Care Quality Commission

Tamaris Healthcare (England) Limited

Southfield Court Care Home

Inspection report

Southfield road
Huddersfield HD5 8RZ
Tel: 01484 432433

Date of inspection visit: 12 and 13 August 2015
Date of publication: 23/11/2015

Ratings

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

Overall summary

The inspection of Southfield Court Care Home took place on 12 and 13 August 2015. The visit on 12 August was unannounced and the visit on 13 August was announced. We previously inspected the service on 28 May 2014 and at that time we found the provider was not meeting the regulations relating to management of medicines and assessing and monitoring the quality of the service. We asked the registered provider to make improvements. On this visit we checked to see if improvements had been made.

Southfield Court is a purpose built care home providing accommodation and nursing care for up to fifty older people, some of whom are living with dementia. The home is situated in Almondbury village and is approximately two miles from the town of Huddersfield.

The service is required to have a registered manager. 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.

There had been no registered manager at the home since 8 April 2015. A temporary peripatetic manager had been

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managing the service since that time. A new manager had been in post for three weeks at the time of our inspection. They had submitted their application to commence registration with CQC. At the time of our inspection this was not finalised.

People who used the service we spoke with told us that they felt safe and the visitors we spoke with told us they felt confident that their relative was safe at Southfield Court.

People who used the service, staff and visitors were not always protected against the risks of unsafe or unsuitable premises because the service had not carried out the necessary safety checks and addressed issues noted by the local fire safety office which ensured people were kept safe. This was a breach of regulation 12 (2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, premises safety

Our inspection on 28 May 2014 found the registered provider was not meeting the regulations relating to the management of medicines. On this visit we checked and found the recording of the receipt and administration of people's medicines was not always clear. This meant people who used the service were not always protected against the risks associated with the recording, receipt and administration of medicines because the provider did not have appropriate arrangements in place. This was a breach of regulation 12 (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe management of medicines

Staff had a good understanding about safeguarding adults from abuse and who to contact if they suspected any abuse. Risks assessments were individual to people's needs and minimised risk whilst promoting people's independence.

There were not always enough staff available to respond to people who required assistance in a timely manner

Staff were not always provided with training and support to ensure they were able to meet people's needs effectively. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's capacity was considered when decisions needed to be made. This helped ensure people's rights were protected when decisions needed to be made.

People told us they enjoyed the food. Staff supported people to eat and drink in a kind, caring way.

Accurate records were not always maintained in relation to care that was being delivered. This was a breach of Regulation 17of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Throughout our inspection we observed staff interacting with people in a caring, friendly, professional manner. Staff were able to clearly describe the steps they would take to ensure the privacy and dignity of the people they cared for and supported.

People had access to external health professionals as the need arose

The home employed an activities organiser to organise and enable people to participate in activities however; there was a lack of meaningful activities for a number of people who lived at the home.

People were able to make choices about their care. Peoples care plans detailed the care and support they required and included information about peoples likes and dislikes

People told us they knew how to complain and told us staff were always approachable. Comments and complaints people made were responded to appropriately.

People we spoke with felt that consistent management had not been in place in recent months, although they spoke highly of the peripatetic manager and the new manager

The peripatetic manager had held occasional meetings with staff, and the relatives of people who lived at the home to gain feedback about the service provided to people.

The registered provider had an overview of the service. They audited and monitored the service to ensure the needs of the people were met and that the service provided was to a high standard, however this system had not picked up the problems we found with premises safety, supporting staff and keeping accurate records

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The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

People told us they felt safe

People who used the service, staff and visitors were not always protected against the risks of unsafe or unsuitable premises.

People's medicines were not always managed safely

There were not always enough staff available to respond to people in a timely manner

Requires improvement

Is the service effective?
The service was not always effective

Staff were not always provided with training and support to ensure they were able to meet people's needs effectively

People's consent to care and treatment was sought in line with legislation and guidance.

People were supported to eat and drink enough and maintain a balanced diet

People had access to external health professionals as the need arose

Requires improvement

Is the service caring?
The service was caring.

Feedback from people and their relatives was that staff were caring.

Staff were respectful in their approach and were able to tell us how they maintained people's privacy and dignity.

People were supported to make choices and decisions about their daily lives.

Good

Is the service responsive?
The service was not always responsive.

Activities were provided but this was not at a level which would meet the needs of all the people living at the home.

People and their representatives were involved in the development and the review of their support plans where possible

People told us they knew how to complain and told us staff were always approachable.

Requires improvement

Is the service well-led?
The service was not always well led

Requires improvement

Summary of findings

Accurate records were not always maintained

The registered provider monitored the quality of the service, but the systems had not picked up the problems we have evidenced in our report.

The culture was positive, person centred, open and inclusive.

People we spoke with spoke positively about the new manager

Southfield Court Care 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 12 August and was unannounced. The inspection team consisted of three adult social care inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience on this occasion had experience in supporting people living with dementia. One inspector visited the service again on 13 August 2015, this visit was announced.

Prior to our inspection we reviewed all the information we held about the service. This included information from notifications received from the registered provider, and feedback from the local authority safeguarding and commissioners. Before this visit we had received information of concern about staffing levels at the home.

We had not sent the provider a 'Provider Information Return' (PIR) form prior to the inspection. This form enables the provider to submit in advance information about their service to inform the inspection.

We used a number of different methods to help us understand the experiences of people who lived in the home. Not all the people who used the service were able to communicate verbally, and as we were not familiar with everyone's way of communicating we were unable to gain their views. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way

of observing care to help us understand the experience of people who could not talk with

us. We spoke with four people who used the service and 13 visitors. We spent time in the lounge areas and dining rooms on both units and observing the care and support people received. We also spoke with eleven members of staff as well as the peripatetic manager, an area manager and the new manager. We looked in the bedrooms of eight people who lived at the home. During our visit we spent time looking at nine people's care and support records. We also looked at three records relating to staff recruitment, training records, maintenance records, and a selection of audits.

Requires improvement

Is the service safe?

Our findings

People we spoke with told us that they felt safe and most of the visitors we spoke with told us they felt confident that their relative was safe at Southfield Court. One visitor said their relative, "(name of relative) doesn't know us anymore, but we feel they are well looked after and safe."

Relatives we spoke with told us if they had any concerns about the way their relative had been treated they would talk to the staff team about it.

People who used the service, staff and visitors were not always protected against the risks of unsafe or unsuitable premises. The home employed a maintenance person who carried out safety checks within the home. We looked at the health and safety check book and the fire safety check book for the service. In the fire safety book we saw the checks had not been carried out in line with the policy of the service. We asked the manager about this, they told us the maintenance person had not been at work for twelve weeks and some of the checks had not been carried out in their absence. For example, the weekly check on the fire escape routes had not been carried out since February 2015. The last fire drill had been carried out on 22 January 2015 and the emergency lights had last been inspected in May 2015.

In November 2014, the local fire service carried out an inspection and assessment of the building. There were some areas of concerns noted such as no fire warden in place, no evacuation chairs on the first floor. We asked the area manager whether the issues highlighted had been rectified. They told us they had not been addressed and they would rectify this. Additionally, the fire safety inspection noted the fire door in the ground floor lounge was missing a handle bar. This would make it difficult to open the door in an emergency. On the day of inspection, we noted the handle was still missing. This meant people were at risk of harm because the service had not carried out the necessary safety checks and addressed issues noted by the local fire safety office which ensured people were kept safe. After the inspection we contacted the manager and the issues had been rectified.

There was a Personal Emergency Evacuation Plan (PEEPs) in place for each person. PEEPs are a record of how each person should be supported when the building needs to be evacuated. We were told by the area manager that the PEEPs should be kept in a blue folder in each person's bedroom. We checked in two blue folders and the PEEPs were not there. They told us they would address this.

We observed one corridor that had been decorated with synthetic grass. We saw on one section, the grass had been removed, and there were a number of staples and panel pins sticking out of the wall above the handrail. Staff were alerted to this and it took over 2 hours to remove these. There were also fairy lights in the corridor, with trailing electric wires on the floor. A number of decorations and memory prompts were fixed to the wall with staples. This means people who used the service, staff and visitors were not always protected against the risks of unsafe or unsuitable premises.

The above issues were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people who used the service, staff and visitors were not always protected against the risks of unsafe or unsuitable premises

We saw the entrance to the home was clean and welcoming. Some of the paintwork in the bedrooms and en-suites bathrooms was worn and chipped. There was a plastered hole in the wall of one of the bedrooms we went into that had not been decorated. This person spent most of their time in the bedroom. One visitor asked a member of staff why the door of the en-suite in their relative's room was missing. The member of staff responded "Some of them have fallen off, so we took them out. We haven't got a maintenance man at the moment."

Water temperature checks were up to date as were the checks on the extractor fans. We saw that electrical services had been checked in June 2015. We saw that suitable equipment was in place to meet the assessed needs of people who used the service for example: profiling beds, pressure relieving cushions, sensor mats and hoists. We saw from the minutes of the Health and safety committee meeting in January 2015 that suitability of equipment was discussed and new hoist slings had been ordered.

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Requires improvement

Is the service safe?

We saw people's medicines were stored safely. There was a medicines room located on both the ground and first floor of the home. Both rooms were spacious and clean with hand washing facilities available. Temperature checks were recorded daily for the rooms where medicines were stored and for the medicines fridge.

The medicines fridge stored bottles of eye drops for a number of people. We noticed that one of the three boxes of opened bottles of eye drops were not annotated with the date of opening. The pharmacy dispensing label was dated, 19 June 2015 and recorded 'discard 28 days after opening'. When we looked on the persons current MAR which commenced 24 July 2015 current we saw this medicine had not been administered, however, there was a risk this person may receive medicine which was out of date.

We saw nutritional supplements were stored in the medicines room and were clearly labelled to identify who they were prescribed for. Where people were prescribed topical creams the MAR informed staff to refer to the 'topical application record'. We looked at the topical application record for three people. These were retained in peoples bedrooms and detailed the name of the cream, where to apply it and when. Staff recorded on the form when they had applied the cream. This meant the records accurately reflected when creams were applied to people and by whom.

We checked one medicine which was stored in the controlled drugs cupboard. The stock tallied and each entry was completed and checked by two staff. We noted the staff completed a stock check of all the medicines stored in the controlled drug cupboard to ensure that all the stock

was accounted for.

We saw a monitored dosage system (MDS) was used for the majority of medicines with others supplied in boxes or bottles. We checked a random selection of five medicines to check if the stock tallied with the number of recorded administrations. We were not able to evidence that three of the medicines were correct because the recording of medicines which had been booked in or carried forward from the previous month were unclear and we were therefor not able to establish a starting balance. We checked two boxes of identical medicine which were prescribed for two people. We found the stock for one person had nine tablets when there should have been eight remaining, the stock for the other person had seven tablets when there should have been eight. This indicated staff may have administered the medicine from the wrong persons tablet box.

We saw that the key to the nurses' office which contained emergency medication and first aid equipment was spinning in the lock and took time to open presenting a risk that medical assistance would be delayed in an emergency. We were told that this had been reported and it was an intermittent problem and was due to be mended on 13 August. This was addressed with the peripatetic manager on the day of our visit and the fault was rectified on the same day.

The nurse we spoke with told us two people required their medicines administering covertly. Covert administration of medication occurs when medication has been deliberately disguised, usually in food or drink, in order that the person does not realise they are taking it. We saw a letter from one person's GP giving authority for this person to receive their medicine in this manner. However, the person was no longer registered with this GP practice and the letter was from the person's previous address. The person had not been re-assessed in relation to their capacity to make a decision regarding their ability to take their medicines. A best interest discussion had not been recorded in relation to the use of covert medication. The care plan stated the medicine should not be given with a hot drink as it could change the efficacy of the medicine. In the daily records we saw staff had been giving the medicine in hot drinks. This meant there was a risk this medicine might not work properly which could affect the person's health and wellbeing.

The other person who received their medicines covertly had a risk assessment in place, however this risk assessment was dated November 2012 and there was no evidence this document had been reviewed. One of the medicines listed on the individuals MAR was not listed on the risk assessment. The homes covert medication policy stated that a mental capacity and best interest assessment was required for the administration of covert medicines. There was no evidence in the care records that capacity assessments or best interest discussions had taken place at the home in relation to the covert administration of medicines for this person.

Requires improvement

Is the service safe?

The above issues evidenced a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because medicines were not always administered in a safe way for service users

The peripatetic manager had a good understanding of safeguarding and the procedures to follow to keep people safe. We spoke with six staff members in depth. They told us they had received training in safeguarding and they were able to tell us what they would do if they had any concerns. Staff gave us a description of the different types of abuse they may come across in their work. One member of staff said, "If I thought anyone was getting mistreated I would speak up." Another said, "If I heard anything I wasn't happy with I would address it straight away." Another member of staff said, "Yes it's safe. Any shouting or physical abuse I would report to the nurse or managers. I haven't seen any abuse." This showed that staff were aware of how to raise concerns about harm or abuse and recognised their personal responsibilities for safeguarding people using the service.

We saw that safeguarding incidents had been responded to appropriately and action taken to keep people who used the service safe. We saw the home had a safeguarding policy which had been reviewed in November 2014 and was visible around the home. This demonstrated the home had robust procedures in place for identifying and following up allegations of abuse, and staff demonstrated knowledge of the procedures to follow.

We looked at the care records of nine people who used the service and saw that comprehensive risk assessments were in place for a range of issues including hydration and nutrition, mobility and falls, skin integrity and choking. We saw these assessments were reviewed regularly, signed and up to date. The members of staff we spoke with understood people's individual abilities and how to ensure risks were minimised whilst promoting people's independence. They told us they recorded and reported all accidents and people's individual care records were updated as necessary. The manager or nurse on duty recorded all incidents or accidents on the computer system. This included action taken to reduce the risk and immediate action taken to keep the person involved safe. The manager and nurses on duty were able to confidently describe the procedure to follow and what action had been taken following falls and incidents to prevent them from happening again.

We saw in the incident and accident log that incidents and accidents had been recorded and an incident report had been completed for each one. For example we saw in the care file of one person who used the service, a letter from the falls team, suggesting that a low bed and sensor mat could be used. We saw this was in place in the person's bedroom. The mobility care plan was reflective of the advice given by the falls team and a body map had been completed in the file following a previous fall. The person's care plans and risk assessments had also been updated accordingly. This showed the home analysed incidents that may result in harm to people living there and made changes to their care or treatment where necessary.

We saw the registered provider had a system in place for analysing accidents and incidents to look for themes and lessons learned. This demonstrated they were keeping an overview of the safety in the home.

We saw one person who used the service fall in the corridor whilst being accompanied by a worker from an outside agency. The worker from the outside agency lifted the person unaided and did not follow the homes falls policy. We made sure that the person who used the service was checked by the nurse and the manager was informed in line with the homes falls policy. This meant that the worker from an outside agency did not follow the homes policies and procedures whilst on the premises and that the worker may not have the skills and knowledge to keep people who used the service safe. The peripatetic manager was alerted to this immediately.

There were adequate staff to keep people safe and meet their needs, however there were not always enough staff available to respond to people who required assistance in a timely manner.

One relative we spoke with said, "I understand there are a lot of people, but I don't think they should say 'wait till we have done this or that'. My relative is not changed enough. They don't seem to come and check to see if they are wet. I think they rush a bit with them. I know they have a job to do and it's a hard one." Another said, "Some more staff would be nice, but I think that's a pipedream. Sometimes I wish it didn't smell, but they always rectify it by the next day. I've got no complaints really." One relative we spoke with said, "The staff are very good and caring, but I wish there were more so there could be a regular one in this lounge, but it's difficult."

Requires improvement

Is the service safe?

On the day of our visit there were 48 people using the service, 23 on Willow Unit and 25 on Beech Unit. This unit is designed to meet the needs of people living with dementia. There were three carers and one agency nurse on duty on Willow, to support 23 people, many of whom had complex needs. There was one nurse and four carers on duty on Beech Unit to support 25 people. Five people who used the service had carers from an outside care agency to provide one to one support during the day in line with their assessed needs.

The peripatetic manager told us there were generally enough staff. They showed us a tool which was used to determine staffing levels required according to the level of peoples' need. The date of the last assessment using this tool was July 2015. The tool calculated that 5.3 staff were required at night across both floors to meet people's assessed needs or two nurses and 3.4 carers. The peripatetic manager said they preferred there to be four carers on duty at night so that carers 'were not running between floors' when two carers were needed to support people through the night. We looked at the night rotas for week beginning 3 of August and saw on four of the seven nights there had been two nurses and three carers on the night rota. This meant that people requiring support to transfer on different floors at the same time might have to wait for two carers to become available.

Two members of staff we spoke with told us they felt there were not enough staff on duty. They felt this gave them little time to spend with people when supporting them with their personal care. One staff member told us "Ideally more staff would help us carry out more person centred care. We do a good job in the time we are given." These staff felt they didn't have time to socialize with people and felt they were rushing around trying to meet people's needs. Another member of staff we spoke with told us that there were enough staff to meet the physical needs of people who used the service but there was no time to sit and talk with people. Three members of staff we spoke with felt that there were enough staff. One said, "It's busy. There are normally three or four staff. We use quite a few agencies." One member of staff felt that there were enough staff at the moment. "It has got better in the last few weeks. There are not always enough staff, but we have got some new people."

During our inspection we observed a homely atmosphere where staff obviously knew people well.

We saw there were not always enough staff available to respond to people who required assistance in a timely manner. During lunch we observed one member of staff, who was supporting a person who used the service to eat respond to another person who required support with personal care. They supported the person to their room, leaving the chair and floor soiled during lunch. Having supported the person with personal care they returned them to the lounge, cleaned up the chair and floor of the dining room and returned to supporting another person who used the service to eat. There were no other staff members present. This meant there was also a risk of harm from infection to people and people were left unsupported in the dining area.

Around noon on Beech unit we observed a person going into another person's bedroom. The person started shouting at them to get out. There were no staff members around. The nurse in charge was alerted to this incident by a member of the inspection team.

We saw lunch commenced at 12.50pm and one person received their lunch at 1.30pm when staff became available to support them to eat. We observed that between 12.30 and 12.50 there was no staff presence in one of the lounges on Beech Unit. We carried out a SOFI in the downstairs lounge for 15 minutes and during that time, no staff came into the lounge or interacted with people. We observed a number of long periods where the "quiet lounge" on Beech unit had no staff presence, whilst there were a number of residents using the lounge. We observed in the upstairs lounge between 11.20am and 12.30 the only staff interaction was when a member of staff brought drinks in for people. While we did not observe any poor interactions this was a missed opportunity for better interactions with people who use the service. The above instances show that there were not always staff available to meet the needs of people in a timely manner.

We looked at three staff files to check that procedures had been followed to make sure staff employed at the home were suitable to work with vulnerable people. We saw staff members had completed an application form and references had been sought. One of the files we checked was for a registered nurse, we saw documented evidence the registered provider had checked to ensure the nurse's registration was current. This showed the registered provider had ensured staff members were continuing to meet the professional standards that are a condition of

Requires improvement

Is the service safe?

their ability to practise. We found that the Disclosure and Barring Service (DBS) had been contacted before they started work at the home. The DBS has replaced the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA) checks. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups. This meant there was a system in place to ensure staff remained suitable to work with vulnerable people.

Requires improvement

Is the service effective?

Our findings

Staff were not always provided with training and support to ensure they were able to meet people's needs effectively.

The staff we spoke with told us they had completed induction training when they started working at Southfield Court. They told us they shadowed more experienced staff for about three shifts before being counted on the duty rota. We saw in the file of one person who had recently started working at Southfield Court, there was no evidence they had completed an induction.

The members of care staff we spoke with told us they had completed e-learning in moving and handling, infection prevention and control, pressure area care, dementia, first aid, food hygiene, fire safety, mental capacity and safeguarding. Staff said the training was useful and gave them the skills and knowledge to do their job. One staff member told us they had been 'a resident for the day' and had enjoyed the experience. They told us it made them think about how they approached people and worked with them. Another staff member told us this was really good for staff to feel what it was like as a resident.

We saw on the homes computer system that mandatory training in safeguarding was 72% complete, infection control was 77% complete, fire safety 67% complete, equality and diversity 54%, food safety 48%, health and safety 54% and mental capacity 17% complete. The peripatetic manager told us they had put signs up in the staff rooms to remind staff to update their e-learning.

We sampled three staff members computer training records detailing the mandatory training that had been completed or renewed. One member of staffs training was all up to date. One was up to date except for the mental capacity training. The third was up to date apart from moving and handling theory and mental capacity. This showed us that some staff may not always have the skills and knowledge required to do their job effectively as some of their essential training was not up to date.

We saw on the homes computer system that moving and handling theory training was 50% up to date. The computer record showed that 39% of staff were not up to date with practical training in moving and handling. One member of staff we spoke with told us they had completed 2 days practical training in moving and handling conducted by a senior carer at the home, but this was not recorded on the system. The manager showed us registers from practical moving and handling training with the signatures of 13 members of staff completed since December 2014. Not all these staff members training records had been updated on the system so the computer system was not always an accurate record of training completed. This would make it difficult to ensure that the training needs of staff were monitored and addressed in order to ensure that people who use the service were protected from harm.

One of the nurses we spoke with told us some of their training needed to be renewed, for example in catheter care. We saw a nurses meeting had been held in June 2015 which discussed professional development and some training needed to be updated such as wound care identification and treatment, catheter care and phlebotomy. The peripatetic manager told us phlebotomy is not mandatory training for nurses at the home as district nurse would complete interventions that nurses at the home were not trained to complete. We saw that nurses' had completed mandatory training in other topics, for example, medicines management and competence checks, use of Percutaneous endoscopic gastrostomy (PEG) feeds and use of syringe drivers.

Staff did not always receive regular management supervision to monitor their performance and development needs and ensure they had the skills and competencies to meet people's needs

One member of staff we spoke with said, "In general I feel supported. I always speak to the nurse. I have never had supervision. I started working here a year ago." The home's policy on staff supervision was that supervision should take place six times a year including one appraisal. Two of the members of staff we spoke with could not recall having had an annual appraisal. The nurses we spoke with had not had any supervision with a manager in the last year. There were minutes of a group supervision meeting which had been attended by nurses.

We looked at the supervision matrix for 2015 and saw that two of the staff we spoke with had supervision in February 2015 and none since. The members of staff we spoke with told us this was correct. There was no evidence of the supervision that was recorded on the matrix present in the supervision files. We saw there were records of group

Requires improvement

Is the service effective?

supervision with the manager for two members of staff in March 2015. There were other documents related to supervision but these were haphazard, not filed and the matrix did not correspond to the records.

This represented a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because persons employed by the service provider in the provision of a regulated activity did not receive such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform.

The registered provider had policies and procedures in place in relation to the Mental Capacity Act 2005 (MCA) and consent. The MCA sets out what must be done to make sure the rights of people who may need support to make decisions are protected. Our discussions with the peripatetic manager and staff showed they had a good understanding of the MCA and issues relating to consent. One member of staff we spoke with said, "People are all different in their capacity and ability for decisions." Another said, "People have rights, protect them." Another said, "If I had any concerns about someone's capacity to make decisions I would talk to the nurse." One member of care staff we spoke with admitted that they did not understand the MCA or DoLs.

We saw in the care records we looked at that people had MCA and best interest decisions recorded in relation to important decisions. We saw that people who used the service had a cognition care plan which included information about capacity and consent, as well as a rights care plan. For example in one file the rights care plan said staff members and the person's relative could make simple decisions with the person, however, capacity and best interest meetings had been held in relation to bigger decisions, such as using a door sensor alarm. One member of staff told us that no one who used the service required restraint, but some may be resistive to care. They said they would talk to them, try different techniques, leave them and go back and try a different member of staff. We saw in the care files of two people that a mental capacity assessment and best interest decision was in place regarding hand holding during personal care. This meant that the rights of people who used the service who may lack the capacity to make certain decisions were protected in line with the Mental capacity Act (2005) and guidance.

We saw in the care file of one person who used the service that a best interest check list had been completed relating to support with hygiene, however neither the inspector nor the peripatetic manager could read the handwriting to understand what action needed to be taken in the persons best interest. Later in the day it was discovered that it was in relation to hand holding during showering, however a member of staff would have been unable to read the care record. This could result in the needs of the person not being met appropriately. The manager rectified this on the day of our visit.

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, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. We saw that mental capacity assessment had been completed with all people who used the service in relation to living at Southfield Court for the purposes of care and treatment and an application for a standard DoLs authorisation had been made to a supervisory body. We saw DoLs applications had been authorised for two people by the supervisory body responsible. We saw in the file of one person that a DoLs had been authorised in February 2015. The care plans discussed the risk of loss of autonomy as well as the benefits of the restrictions for the person. All the Dols paperwork was present in the file along with the contact details of the relevant person's representative. This meant that the human rights of people who used the service were protected and they were not unlawfully restrained.

People at Southfield Court were supported to have sufficient to eat, and drink and to maintain a balanced diet. One person told us "The food is very good. There is always a plateful." The people who used the service that we spoke with told us they enjoyed the food at lunch time. The visitors we spoke with had varied opinions about the food. One visitor said the food was very good and there was plenty of it. One relative said there wasn't enough cultural food offered such as halal meat or Caribbean food. This was confirmed by the menus we looked at, which were not culturally varied.

We observed lunch in the upstairs dining room and adjoining lounge. There was a choice of two main meals.

Requires improvement

Is the service effective?

The menu was: sausage and onion or beef stew with mashed potato, carrots and swede. The food looked appetising and the portions were good. There was no choice of dessert listed. Some of the menu items listed had picture cards on the wall, but not all. There was no vegetarian option listed. Staff told us if people wanted a vegetarian meal, the chef would be able to offer an alternative. We saw that staff supported and encouraged people to eat. Two people became distracted half way through their meals and started to leave the room. They were intercepted by staff who encouraged them to "Have a bit more dinner", or "Would you like your pudding now?" and persuaded them to come back to the table. Interactions between staff and people were friendly, respectful and supportive. People were not rushed with their food, and drinks were available throughout the day.

We observed two staff members supporting people to eat in their rooms on Willow unit. They supported the person to eat at their own pace, offering a drink at frequent intervals to help them swallow their food. In the downstairs dining room we saw that care staff spoke with a person in a friendly way whilst supporting them to eat and explained what they were doing. We saw a member of staff showed photo cards to a person in order to help them to choose their meal.

We saw in the care files of one person there was an eating and drinking care plan, which included an oral assessment, information about a pureed diet, thickening of fluids and a weight record. The person's choking risk assessment had been updated monthly.

The nurse on duty told us people were weighed either weekly or monthly dependant on risk. If weight loss occurred they informed the family and referred the person to the GP. All food at the home was fortified. The weight of all the people was recorded on the monthly observation reports to managers and a spreadsheet of people's weight across the year could be viewed to look for patterns in weight in order to take action. The peripatetic manager told us the system highlighted any issues of concern such as weight loss in red to make it clearer when action was required. This showed a system was in place to monitor the weight of people and to ensure staff acted on any concerns.

Daily food and drink intake was recorded in a daily record which was either kept in the person's room or in the nurses' office. We saw in the records of one person there was no record of the person eating an evening meal for the last four days. On one of the days, 'offered but refused' was recorded and there was no entry at all on the other days. We spoke with the peripatetic manager about this. They told us the person tended to eat at lunch time and there were no concerns about nutrition for the person. We looked at the person's weight records and saw that there had been no significant loss of weight. The manager said that staff had been told to record when food is offered and refused on every occasion.

We saw that whilst most people were informed of the choice of food and supported to eat at their own pace, one person who used the service was not supported to eat and drink in a way that maximized their nutrition and hydration in line with their assessed needs. We observed one person who was seated in the upstairs lounge from around 10.30am until 2.30pm. The persons eating and drinking care plan said that the person 'needs a lot of verbal prompts & encouragement during meals'. We saw staff gave some prompts, but these were irregular and no-one sat with the person to encourage and support them to eat. The person was slouched backwards which made it difficult for them to eat. The records on 12 August 2015, the day of our Inspection, said the person refused breakfast, had a mid-morning banana and cup of tea, ate lunch and pudding. The person was observed not to have eaten pudding, drunk the tea or eaten the entire banana. We discussed this with nurse on duty. The person had been recently admitted to the home and slight weight loss was recorded. The nurse told us the person had been referred to the GP and commenced food supplements. However the opportunity to improve nutritional intake through basic care and support had not been fully utilised by the home and the food intake had been inaccurately recorded.

We were told by staff that another person was at risk of weight loss and the GP was involved. We saw in the person's food record that no mid-afternoon, mid-morning snacks or supper had been recorded as being given from 3 August 2015 until the day of our inspection on 12 August 2015. Snacks were observed on the tea trolley to be available. This was a missed opportunity to support better nutrition.

The above issues meant people may be at risk of inappropriate care because accurate and appropriate records were not always maintained.

Requires improvement

Is the service effective?

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

People who lived at Southfield Court were supported to access healthcare. A visitor said “They're very good at getting the doctor in if there's a problem.” Another visitor said “They do keep an eye on things. They've been monitoring swelling on (person’s) hand. They keep me informed about things that happen. They call me at home if there's any problem, and if I'm worried I talk to the carers or the nurse. She's very good.” Residents and relatives we spoke with said that they or their relative received their medication on time and felt confident their health needs were being met. We saw that a relative noticed a mark on the arm of a person and the member of staff said it had been noticed that morning and the GP had been called and would be visiting that day. We saw appropriate medical attention was sought when people showed signs of ill health, for example, the GP was called to see a person who had become lethargic and did not appear to be responding to their prescribed medicines on the day of our inspection. The GP visited a number of people during our visit. The nurses we spoke with said the home had a good relationship with local GP’s. The staff we spoke with felt the nurses were good at referring people for health related support when required. During our inspection one person became ill and was taken to hospital. We saw in the care files of people they had regular access to health services, such as the optician, GP, chiropodist, district nurse and falls team. This showed people received additional support when required for meeting their care and treatment needs.

We saw the environment had been designed to support people living with dementia to live well, however people who lived at Southfield Courts individual needs were not always met by the adaptation, design and decoration of the service.

Handrails were available along all the corridors to aid mobility. The corridors on Beech unit had themes for orientation and stimulation, such as music, gardens, the library, seaside, hobbies and interests. There was a games themed corridor with pictures of darts players from the 1970s and 1980s next to a dart board which was relevant to the age group of people who used the service. The colour of the bathroom and toilet doors was identical and different to the colour of all the bedroom doors for identification and orientation. There was seating on the corridors.

The bedrooms of people were numbered and named with a life history about each person on display outside their room. People’s bedrooms were clean, odour free and personalised. In the shower room the toilet had a blue seat and hand rails in contrast to the wall colour to support its safer use by people who may be visually impaired. The dining rooms had pictures on walls of coffee, food and drink and there was a reminiscence board with the day, date and weather.

One visitor said “It's such a lovely day, but sadly the back garden isn't accessible.” It was a hot sunny day on the day of our inspection. We were told that the garden was not secure and so people were not able to go outside without staff. The peripatetic manager said that a request had been submitted for this work as the handy person had been off sick for several months. This meant that only one or two people were able to go outside with the support of the activity coordinator on the day of our inspection.

In the lounge on Beech unit we saw chairs were arranged around the edge of the room, which was not conducive to social interaction. The TV was on the wall above the fire and so people seated to the side of the fire were not able to see the TV should they wish to do so. This meant that peoples well -being was not always effectively supported by the environment.

Good

Is the service caring?

Our findings

The service was caring. One visitor told us "The nurses are nice." Another said, "They've helped me find the firm to get their chair made. I feel like they support me too. They know I'm anxious at the moment and they're very good and kind." One member of staff providing 1:1 support for a person who used the service said, "This is one of the nicest homes I've been to. I think the staff are quite good here. The way they speak to people."

During our inspection we observed staff speaking with people in a kind, caring and respectful manner. Visitors told us they could 'come and go' as they pleased and that they were kept informed of things that happened to their relative when they weren't there. Staff clearly knew residents and visitors well. One member of staff told us some staff worked on the same unit for continuity and others worked across both units as staff need to know the needs of all the residents. One of the nurses on duty told us, "We try to ensure that we use regular agency nurses and try to have the homes own nurse on duty each day for consistency." This meant most of the time, people were supported and cared for by staff who knew them.

Staff we spoke with enjoyed working at the home and supporting people who used the service. One staff member told us "I love working here; I really enjoy spending time with the residents." One member of staff we spoke with said, "The residents and staff are lovely." We saw one person having their nails painted. The activity coordinator sat down next to the person and spent time talking to them, explaining what they were doing. We saw their interaction was warm and respectful. We heard staff speak with people in a kind and caring way whilst supporting them to eat and also when offering a choice of meal and drink

People were supported to make choices and decisions about their daily lives. We saw care files of people contained information about their tastes and preferences in the 'this is me' section. For example their favourite colour, that they were scared of the dark and liked to talk to people, listen to Tom Jones and watch the Two Ronnie's. There was a section on lifestyle choices and a communication care plan which indicated how people could be supported to communicate their preferences. Staff we spoke with felt they had a good understanding of the needs of people. The care plans had a personal history of the person. This gave staff a rounded picture of the person and their life and personal history before they went to stay in the home.

The members of staff we spoke with were aware of how to promote the dignity and privacy of people who used the service. One said, "Close curtains, knock on doors, give them options. Think about the person not the dementia." We saw a member of staff informing a person who was in a recliner chair what they were doing before moving the chair to a more upright position in order to support the person to drink. We saw that a member of staff wiped the mouth of a person after explaining what they were doing in a friendly and discrete way. We saw that whilst people were using the hoist to transfer, staff spoke encouragingly and reassuringly to them and informed them what they were doing and why. We saw that there was a dignity curtain around the shower area in the shower room and people's wardrobes were tidy and contained their own labelled clothing. We saw that clocks in communal areas and bedrooms were all set at the correct time. Staff felt people were treated with dignity and respect. We saw staff knock on people's doors before they entered and speak with people in a respectful way. We saw that one person was walking down the corridor at 10.40am in their night clothes, which were slightly soiled at the back. Two members of staff walked past them and spoke nicely to them but didn't check to see if the person was ok. This meant that on that occasion the person's dignity was not promoted.

Requires improvement

Is the service responsive?

Our findings

Activities were provided at Southfield Court but this was not at a level which would meet the needs of all the people living at the home. One visitor said "Activities are very important. Us relatives did some before the two activities coordinators were hired. Two were appointed but one is off sick. Relatives help with some activities, such as baking and music events. I'd like the activities coordinators to have more hours."

An activity coordinator was contracted for 23 hours and was currently working for 30 hours a week, six hours a day over five days. Another activity coordinator who was contracted for 18 hours had been on sick leave for six months and not all these hours had been covered by other staff. The activity timetable was not visible in the home and we were told this was because there was no handyperson to hang the notice board. We requested the timetable and saw it included holy communion, ball games, sensory items, nail painting, reminiscence cards and books, baking, gardening, crafts, board games, movies and trips to village. The activity co-ordinator told us, "Today we did sensory activities like stacking cups. I take people into the village quite a lot. Some of the wives help out. We go in the garden quite a lot. The garden needs securing. I would like to see that happen." One of the staff members we spoke with told us some people who lived at the home went to a local 'Singing for the Brain' group run by the local Alzheimers Society. The activity co-ordinator told us, "The best thing about working here is the enjoyment people get from activities I do. It makes a difference spending 10 minutes with someone."

We saw in one person's journal the activities that had been recorded were a birds of prey visit to the home on 11 July 2015, visits from relatives on 1, 2 and 8 of August 2015 and sat out with member of staff on 7,9 and 12 August 2015. The activity co-ordinator noted in the daily journal that they had looked at a book or painted their nails, but on six out of the last 12 days no activities were noted. Another person's journal recorded activities on 4 August 2015, holy communion & musical instruments, on 7 August 2015, listening to music, on 8 August 2015visited by a friend. On three out of the six days we looked at no activity had been recorded. The activity co-ordinator told us, "I would like to see care staff being able to do activities with people when I am not here." Enabling people who are living with dementia to take part in meaningful and enjoyable activities is a key part of 'living well with dementia'.

People at Southfield Court received personalised care that was responsive to their needs. The staff we spoke with had a good awareness of the support needs and preferences of the people who used the service. We saw in the care files of people that their preferences and interests were recorded in the 'my preferences', for example one person liked watching football, mint tea, mineral water or a small beer. We saw care plans were person centred and provided information about the individual that would enable them to receive person centred support, for example, the person wears their hair short with a side parting and prefers to wear pyjamas in bed. This is important as some of the people who lived at the home had memory impairments and were not always able to communicate their preferences.

Care plans covered areas such as mobility, hygiene, communication, continence, medication, skin integrity, rights, finances, relationships, cognition and emotional needs. Care plans were reviewed monthly by the nurse on duty and we saw these reviews were signed and up to date. These reviews helped in monitoring whether care records reflected people's current needs so that any necessary actions could be identified at an early stage.

One staff member told us the care plans were not always easy to read because of the hand writing. This was confirmed in two of the nine care plans we looked at. We saw that changes to the care plans had been made as necessary following changes in the person's needs. One relative was unsure whether their relative was having two showers a week as they had requested and when we checked in the care file we saw that two showers a week were being recorded. This showed care planning took account of people's changing care needs.

One relative we spoke with told us they were invited to their relative's annual reviews and their daughter attended for them. Relatives we spoke with told us they were included in care plans and reviews and that they felt fully involved in and informed of developments in their relative's condition. One relative said, "I am involved in discussing their care plan and if I have any worries I talk to the named worker." In seven out of the nine care plans we looked at there was evidence that people who used the service or

their representative had been included in their development. We were told no one had an advocate at the time of our inspection, but staff were aware of how to refer for advocacy if needed. We saw in the care file of one person that an annual review had taken place in March 2014. We did not see evidence that a further annual review had taken place since. The peripatetic manager told us that new care plan documents that were being introduced including six monthly care plan review meetings to which relatives would be invited.

One visitor said "We were a bit disappointed this morning that we found (relative) still in bed. It's a lovely day, and it would have been nice to take (relative) out." We spoke with a member of staff regarding this and they told us that the person usually gets up after lunch so that they can go out with their spouse in the afternoon without pressure care being an issue. We saw in the care plan that the person needed support with repositioning four hourly in bed and two hourly in their chair. This meant that care practice reflected the care plan and the assessed needs of the person.

Staff told us there was a handover between all shifts. A handover sheet was used to give agency staff basic information about each person, their room number, if the person needed hoisting, health needs and any key information. One member of staff said "Sometimes you don't get the best handover, and so it's hard to know what's happening with people and how they've progressed. It's hard to catch up". Another member of staff told us, "There is a daily journal in each room. Relatives and staff can make comments about the person's mood or activities."

We saw from the daily journal in three people's bedroom that their daily food and drink intake was monitored, as well as position changes and the person's mood was noted and any interactions with staff or activities. Some people had been assessed as being at risk of developing pressure ulcers and staff had to reposition people every two hours to prevent the development of pressure ulcers. We looked at the repositioning chart for a fourth person who used the service. The chart showed that staff had stopped recording position changes after 10:30pm. We talked to the regional manager about this and they told us they would address this with the staff.

This meant people may be at risk of inappropriate care because accurate and appropriate records were not always maintained.

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

We observed staff offering choices, whether they wanted their desserts sweetening, or the colour of nail varnish they preferred. One member of staff we spoke with told us that people who used the service are usually supported to rise for the day between 9 and 10am. "People are able to get up earlier or eat in their rooms if they wish." This showed that the service responded to the needs and preferences of people who use the service.

People who were able to do so and relatives, told us they would feel comfortable raising issues and concerns with any of the staff. One relative told us they had set up a relatives support group. This has replaced the in-house relatives and residents meetings, which had not been well attended. The manager attended for part of the time, to hear concerns raised. The new group had built links with the local church and there was a Holy Communion offered twice a month in the home. The visitor who started this group told us that they had been involved in recruiting the new home manager. Another visitor told us they had been invited to a relatives meeting a while ago but hadn't attended

The peripatetic manager told us there had been no recent complaints. We looked in the complaints and compliments file for the home. A thank you letter from the relative of a person who used the service in December 2014 said, 'the staff always polite and caring, treated my dad as a person, not a number and this kept his dignity.' Another complimentary letter was received in January 2015. In February 2015 a relative complained about care records not being filled in and the pressure mat not working in their relatives' room. The action taken was noted as mat replaced and paperwork issue addressed in supervision with staff

We asked the peripatetic manager how they gained the views of people who used the service or their representatives. They told us, "I used to walk round and talk to service users' and relatives were always talking to me. They can also use the ipad in the foyer to feedback." We saw that one relative had used the ipad to provide feedback to the home in August 2015 and they were, "likely" to recommend the home to a friend. The peripatetic manager told us they had done a survey of the quality of the food, which resulted in different snacks being offered between meals such as crisps. One relative told us the food

Requires improvement

Is the service responsive?

never seemed to be warm enough, but following a food survey it had improved. This demonstrated people's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

The peripatetic manager said if people are not happy with any aspect of the service they could talk to her and she would deal with it straight away. One visitor told us they did feel the service listened to them if they weren't happy, for example, they had complained about their relatives' room not being cleared of cups and this hadn't been an issue since. One visitor said, "I think that they should all have their own towels and flannels in their rooms, but they have to go to the laundry." A member of staff also said "Sometimes when we come on in the morning, the linen cupboard is empty, if it's been a bad night, and there are no towels until the afternoon." The peripatetic manager told us that she had ordered extra towels whilst she was managing the service and would look into why this was still problematic. An Issue of a person's clothes not being ironed was raised at a relatives meeting in January 2015 and this concern was also raised by a relative at our inspection. They told us, "My biggest moan is the laundry. Shirts are not ironed. My relative has always been very smart and proud. I took the shirt to the manager, but it still wasn't ironed." The manager said they had dealt with a lot of minor issues; however these had not been recorded. This meant there was not always evidence to show comments and verbal complaints people made had been responded to appropriately.

Requires improvement

Is the service well-led?

Our findings

The home was not always well led. One relative said, “I feel it's a good home, I wouldn't have my relative here if I didn't”. Another said, “I've seen a lot of changes here over the years. I feel like it's moving in the right direction now. We have high hopes of the new manager.” Another relative we spoke with said, “The new manager seems very, very nice.” When asked if they would recommend this home one relative said, “Yes and no. Some of the staff and nurses are very nice. I think it needs pushing a little bit.” One visitor said “I think it’s good in comparison to other homes.” Another said, “They spend money on daft stuff and leave the basics.”

The staff we spoke with looked forward to having a manager in place. They told us they felt the service had been impacted upon because there hadn’t been a manager in place for some time. One member of staff told us that the recent peripatetic manager had a ‘very calm approach, never got irate, spoke to staff in a lovely way.’ And the new manager seemed approachable.

The new manager of the service had been in post for three weeks and was not present on the first day of our visit as they were attending induction training. They were present on the second day of our visit. We asked the new manager about their philosophy of care and they told us that they supported the registered providers PEARL system, which stands for positively enhancing and enriching residents lives. Information on the wall of the home explained the PEARL system which is a method of ensuring that support to people was dementia friendly, including dementia mapping, dignity, occupation and attachment. We saw that a PEARL advisor was completing an audit of care plans looking at issues of support for people living with dementia on the day of our visit. This meant the manager was open to new ideas and keen to learn from others to ensure the best possible outcomes for people living within the home.

We saw that during the peripatetic managers three months working at the home they received one visit from a regional manager. The temporary manager told us that she had discussed management support with regional managers and the new manager had received a number of support visits. She was also supporting the new manager for one day a week for four weeks to ensure continuity. The new manager said that they felt supported. They had completed 2 days of induction training and two more were planned for later this month. The new manager had completed NVQ level 5 in management prior to commencing work at the home.

One visitor said “The staff are very good. I am hopeful that the new Manager will support the nurses. We need some leadership, I don't think the nurses are supported enough to build teams in their sections.” Meetings with staff, people who live at the home and their relatives are an important part of the registered provider’s responsibility in monitoring the service and coming to an informed view as to the standard of care and treatment. We saw that a nurses meeting had been held in June 2015 which discussed issues such as room documentation being checked and completed, implementing the new care plan formats, cleaning to be done by care staff and professional development. One member of staff told us that the home “Has the potential to be a lovely home, we have some fantastic staff.” They told us that staff meetings were hit and miss. “We express things in the meeting, but nothing changes.” They felt that team work and communication were an issue at present. Some staff we spoke with felt the team worked well together on the whole. One staff member told us “Some staff are new and need more guidance; this had led to a lack of consistency.” Another told us “I would like to see a more uplifting atmosphere and I am looking forward to the meeting with the new manager.” We were told that the new manager had arranged a staff meeting in a few weeks’ time.

We found there were gaps in the way the registered provider monitored the overall service. A variety of checks were carried out on a monthly basis by the manager including checking that nurses registration was up to date, observing lunch, hoist and sling checks, mattress checks, updating the needs and staffing level assessment and evaluation of care plans

We asked the managers about audits at the home. We were shown the home's audit

schedule. Audits included; medication, skin integrity, infection control and falls and mental capacity assessments that had been updated. We saw on 3 August 2015 falls figures for 2 years had been printed out to see any patterns that might help with future prevention. We saw follow up actions were recorded on the registered provider's computer system and stayed on the 'to do' list until they were completed. We saw the regional manager

Requires improvement

Is the service well-led?

had visited on 6 August 2015 and completed a medication audit and daily walk round with the new manager. We saw that action had been taken to improve the quality of the service for example, all the cushions on chairs in the communal areas had been replaced in July 2015. Following a daily walk round by the new manager we saw evidence that a new head board had been ordered for a bed and staff had been spoken to regarding spilt food and dirty nails of one of the people who used the service. A quality facilitator has been employed by the provider in January 2015 to improve quality assurance systems across a number of homes. A quality and clinical governance meeting had been held in January 2015 and discussed various issues including complaints from relatives, training, and medication management systems. This demonstrated the home had a quality assurance and governance systems in place to drive continuous improvement, however this system had not picked up the issues we found with premises safety, the administration of medicines, staff training and support, and keeping accurate records.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who used the service, staff and visitors were not always protected against the risks of unsafe or unsuitable premises because the service had not carried out the necessary safety checks and addressed issues noted by the local fire safety office which ensured people were kept safe. Regulation 12 (2) (d).

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 Medicines were not always administered in a safe way for service users because appropriate arrangements were not in place for recording, safe keeping, dispensing, safe administration of medicines used for the purposes of the regulated activity. Regulation 12 (2) (G)

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not always maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Regulation 17 (2) (c)

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Action we have told the provider to take

Treatment of disease, disorder or injury	Persons employed by the service provider in the provision of a regulated activity did not receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2) (a)