

Central and Cecil Housing Trust

Homemead

Inspection report

28 Park Road
Teddington
Middlesex
TW11 0AQ

Tel: 02089775002
Website: www.ccht.org.uk

Date of inspection visit:
29 August 2017
30 August 2017

Date of publication:
09 October 2017

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

We inspected Homemead on 29 and 30 August 2017. The inspection was unannounced. We had previously carried out a comprehensive inspection in November 2015 where the overall rating was Good.

Homemead provides accommodation and personal care for up to 26 older people with dementia. At the time of our inspection there were 25 people living in the home. The home is situated in its own grounds and has three floors, served by a lift.

The home has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

People who lived at the home were protected from the risk of abuse happening to them. People told us they felt safe and well cared for at the home and they would not be afraid to tell someone if they had any concerns about their safety or wellbeing. Comments included "They are all very kind" and "The staff are lovely."

However, there was a risk to people that they may not always receive medicines in a safe way because of discrepancies in recording and reporting as well as a lack of clarity amongst staff of areas of responsibility towards aspects of medicines management.

Staff provided attentive care to people. However, we found that at times there were insufficient numbers of staff on duty and that reviews of staff ratios had not fully taken into account the needs of people or views of staff.

There were systems in place to audit and monitor the quality of the home. However, these were not used sufficiently well to enable the provider to evaluate and improve their practice.

Risks to people's health, safety and welfare were well managed. Risks had been assessed and where appropriate a risk management plan had been put in place for aspects of people's care and support. Risk management plans covered aspects of care such as, nutrition, choking, mobility, moving and handling, pressure care, physical and emotional health. These then formed part of the persons care plan.

Risk management plans clearly identified what the risk was and provided staff with instructions about how they needed to manage the risk to ensure people received safe care and support whilst enabling them to remain as independent as possible.

The premises were free from hazards and were clean. The outside areas had some debris, old leaves and general untidiness which could, if left unattended present a risk of slipping or other damage to people or

visitors. The registered manager and operations director assured us that this would be quickly looked into.

There were procedures and policies in place to control infection. We looked around the home and saw that all areas were clean and hygienic. Staff had received infection control training and records confirmed this.

People spoken with were happy with the support provided by the staff working at Homemead. One person told us, "The staff are very helpful and do all they can." A relative said, "I can't fault them. They know exactly what to do and how to make [my relative] comfortable."

There was a consistent team of staff working at the home who were appropriately trained. The provider had made improvements in reducing dependency on agency staff over the previous 12 months and all staff were now employees of the organisation.

The home ensured that wherever possible people were asked for their consent before care plans were agreed, medicines given or access to their rooms or personal information was requested. Records of signed consent forms were contained in people's care records including Do Not Attempt Resuscitation (DNAR) forms where people had requested these.

We observed staff supporting people to choose and prepare their lunch as appropriate. The chef spoke passionately about how people were consulted about their meal preferences and how menus were planned with the aim of making the meals not only nutritiously balanced but presented in a way that encouraged people's appetites.

When we visited at night we found that people were able to request snacks, including cereal and toast, as well as having plenty of fluids such as tea or juice.

People told us that the staff were kind and caring towards them and felt that staff had positive caring relationships with them. One relative told us, "The home is small and friendly. The staff work very hard and are very caring. We can visit anytime."

People's privacy and dignity were respected and promoted. Some people chose to spend time in their room, others chose to sit in quiet areas or move freely around the units. People and relatives told us it was their choice to spend time alone in their rooms and that staff respected their decision.

Bedrooms were personalised with people's belongings, such as ornaments, family photographs and small pieces of furniture. People received personal care either in their own room or bathrooms with doors closed. During our inspection we observed how staff interacted with people who used the home and found it to be respectful and sensitive. For example, before entering a bedroom or bathroom, staff knocked and waited before opening the door.

People said they felt confident that any problems or complaints that might arise would be dealt with by the management in a satisfactory way. A copy of the complaint's procedure was displayed near the main entrance to the home. This procedure told people how to complain, who to complain to and the times it would take for a response.

The home demonstrated good management and leadership through having an experienced registered manager in place with the support of a deputy manager and senior staff members leading on each shift. The registered manager understood their responsibilities and was supported by a wider managerial team.

You can see what action we told the provider to take at the back of the full version 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?

The service was not always safe. We found that there were some discrepancies in medicines recording and that there were insufficient numbers of staff deployed to provide safe care to people.

Training records showed staff had received training and guidance on safe care.

People who lived at the home were protected from the risk of abuse happening to them and staff were supported with information to guide them in the event of a safeguarding concern being identified.

Requires Improvement ●

Is the service effective?

The service was effective. People were supported to have their assessed needs, preferences and choices met by staff with the necessary skills and knowledge.

Staff understood the relevant requirements of the Mental Capacity Act 2005 and the rights of people to make their own choices where possible. Where people lacked capacity staff acted in their best interests.

People were supported to have enough to eat and drink. Meals were appropriately spaced and flexible to meet people's needs and people had a diet that was balanced and nutritious.

People were supported to maintain good health and had access to healthcare services which offered on-going healthcare support.

Good ●

Is the service caring?

The service was caring. Positive caring relationships were developed with people using the service and they were treated with kindness and compassion in their day-to-day care.

People were supported to express their views and be actively involved in making decisions about their care, treatment and support.

Good ●

Is the service responsive?

The service was responsive. People received personalised care that was responsive to their needs.

The service had systems and guidance in place to enable people to raise concerns and for those concerns to be listened to and learned from.

Good 

Is the service well-led?

The service was not always well-led. Existing quality assurance systems were not used sufficiently well to enable the provider to evaluate and improve their practice.

The service demonstrated good management and leadership through the registered manager, deputy and team of senior staff.

The registered manager and staff promoted a positive culture that was person-centred, open, inclusive and empowering.

Requires Improvement 

Homemead

Detailed findings

Background to this inspection

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

The inspection took place on 29 and 30 August 2017 and was unannounced. The inspection was carried out by two inspectors.

Before the inspection we reviewed information we had gathered from the home. This included notifications and other communications sent by the home and a Provider Information Return form which asked the provider to supply us with information.

During the inspection we spoke with eight people who used the service, two relatives, two visiting professionals and a visitor. We also spoke with the registered manager, the deputy and 5 members of staff, as well as with the home administrator and two members of the senior management team.

We reviewed policies, procedures and records held in the home, including four staff records, four care records and four medicines records.

Is the service safe?

Our findings

People were not always supported in a safe way when receiving their medicines. We looked at a sample of medicine administration records (MAR) and spoke with the person designated as the "Medicines Champion". We looked at the MAR for four people. Sample staff signatures were on the front of the MARs which were helpful for auditing and quality monitoring.

We noted that one person was not provided with a particular medicine on 14 and 16 August but was provided with it on 15 August. The two missed days could not be explained. For another person we saw that the number of tablets remaining to be administered was greater than they should have been, had they been regularly administered at the correct dosage.

Staff told us they did not count the number of pills in a packet before or after giving the medicine and the Medicines champion when asked said the medicine audits were not her responsibility. But the chart in the staff room said that it was.

These issues meant that there was a risk to people that they may not always receive medicines in a safe way because of discrepancies in recording and reporting as well as a lack of clarity amongst staff of areas of responsibility towards aspects of medicines management.

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

The medicines trolley was securely locked and was stored on the ground floor. Records of temperatures taken of the medicine storage room and fridge were taken daily. During July and August fridge ranged between 2 and 8 degrees and room between 20 and 28 degrees. This satisfied the storage conditions for most medicines which are that medicines stored in a fridge between 2-8°C OR in a room with temperatures above 25°C (although some medicines now suggest storage not above 30°C).

The senior on night care duty was able to demonstrate how medicines were administered to people and this was done in a safe, competent and caring manner. There was a clear list of people who required medicines to be given covertly, and this was confirmed in their care plan.

The home did not always deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they could meet people's care and treatment needs. During the day, between 8am and 8pm there were normally two senior care staff with three care assistant staff on duty, with one of the senior care staff acting as a care assistant. This was to provide care for 25 people over three floors.

We were informed that up to six people who each required the support of two care staff whenever they required help or assistance. The number of day staff on duty had been reduced as the number of people living in the home had reduced. Previously there had been the equivalent of one senior care staff and five

care assistants working during the day. In staff supervision notes that we looked at we saw that this had been raised as an issue in February 2017, where it was felt that reducing the number of care assistants from five to four did not take account of the needs of people in the home.

Our own observations during the inspection were that staff were constantly busy and attentive to people's needs. Many of those needs were for people in their own rooms which left many people in communal areas unattended at times and with little to engage them.

When we visited at night we found there was one senior care staff with two care assistants. At the time of our night visit there were 15 people still active as well as a further ten who were receiving assistance with personal care and going to bed. The senior care staff was occupied with the administration of medicines. The two care assistants on occasion had to be absent from the communal areas of the home at the same time, as they were required to assist people on different floors. This meant that there were occasions when there was no one present to ensure people's safety whilst moving around or to attend to requests for assistance.

Monthly checks by the registered manager to the home at night had also recorded that 15 people were still active at night. We were therefore satisfied that the number of people awake at night times was fairly consistent.

The latest brochure for prospective residents of the home states that "We guarantee a staff to resident ratio of 1:5 at peak times". The brochure did not specify what it meant by "peak times". However, we found that between 11pm and 12 midnight there were over half of the home's 25 people still active, but with only three staff on duty.

Records of staff supervision indicated that the issue of staffing numbers at night had also been a matter of concern to staff and had been raised although it was not clear what action had been taken to explore this further. We noted that monthly night visits by the registered manager usually lasted one hour between 10pm and 11pm and that this length of time may not be sufficient to experience the full impact of caring for 25 people with only three staff. During our night visit people were still active between 12 midnight and 1am.

We saw that one night visit audit completed by the registered manager in July 2017 made mention of a person whose behaviour required support. It also stated that staff were advised to use their mobile phones when assisting people in order that they could contact each other in an emergency.

All of the above were indicators that there were insufficient numbers of staff on duty in the home to make sure that they could meet people's care and treatment needs.

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

People who lived at the home were protected from the risk of abuse happening to them. People told us they felt safe and well cared for at the home and they would not be afraid to tell someone if they had any concerns about their safety or wellbeing. Comments included "They are all very kind" and "The staff are lovely."

Staff were supported with information to guide them in the event of a safeguarding concern being identified. For example we looked at the home's safeguarding policies and procedures and saw that they were reviewed and updated regularly. These included safeguarding, complaints and whistle blowing procedures.

The registered manager and staff were able to tell us the procedure and actions they would take in the event of a safeguarding allegation, which demonstrated that the provider would respond appropriately to any allegation of abuse with the aim of keeping people safe. Staff were knowledgeable about the different types of abuse and the signs which indicate abuse may have occurred.

Care workers and senior staff were familiar with Whistle Blowing. One member of staff told us "I would contact CQC or social services if I felt no one was doing anything about bad practice."

Staff told us they had completed up to date training in safeguarding and records confirmed that staff had either attended safeguarding training in the last 12 months or were due to attend the next scheduled training event. This included refresher training. In staff rooms and communal areas there was guidance and relevant contact details for people in the event that they might wish to raise a concern, complaint or provide feedback.

Risks to people's health, safety and welfare were well managed. Risks had been assessed and where appropriate a risk management plan had been put in place for aspects of people's care and support. Risk management plans covered aspects of care such as, nutrition, choking, mobility, moving and handling, pressure care, physical and emotional health. These then formed part of the persons care plan.

Risk management plans clearly identified what the risk was and provided staff with instructions about how they needed to manage the risk to ensure people received safe care and support whilst enabling them to remain as independent as possible. For example, one person had a behavioural risk assessment which included relevant signs to look out for as well as possible ways to resolve any issues. Incidents that had occurred were fully documented.

The provider had a staff recruitment and selection policy and procedure. Recruitment procedures ensured that people were protected from having unsuitable staff working at the home. We viewed a sample of five recruitment records and found that information and checks required by law for recruiting new staff were obtained. The recruitment process included details of previous employment, checks made under the Disclosure and Barring Scheme (DBS) and reference checks. Staff confirmed that they had completed an application form, attended interview and underwent appropriate checks prior to starting work. This ensured staff were fit and suitable to work in a care setting.

Training records showed staff had received training and guidance to enable them to care for people in a safe way. In addition to safeguarding training, training also included first aid, moving and handling and fire safety. Staff had been trained to use specialised equipment, such as hoists, safely. This helped people and staff to feel reassured when using such equipment.

The premises were free from hazards and were clean. The outside areas had some debris, old leaves and general untidiness which could, if left unattended present a risk of slipping or other damage to people or visitors. The registered manager and operations director assured us that this would be quickly looked into.

There were procedures and policies in place to control infection. We looked around the home and saw that all areas were clean and hygienic. Staff had received infection control training and records confirmed this.

Is the service effective?

Our findings

People spoken with were happy with the support provided by the staff working at Homemead. One person told us, "The staff are very helpful and do all they can." A relative said, "I can't fault them. They know exactly what to do and how to make [my relative] comfortable."

There was a consistent team of staff working at the home who were appropriately trained. The provider had made improvements in reducing dependency on agency staff over the previous 12 months and all staff were now employees of the organisation.

People were supported to have their assessed needs, preferences and choices met by staff with the necessary skills and knowledge. Staff told us they had opportunities for on-going training and there was a system in place to make sure staff received relevant mandatory training that was kept up to date. Records showed that staff had undertaken training across a number of areas. In addition to those already mentioned other training included dementia awareness, mental capacity, equality and diversity and person centred care.

Staff told us, and records confirmed that they were supported by the registered manager and senior staff both through formal one to one supervision meetings and more informal day to day contact. During these meetings issues were raised, performance was discussed and training was arranged. There were regular staff meetings and handover meetings where information regarding the home and the care of people could be exchanged.

The home ensured that wherever possible people were asked for their consent before care plans were agreed, medicines given or access to their rooms or personal information was requested. Records of signed consent forms were contained in people's care records including Do Not Attempt Resuscitation (DNAR) forms where people had requested these.

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).

The manager had submitted DoLS applications for authorisation where people's liberty had been restricted in the home. At the time of our inspection 23 people had DoLS authorisations.

Staff had completed MCA and DoLS training that helped them to understand issues around capacity and support people effectively. Throughout our inspection staff offered people choices and supported them to make decisions about what they wanted to do.

People told us they enjoyed the meals provided to them and could choose what they wanted to eat. One person told us, "You always get nice meals here. Sometimes I can't finish it all."

We sampled the food at lunchtime and found that what was on the menu was what was available on the day. We saw that people had a choice from the main menu, and those who did not wish anything from the menu would have a specific alternative meal provided. People could eat where they found it most comfortable and communal dining areas were designed to allow small groups of people to eat together

We observed staff supporting people to choose and prepare their lunch as appropriate. The chef spoke passionately about how people were consulted about their meal preferences and how menus were planned with the aim of making the meals not only nutritiously balanced but presented in a way that encouraged people's appetites.

When we visited at night we found that people were able to request snacks, including cereal and toast, as well as having plenty of fluids such as tea or juice.

People's health needs were met. Health action plans addressed people's past and current health needs and staff kept accurate records about people's healthcare appointments and any action required. There was information about each person which helped hospital and other clinic based staff understand how best to support a person, should they ever need to attend a hospital.

We saw that the home worked well with other agencies such as pharmacist, GPs, social services and health services. During our inspection we saw and spoke with a visiting nurse and an advocate for someone. Both spoke positively about the home and the staff team.

Is the service caring?

Our findings

People told us that the staff were kind and caring towards them and felt that staff had positive caring relationships with them. One relative told us, "The home is small and friendly. The staff work very hard and are very caring. We can visit anytime."

During our inspection we observed how staff and people interacted with each other and how they spoke with each other. We found that staff knew people well, understood their diverse needs and abilities and spoke with them in a kind and respectful manner. Staff supported people in an unhurried manner, moving with people at their own pace and allowing enough time for people to do what they wanted to do.

Activities in the home, along with other events such as mealtimes or appointments for administration of medicines were offered in such a way that people understood to the best of their abilities that they had a choice.

We found that people were involved in making decisions and planning their own care. Care plan reviews and risk assessments took the views of people and their relatives into account. This was complemented by some staff having attended a training session on "Rights, Choice and Risk" when providing care to people with dementia. Throughout the day we saw and overheard behaviour and conversations between people and staff which focussed on staff making sure that people understood what was happening and could make choices.

At night, the situation was similar, with the senior care staff leading the care assistants by example by demonstrating good personalised care which involved people and engaged them. In contrast, the two night care assistants, whilst polite and helpful, did not interact positively with people using the home without prompting from the senior care staff.

Looking at staff records we noted that the two night care assistants had been employed for less than 12 months. This allowed us to have a discussion with senior management regarding the benefit of possibly having the more experienced staff working at times when there was least opportunity for wide supervision and guidance, particularly as a significant number of people were still active at night.

People's privacy and dignity were respected and promoted. Some people chose to spend time in their room, others chose to sit in quiet areas or move freely around the units. People and relatives told us it was their choice to spend time alone in their rooms and that staff respected their decision.

Bedrooms were personalised with people's belongings, such as ornaments, family photographs and small pieces of furniture. People received personal care either in their own room or bathrooms with doors closed. During our inspection we observed how staff interacted with people who used the home and found it to be respectful and sensitive. For example, before entering a bedroom or bathroom, staff knocked and waited before opening the door.

We listened to how staff spoke with people and found this was relaxed and casual as well as appropriately professional, with staff addressing people by their preferred name. Staff responded promptly when asked a question and took time to explain their actions. For example, staff reminded someone who had entered and left a room several times where they were and offered suggestions such as going for a walk or joining in with the game in the lounge that was happening.

We spoke to visiting professionals who told us they felt happy with the caring attitude of the home. One professional told us, "The staff are a good group. They are good at communicating and are very caring. They follow advice and act on any nursing recommendations we give."

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. One person told us, "I get everything I need here. I'm very happy." A relative said that she was pleased at the way staff knew her relative's routine and said, "We couldn't ask for more, really."

During our inspection we saw that one person received the support of an advocate who visited once per week and who told us, "The home seems nice, staff are very nice and chat to people."

Care records were individual to each person and contained information about people's life history, their likes and dislikes, cultural and religious preferences. Care records included details such as personal achievements, places visited and family relationships. In some care records there were sections titled "This is Me" and "My Life Story". The registered manager and staff described the purpose of these as providing a more person-centred profile of people and their life history, their achievements and interests so that staff could get to know people on a more intimate level.

The registered manager confirmed that there was a review of personalised documentation taking place. At present there was information contained in people's "Hospital Passports", "This is Me" and "My Life Story". There was a plan to pull the relevant information into just one simplified document.

The registered manager and staff also spoke positively about the "Resident of the day", where someone would have a special focus and where staff would engage with them on activities and interests of their choice. Details of who the person was were displayed and all staff were aware. One member of staff told us, "It gives us a chance to be with people on a different level."

People's requests for assistance throughout the day were responded to promptly and call bells were responded to within a reasonable timeframe.

We observed, and people confirmed they were able to come and go as they pleased, including when to get up or go to bed. The home also supported people to maintain relationships with family, relatives and friends. This was achieved through an open door visiting policy, regular meetings for relatives where they could share information and ideas, and involvement in the care plans of people.

One relative told us how they accompanied their relative on a river trip with staff and said that there were plenty of activities for people who wanted them. During the inspection we saw that there was a basic programme of activities each day which people could choose to do and there was staff assistance and support for these.

The home had a senior care staff responsible for overseeing the activities within the home. We saw a full programme of activities for people which were prominently advertised and displayed. There were photos of activities and trips that had already taken place displayed in the entrance hall.

People said they felt confident that any problems or complaints that might arise would be dealt with by the management in a satisfactory way. A copy of the complaint's procedure was displayed near the main entrance to the home. This procedure told people how to complain, who to complain to and the times it would take for a response.

There had been no complaints within the last 12 months. However, there had been a significant incident in 2015 regarding monitoring and responsiveness to people by the home which had resulted in the home reviewing its practice, policies and procedures during the course of 2016. At the time of this inspection the provider expressed confidence that everyone had learned from this and that the systems and procedures now in place were more responsive to people's needs.

Is the service well-led?

Our findings

While the service had systems and procedures in place to help deliver high quality care, it did not always use its audits and information to make improvements or address issues that needed resolving.

There were various quality audit systems in place at the home. Monthly Regulatory Governance Audits were carried out by the Quality and Compliance Manager, a member of the senior management team. They audited the quality of care based on the CQC standards of Safe, Effective, Caring, Responsive and Well-Led. These audits contained comments and, where appropriate, any recommendations or actions that the home should take.

CREWS (Caring Responsive, Effective, Well-Led, Safe) audits were audits carried out by the home manager, again monthly, in line with CQC standards. These were slightly more specific in looking at particular aspects of the home or people and staff, such as the cleanliness of the premises, making sure specific people had a proper mattress, or that staff had had training in a specific subject.

Other audits included audits of staff supervision (to ensure they had been carried out), a Performance report on the business of the home, a weekly night audit, monthly reviews of care documentation, and an analysis of falls within the home.

We found that there was a mechanical, "tick-box" element to all of these audits. Audits had indeed been carried out, and carried out thoroughly. However, there was no evidence of organisational or management conclusions being drawn from these audits and there was no evidence that any of their findings were taken into account when developing wider strategies or business plans for the home. The exception to this was with regard to the premises where refurbishment and development formed part of a five-year plan.

These audits did not pick up on medicines errors, for example, and therefore the provider would be unable to ensure a robust training and development plan for staff, nor did they measure its effectiveness. The audits did not include references to staff concerns expressed at supervision regarding the reduction in staffing levels and how the provider planned to address them.

This meant that there was a risk that errors could be repeated and a risk that staff could feel that supervision and speaking up was of little value. In other areas, the audits concluded with action plans for the manager to implement within the home, but without any organisation-wide review of how well the provider understood the feedback and information gathered from these audits and what its own plans were to develop a culture of excellence within the home.

The provider did not demonstrate that the systems in place helped them to adequately evaluate and improve their practice in respect of the processing of the information obtained through their audits and checks.

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

2014.

The registered manager promoted a positive culture that was person-centred, open, inclusive and empowering for staff and the people living in the home. One staff member told us, "There have been some changes here and they're all for the better." Another member of staff said, "The manager is really good. You can go to her with any problem and she will listen."

People using the home told us that they liked the manager and the staff. One person said of the senior care staff who organised activities, "She's great. She'll come round and talk to you and try to get you involved in what's going on." A relative told us, "I can visit anytime I want and the manager and staff always make me feel welcome."

We observed people throughout the inspection and saw that they were at ease with moving around the home, speaking to staff and choosing what to do. If someone was disoriented a member of the staff team would discreetly guide them back to a familiar place where they felt more comfortable.

Policies and procedures emphasised the importance of people's rights to make their own choices, to be respected and to privacy. Meetings for people and their relatives were held regularly. In addition, information and guidance was displayed publicly as well as in the form of a brochure which described the sort of lifestyle people could feel they were entitled to.

The home demonstrated good management and leadership through having an experienced registered manager in place with the support of a deputy manager and senior staff members leading on each shift. The registered manager understood their responsibilities and was supported by a wider managerial team.

CQC registration requirements, including the submission of notifications and any other legal obligations were met, and records were held securely and confidentially.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>People's medicines were not always managed so that they receive them safely. We found discrepancies in recording of medicines administration and some confusion regarding who was responsible for auditing.</p> <p>Regulation 12(1)(g)</p>
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider did not demonstrate that the quality assurance systems in place helped them to adequately evaluate and improve their practice in respect of the processing of the information obtained through their audits and checks.</p> <p>Regulation 17(1)(f)</p>
Accommodation for persons who require nursing or personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>We found that there were insufficient numbers of suitably qualified, competent, skilled and experienced staff in order to meet the needs of people. The provider had not fully considered the different levels of skills and competence required to meet the varied and complex needs of people.</p> <p>Regulation 18(1)</p>

