London Residential Healthcare Limited

Chestnut House Nursing Home

Inspection report

Chestnut Road
Charlton Down
Dorchester
Dorset
DT2 9FN

Tel: 01305257254
Website: www.lrh-homes.com

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Chestnut House Nursing Home was last inspected on 2013. The home was found to be meeting all requirements in the areas inspected.

Chestnut House is a purpose built care home accommodating older people. The home is registered to provide accommodation for 85 people who require nursing or personal care. At the time of the inspection there were 78 people living at the home. It comprises of two main areas; people with nursing care needs are resident on the ground floor; people with enduring mental health needs live on the two upper floors. The second floor is allocated for the care of females only.

There was a registered manager in place who had been in post for a number of years. 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.

The provider was meeting the some of the requirements of the Mental Capacity Act 2005 but further improvements could be made in the assessments of people's mental capacity. People's views or people important to them did not consistently have their comments recorded. Not all best interest decisions were complete. Staff understood some of the concepts of the Act, such as allowing people to make decisions for themselves. The staffs understanding of the act was consummate to their role

The risks people took were not consistently managed. Although risk assessment and plans had been put in place to minimise these risks changes in observational systems had had not considered these risk assessments and had put people at risk of harm. The registered manager was made aware of this and took steps to reintroduce the recordings of observations which had previously been in place instead of just visual observations without recordings being undertaken.

The provider had systems in place to ensure the quality of the service was regularly reviewed and improvements made but some of these processes need improvement. Medicines audits needed to be more robust to acknowledge all of the dispensing carried out by staff. Guidance to staff in relation to managing difficult behaviours was ambiguous and not fully understood by staff meaning that people and staff could be put at risk of harm.

The management at the home had developed an open culture through regular meetings with the people living there and people important to them. The staff told us they felt supported by the management and that their opinions were valued.

The staff knew people's needs well but the care records did not always reflect their comments. One person told us, "I don't want for too much, staff know what I need and how to help me, I don't have any

complaints". Visiting relatives told us about how they considered their relatives were well cared for and how staff ensures their (relative) needs were met.

The staff demonstrated a caring and compassionate approach to people living at the home. People were offered choices at mealtimes such as where to sit and what to eat. The provider had a system to offer a choice of food during mealtimes.

People told us there were enough staff to meet their needs and our observations confirmed this, however, how they were deployed at key times of the day needed to be reconsidered in order to meet people's needs.

The staff told us they worked well as a team and enjoyed working at the home. The home offered many activities such as a pub night in a purpose built bar area at the home. The provider was also using many initiatives to work with people with dementia such as 'Namaste' principles in use at the home. (Namaste Care is a program developed to offer meaningful activities to people living with dementia.)
The home was awarded accreditation with the Gold Standards Framework in Care Homes and achieved a beacon status. This is a nationally recognised award which recognises the high quality of care provided for people at the end of their life.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the back of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe. The risks people faced were not managed consistently. People had risk assessments and care plans to keep them safe but some of these records required to be updated. This put some people at risk of harm that could be avoided or minimised.

People were supported by sufficient staff to meet their needs but the provider needed to consider how these were deployed at key times of the day.

People's medicines were stored and recorded safely. People generally received their medicines when they needed these and at the required times.

The recruitment of staff was safe as the provider had carried out the necessary checks on new member of staff

Is the service effective?

Requires Improvement

The service was not consistently effective at meeting people's needs. The system in place to ensure people did not receive food that may cause them harm was not effective.

People were supported by staff that had the necessary skills and knowledge to meet their assessed needs, preferences and choices and respect their rights. Staff training included understanding dementia and positive behaviour approaches.

People had access to health and social care professionals when required, Staff were proactive in ensuring emerging needs were acknowledged and acted upon.

Is the service caring?

Requires Improvement

not kept in a confidential manner. Staff demonstrated a caring approach to their work. People were respected as individuals. People were treated in a kind and friendly manner.

Staff were aware of people's daily routines and supported them in the way that they wished. This information was not always

recorded in people's care plans which put them at risk of receiving inappropriate care.

People made individual choices about how they spent their time with the guidance of staff.

People were supported to maintain contact with friends and family.

Is the service responsive?

Good

The service was responsive to people's needs. Care plans were in place, which described the care and support each person needed. Where people could comment they had been consulted about the way they wanted to be supported but not all. Where people could not comment people important to them had been consulted.

People were encouraged to be actively involved in their care with regular meetings involving family and other health and social care professionals when required.

There was a range of activities for people to be involved in.

People knew how to raise concerns. Staff knew how to respond to complaints if they arose.

Is the service well-led?

Requires Improvement

The service was not consistently well led. The system to ensure the quality of the service was reviewed and improvements made was not fully used. This meant that some areas of the service were not regularly audited and areas for improvement not recognised.

There were systems in place to involve health and social care professionals, relatives, staff and the people they supported to ensure an open and transparent culture to the service offered.

Staff confirmed the registered manager was approachable and they felt listened too. Regular staff meetings took place; staff told us they felt supported by the management.

Chestnut House Nursing 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 13 January 2016 and was unannounced. The inspection was carried out by two inspectors and a specialist advisor. The specialist advisor was experienced in clinical care and clinical governance.

Before the inspection we reviewed all the information we held about the service. This included notifications regarding safeguarding, accidents and changes which the provider had informed us about and feedback from relatives. At the time of the inspection a Provider Information Record (PIR) had not been requested. 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 were able to gather this information during our inspection.

In order to gain further information about the service we spoke with nine people living at the home and three visiting relatives. We spoke with eight members of staff. We also looked at some concerns about the service raised by members of the public.

We looked around the home and observed care practices throughout the inspection. We looked at nine people's care records and the care they received. We reviewed records relating to the running of the service such as environmental risk assessments and quality monitoring records.
Not all the people living at the home could tell us how they experienced care due to their enduring mental health illness. Observations, where they took place, were from general observations. We also 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 with us.

Before the inspection we spoke with representatives of the local authority's contract monitoring team who had experience of the service.

Requires Improvement

Is the service safe?

Our findings

The risks that people faced were not consistently managed. 12 people had bed rails to protect them from falling from bed. We observed one person trying to climb over the bedrails. We immediately spoke with staff to ensure the person was safe. We spoke to the senior member of staff on duty. They told us they were aware the person tried to climb over the bedrails and they are observed throughout the day. They told us that as the person's door is open they can observe the person during regular or unplanned observations by staff. We looked at the person's care records that informed the person should be checked every half an hour. Staff told us that this level of observation had ceased some weeks ago as the risk had been minimised by the regular recorded observations. To remove these observations undermined the risk assessment and left the person at risk of harm. This meant that this risk was not being managed safely.

When people were assessed as requiring bed rails to keep them safe these were not consistently set up with due regard to the risks people faced. There was no information in people's care records to explain this. We looked in people's care records but there was no recorded evidence of bed rail monitoring from the staff to ensure the bedrails were safe for use. We spoke with the deputy manager about this who advised that the maintenance team undertake monthly inspections of all bed rails in the home. We did not see the outcomes of these assessments during the inspection.

During our inspection we observed one person calling for help from their room. They were shouting 'help' for 20 minutes with no member of staff passing the room or responding. We went into the room and supported them to use their call pendant to alert a member of staff. Their call pendant did not work so we went and sought a member of staff who then supported them and immediately replaced the call pendant for a different one. Later during the inspection we went to see the person again. The room to their door was closed. When we entered the person was laid in bed. They asked us for help to go to the toilet. We spoke to a member of staff and asked them to support the person.

We later asked the senior member of staff if the person could summon help with the call pendant, they told us no. They went on to tell us that the person had a pressure mat to alert staff if the person got out of bed as they were at risk of falls. We went back to the person's room with the senior member of staff and established that the pressure mat was missing. The senior staff member addressed this immediately. We pointed out that the measures to alert staff to the person's movement was only made staff aware if the person got out of bed. The measures did not allow the person to request support when required which put them at risk of harm. They acknowledged that the pressure mat was only partially effective. They told us that staff are always up and down the corridor and would regularly check on the person. We looked at the person's care records that informed the person should be checked every half an hour.

We spoke with the deputy manager about people living at the home who required the half hourly checks and they advised that these had been stopped. We explained that the care plans still detailed that half hourly checks were in place. Later in the inspection the registered manager advised that the hourly and half hourly check documentation had been stopped as a trial only and were told that the checks still took place but were not documented every half hour or hourly, they advised that they were reinstating them with

immediate effect. This meant that changes to the monitoring of people who were at risk had been changed without due regard to people's personal circumstances undermining risk assessments and putting people at risk of harm that should have been avoided.

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

We carried out a SOFI during the dinner period in one area of the home. We observed that there were insufficient staff deployed in the area to ensure people got the support they needed at a time they wanted. We observed that one staff member was initially in the area. We spoke to them who told us there were four people that required support to eat their meal in the area. (Ancillary staff have been trained to assist at mealtimes) They also told us that they would get help to achieve this from one other staff member. We observed that prior to the meal arriving the staff member tried to encourage people to sit at the tables and wait for the food to arrive but two people had difficulty in remaining sat which put extra pressure on the staff member as they tried to reassure them. Although an extra staff member came to help serve the food and support people to eat their food, two people had two wait for support.

We looked at the staffing rotas for the home which informed there were 16 care staff on duty to support people with the physical care needs supported by an activity coordinator to provide some social stimulation. These staff were supported by three clinically trained staff. In addition to the Deputy manager, head of care and registered manager who are all also clinically trained We spoke with the registered manager about our observations at meal time who agreed to consider how staff were deployed at key times of the day.

People's medicines were stored and recorded safely. People received their medicines when they needed these and at the required times. The staff responsible for administering medicines had been suitably trained. We observed people receiving their medicines safely and saw staff carry out safety checks, including staying with people while they took their medicines. The medicines were stored in a lockable area and were well organised. The provider had a system to audit medicines received and dispensed in the home. This system was not fully effective as it did not consider the use of covert and per required needs medication.

People told us that they felt safe living at the home. Staff told us, and records confirmed that they had recently received training in safeguarding. We spoke with four members of staff who told us how they would respond to allegations or incidents of abuse. In addition, we saw evidence that the manager had notified and worked with the local authority when safeguarding concerns had been brought to their attention. We observed the staff interactions with people living at the home and found them to be positive and empathetic. One person told us they did not have concerns about abuse or bullying from staff.

The recruitment of staff was safe. We looked at recruitment records for four members of staff. Each of these staff members had Disclosure and Baring Service check in place together with copies of identity documentation. The provider had taken up references for the staff employed.

Requires Improvement

Is the service effective?

Our findings

People who were noted as at risk of malnutrition were recorded on care plans as being 'weekly weighed.' The results of this were not evident within people's care records; however later discussion with the head of care a separate chart was maintained to record this data. We looked at these and cross referenced the information with people's Malnutrition Universal Screening Tool (MUST) score. (MUST is a clinical tool to assess if people are at risk of malnutrition) We observed there were some MUST scoring inaccuracies that identified some people that were at risk of malnutrition but this risk was not recognised. These meant assessments were not correct and care was not planned to mitigate risk.

The provider had a system to identify people's needs in relation to their diet but this was not always robust. We spoke with the head chef at the home about how they ensure people get the foods they require. They told us a number of people living at the home were vegetarian, some people required a soft or pureed diet or thickened fluids. The system used to identify these people was a white board detailing the individual needs of each person. However the information on the board was not clear to read or understand as some notes had been erased and some were faint. We were not able to clearly determine the dietary needs and risks of each person from the information displayed. We were told by staff that people who require extra snacks (due to concerns of malnutrition) have a snack box which the head chef explained were made up daily. This was to ensure that people living at the home have access to snacks in between meals and overnight). We looked at some of the snack boxes and checked the contents with the head chef. They advised that all of the boxes are made up and then staff on each floor determine what people living at the home can have. For example, one person's individualised snack box contained mini cheddars, a rice pudding, some bourbon biscuits and some 'maltesers'. However the information on display on the kitchen board identified that this person required a soft diet. This meant that the system was not effective and put the person at risk of harm.

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

The people we spoke with and could tell us about how they experienced care told us they are offered a choice of food and the food on offer was good. One person told us "if I don't like what's on offer the staff will always get an alternative". Another person told us "there is always more than enough to eat, staff bring you drinks and snacks throughout the day, I have never eaten so much".

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.

Mental capacity assessments were not consistently meeting the requirements of the Mental Capacity Act (MCA) 2005. We looked at nine people's care records and noted that there were mental capacity assessments in each one. Where assessments identified that a person lacked capacity, a best interest decision was also completed. There was sufficient evidence that these assessments were done consistently. However there were no systems in place for peoples' MCA assessments or best interest's decisions to be reviewed. We noted that many did not include either the views of the person concerned or people important to them. This meant that the process of ensuring staff acted in people's best interest was not complete. The registered manager agreed to look at these records and ensure improvements were made where needed. Staff had a understanding of the act and how this impacted on people's rights. The staffs understanding of the act was consummate to their role .

The registered manager provided evidence that DoLS applications were being made where appropriate and they were also able to evidence where DoLS had been granted. We looked at the records for the applications for people living on the second floor of the home. The paperwork corroborated what the registered manager had told us and evidenced that applications were being made appropriately.

People were supported by staff who had the necessary skills and knowledge to meet their assessed needs and choices. Staff completed induction training when they first started working at the service. We spoke with one member of staff who had recently been employed. They told us the training they had received gave them good insight into the requirements of the role and the needs of the people living at Chestnut House. The people we spoke with told us that staff understood their needs and supported them how they wished, one person told us " they know how to look after me, I know they will help me if I need it".

Staff told us there was sufficient training available such as health and safety, dementia care, end of life care, activities and person centred care. We were told training was a combination of e-learning and face to face methods with some training being provided by external providers. Three members of staff confirmed they had regular one to one meetings with a senior member of staff, where they could discuss their role and their training needs.

People had access to health and social care professionals when required, Staff were proactive in ensuring emerging needs were acknowledged and acted upon. We looked in people's care records that evidenced that peoples GP's and other professionals were consulted and the advice given was acted upon. An example of this was when staff became aware that a person was at risk of malnutrition a GP was asked to refer the person to other services for advice and guidance. Whilst the records demonstrated that referrals had been made some responses by others professionals were slow. We spoke with the registered manager about introducing a system to ensure they could track referrals to ensure others dealt with their requests promptly.

Requires Improvement

Is the service caring?

Our findings

People's care records and daily observation records were not kept in a confidential manner. During the inspection we noted that some people's care and daily records we left unattended in nurse's stations which were unlocked and the door was left open. We also noted some daily observational records were left in communal corridors outside people's rooms. These records contained information that was private and personal to the individuals. As visitors to the care home had unrestricted access to these areas this meant that people's right to privacy was not being respected. We made the registered manager aware of this and they made arrangements for staff members to move the daily notes into people's own rooms immediately.

People's care records did not consistently evidence that people had been consulted about their care. Whilst care records described some of the tasks that people required help with there was little guidance about people's individual routines and how they wished to be supported. The staff we spoke with were able to talk to us about people's individual routines and how they offered choice of what to wear for example. Staff also told us about how they supported people when they became distressed such as sitting and talking with them or supporting them to different locations in the home to avoid stressful situations. People's care records did not always reflect the staff knowledge of the people they supported. This meant that people may not receive care in a consistent manner.

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

People were well cared for. We spoke with people living at the home one told us about how happy they were that arrangements had been made to personalise their room. Another person told us "I don't want for too much, staff know what I need and how to help me, I don't have any complaints". Visiting relatives told us about how they considered their relatives were well cared for and how staff ensured their (relative) needs were met. One visiting relative told us "the family's experience (of care provided) has been very good in relation to their loved ones care over the last 12 months. We observed staff were kind and compassionate for example. We observed one person, who was in a wheelchair, was distressed at being assisted using a hoist. Three members of staff helped them, one reassured them by saying: "we will not let you fall, you are safe, don't worry", whilst the other staff completed the procedure. Staff explained what they were doing at each step such as informing them "we're just going to lift your feet up, is that ok?" This evidenced that staff were treating people with kindness and respect.

Those people who could tell us how they experienced care told us about how staff gained their views about their care needs. One person told us, "staff sit and talk with me about what I like and what help I need. They listen to what I say". One visiting relative told us "the family's experience (of care provided) has been very good" in relation to their loved ones care over the last 12 months. Another relative told us about being involved in decisions about the care of their relative living with dementia. They told us they were happy with the care being provided and they considered the "staff do a great job, sometimes in difficult situations".

The home was awarded accreditation with the Gold Standards Framework in Care Homes and achieved a beacon status. This is a nationally recognised award which recognises the high quality of care provided for people at the end of their life. The registered manager told us the home is currently working on re validation to be able to maintain this award. Following the inspection we were informed that the home has now been reaccredited and has achieved beacon status

Good

Is the service responsive?

Our findings

The service was responsive to people's changing needs. We looked at people's care records some of which showed that where people could comment on their care needs they were consulted, but not all. When people could not comment on their care needs due to their enduring mental health illness people important to them had been consulted. Through our discussions with staff it was clear that staff knew people's individual support needs, people's care records generally reflected what we had been told. Staff described how they ensured people could choose how they were supported. They told us about people's right to have choice.

People's needs had been reviewed and action taken to address any concerns noted. There was recorded evidence that people's needs were assessed prior to them coming to live at the home. One of the assessment records we observed demonstrated that an initial assessment had recently taken place. This demonstrated that due consideration was given to meeting people's needs.

Staff told us about how people chose to spend their time and what activities they enjoyed We observed a planned activity in the second floor lounge during the inspection. People living in the home on the other floors were supported to attend if they wished. The activity was led by an outside agency and 19 people were in the lounge during the activity. The activity included a game with a very large inflated balloon and guessing lyrics in songs from the first part being played. People seemed to enjoy the activity and most participated. People sung the lyrics to the songs when the music was stopped and it was an animated session. Staff also made us aware of other planned activities such as pub nights in the purpose built bar in the home and BBQ's when the weather permits.

The staff also told us about the use of 'Namaste' principles in use at the home. (Namaste Care is a program developed to offer meaningful activities to people living with dementia. This focuses on providing a calming and soothing experience using sound, touch, smell and taste). The home had a dedicated sensory room where people who were experiencing distress and anxiety could go to, supported by trained staff, to try to relax.

People knew how to make a complaint if they wished to. One person told us that, "Staff sort out the problems, I know who the manager is and I would tell them if I needed too. The provider had a complaints procedure which informed people what they needed to do to make a complaint and the time scales for the complaint to be rectified. We looked at the records relating to dissatisfaction about issues at the home. These records demonstrated that the management had addressed issues in line with their procedure.

Requires Improvement

Is the service well-led?

Our findings

At the time of the inspection there was registered manager in post.

Care records had not been audited to provide an overview of the support people received to ensure the care provided was as stated and improvements were made. We asked the registered manager when people's care records were audited, they told us that they should have been audited in December 2015 but due to mitigating circumstances this had not been achieved. The last time the care records were fully audited was in September 2015.

The auditing system for medicines was not consistently effective. We looked at the last medicines audit that was carried out on 18 December 2015. Whilst the audit did not identify any areas for improvement it had not considered the safe and appropriate use of medicines on a 'per required needs' (PRN) basis or the use of covert medicines. We looked at people's care records which evidenced the last time one person's covert medicine had been reviewed was August 2015. The National Institute for Clinical Excellence (NICE) guidance states "covert administration of medication should be regularly reviewed (as capacity, to decide to take medicine's, can fluctuate over time). This meant people may have received medicines inappropriately.

The above demonstrates a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Records showed that staff had recorded some accidents and incidents, although not all concerns had been recorded such as unexplained bruising. We found that there was underreporting in people's care records when people had unexplained bruising. We spoke with the head of care who told us that unwitnessed bruises are not reported on accident/incident reports but unwitnessed skin tears were. The head of care told us that staff try to determine causes of skin damage. A staff member told us that if they identified a bruise or wound they would report to the clinical lead on shift. The staff member told us they knew that sometimes clinical staff complete a body map and take photographs. As not all unexplained bruising was being recorded in accident reports this meant no preliminary investigations and explanations of these issues were considered which may put people at risk of harm and undermine the audit of the accidents and incidents within the home.

There was a lack of clarity about some of the processes and systems used by staff in keeping people safe and meeting their individual needs. This meant the systems were partially effective. An example of this was that we looked at one person's care plan which contained a recording system to monitor their behaviour, sometimes called an ABC chart. This tool documents behaviour which had posed a risk and detailed incidents such as slapping, biting, swearing and grabbing at staff. The home had a 'conflict management folder' with individual plans to manage behaviour for some of the people living at the home. The person's care records evidenced that they displayed behaviour which was difficult for staff to manage but there was no records relating to them in this conflict management folder.

We spoke to the staff about the use of the conflict management tool and they advised that "if there is a

chance of conflict during personal care, then we do the conflict management plan". We asked the same question to the deputy manager who told us that the use of the conflict management tool was based on "those people who pose a risk to other residents." This meant that there was a lack of clarity about managing difficult behaviours and inconsistencies in the use of the available tools within the home which may put people at risk of harm.

The above demonstrates a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager demonstrated good leadership and along? with the staff team. There was an open and transparent culture where the registered manager and staff responsible for leading the staff team listened and responded to what we discussed and the issues we raised.

There was a management structure in place at the home consisting of a manager, deputy manager and senior clinical staff and careers. The people, who could tell us, could identify who the manager was. One person told us about how approachable the manager was and how they often come and talk with them. This was also mentioned by one visiting relative. Staff were aware of the roles of the management team and they told us the manager was approachable and available to discuss issues most of the time, however if not the deputy manager was there to provide advice and guidance. They told us they felt valued and their opinions were listened to. They told us about staff meetings where they could bring up issues and make suggestions for improvement. There was evidence of regular meetings taking place between the people who used the service, their relatives and other professionals involved in their care. One relative confirmed that the provider held meetings with relatives and whilst they were always informed when these were happening they could not always attend.

The head of care told us that there was a weekly review meeting held with clinical staff on duty to discuss any new concerns including the use of bed rails and if people had broken areas of skin. There was also a 10 at 10 meeting which the registered manager and head of care and clinical staff to discuss any new clinical concerns with people living at the home. This meant that the provider had systems in place to address issues on a daily basis.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment (1)(2)(a) The risks people faced were not consistently managed. (1)(2)(b) The systems in place to ensure people did not receive food that could cause them harm was not effective.

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 (1)(2)(c) Peoples care records were not kept in a confidential manner. Peoples care records did provide a contemporaneous record of risk assessments and changes to service delivery. (1)(2)(b)The systems in place to record accident and incidents was ambiguous and did not provide staff with clear guidance on what constitutes a reportable concern. The auditing systems in place to ensure medicines were given appropriately was not effective at preventing misadministration.