of the home was not in place and the domestic staff could not provide us with evidence of what areas of the home had been cleaned, or any evidence of what process was in place to ensure the premises are clean and free from germs.

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

During the two days of our inspection we noted that the deputy managers remained in the office. Staff told us they did not feel supported or adequately supervised by the senior members of the team. However, they reported that the registered manager had an open door policy and they could be approached at any time. Staff commented that the registered manager was visible and approachable and was clearly passionate to drive improvements throughout the service. The registered manager promotes a positive open culture for example we were told about recent medicine errors that had occurred at the home. We were aware of how the service had implemented changes to ensure further incidents do not happen. For example, re training staff in the administration of medication.

Providers and registered managers are required to notify us of certain incidents which have occurred during, or as a result of, the provision of care to people. The registered manager had informed us about incidents and notifications and from these we could see appropriate actions had taken 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	Regulation 18 HSCA (RA) Regulations 2014 Staffing **There were insufficient staff to meet people's needs.** **Regulation 18 (2) (a).**

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People were placed at risk of harm because systems for managing medicines were not safe.** **Regulation 12 (2) (f).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People's social needs were not being met.** **Regulation (9) (1) (c)** **Care plans reviewed did not capture people's choices and preference in regard to end of life care.** **Regulation (9) (3) (b).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **There was no evidence of investigations undertaken when unexplained bruises were found on people's bodies.** **Regulation 13 (3) (5).**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were at risk because systems for controlling and preventing infection were insufficient Regulation 12 (2) (h)

This section is primarily information for the provider

Enforcement actions

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