Teignmouth Care Limited

The White House

Inspection report

15 Woodway Road
Teignmouth
Devon
TQ14 8QB

Tel: 01626299626

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

What life is like for people using this service.

• People were not always kept safe from harm. We were concerned that one person was not safe and made a referral to the local safeguarding authority and police as we were not reassured the service knew how to best support this person.

• There were not enough staff to meet the complex and changing needs of people. We saw people placed at avoidable risk of harm. There were not enough staff to support people to effectively prevent incidents such as falls.

• There were few activities for people to follow. People were not supported to lead lives that were meaningful to them. We saw three people with needs for positive behavioural and emotional support wandering around the home, showing periods of distress and confusion. They received minimal interaction from staff.

• Medicines were not always managed safely. Care staff were administering medicines in a patient and caring way and recording the medicines given with no gaps. However, there were no protocols in place for covert medicine administration or when it was appropriate to administer a medicine prescribed 'as needed'. Some controlled drugs were not safely stored.

• Care plans and risk assessments were not up to date with people's needs, placing people at risk of inappropriate care and treatment.

• People's preferences were not being met. Choices were offered to some people but care staff did not always offer a choice to those people who might not be able to verbalise their preferences.

• Daily recording and monitoring frequency did not match up to care plans and there were gaps in records. We were concerned some people were not being repositioned as often as they should be and some people who required hourly monitoring to remain safe were not being checked on by care staff regularly enough.

• People were not empowered to have choice and control in their lives. They were not invited to contribute to the running of the home, either through their ideas or taking part in domestic tasks to introduce a feeling of purpose.

• There was insufficient manager and provider oversight into the day to day running of the home. There was a lack of senior staff presence on the floor. We had to intervene and ask for managers to assist after two incidents took place in a short space of time.

• Quality assurance was lacking and did not pick up on some of the issues we found during the inspection.

• The service had not always notified the Care Quality Commission of important events or significant incidents by sending in legally required notifications.

• People were supported by staff who cared about their welfare and spoke fondly of them. Relatives told us care staff were kind. We saw care staff approaching people gently and being patient.

• There had been some efforts to make the environment homely and there were planned redecoration and other maintenance works taking place during our visit.

• People had drinks within reach and were offered warm drinks throughout the day. There was a balanced diet on offer. Some people were not happy with the presentation of the food.

• Staff felt supported and informed by the provider on changes that were taking place. Supervisions were starting to take place. Training had been booked for future dates as there were gaps in staff knowledge and training relating to people's needs.

• The provider, who had taken over in May 2018 was open to suggestions and had a programme of improvements for processes, the building and staff support planned.

• We found breaches of legal requirements in eight regulations relating to safeguarding, safe care and treatment, recruitment, staffing, consent, person centred care, good governance and notifying us of significant events.

• The service met the characteristics for inadequate in three of the five domains we inspected and the overall rating is inadequate.

• More information is in the Detailed Findings below.

Rating at last inspection.
This was the first inspection for this location under this provider.

About the service.
The White House is a 22 bed residential care home in the sea side town of Teignmouth, set over three floors. Five of these beds are away from the main accommodation but on site, offering a self-contained bedroom and bathroom with small kitchen area. The service supports mostly older people, some of whom may have advancing dementia, sensory needs and behavioural support needs. There were 17 people living in the service at the time of our inspection.

Why we inspected.
We inspected because we had received information of concern and wanted to see if people were safe

Enforcement.
Please refer to the end of the report to see the enforcement action we are taking.

Follow up.
We will be working with the service and local agencies to improve the care at this service.
The overall rating for this registered provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC. The purpose of special measures is to:
• Ensure that providers found to be providing inadequate care significantly improve

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded. We will have contact with the provider and registered manager following this report being published to discuss how they will make changes to ensure the service improves their rating to at least Good.

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 safe.
Details are in our findings below.

Inadequate

Is the service effective?

The service was not always effective.
Details are in our findings below.

Requires Improvement

Is the service caring?

The service was not always caring.
Details are in our findings below.

Requires Improvement

Is the service responsive?

The service was not responsive.
Details are in our findings below.

Inadequate

Is the service well-led?

The service was not well led.
Details are in our findings below.

Inadequate

The White House

Detailed findings

Background to this inspection

The 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 checked 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.

Inspection team.
The inspection team consisted of one adult social care inspector, one pharmacist inspector and one adult social care assistant inspector on the first day. On the second day the inspection team consisted of two adult social care inspectors.

Service and service type.
This is a residential care home that provides accommodation and personal care to people.
The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. However, the registered manager was no longer in post and a new manager had been recruited who had not yet been registered, but had put in an application.

Notice of inspection.
This inspection was unannounced.

What we did.
Before the inspection we gathered information we had about the service from ongoing monitoring, notifications the service had sent in to us telling us about important events and feedback from agencies who had been working with the service.

During the inspection we spoke with seven people, three relatives, and two professionals. We met with five care staff. We also spoke with the deputy manager, the nominated individual, the provider, and briefly spoke with the project manager and office manager when we needed information.

We looked at four staff records which included, recruitment, training, and supervision documents. We looked at records of accidents incidents and complaints. We examined how medicines were managed, stored and administered. We saw eight medicine administration records (MAR) and looked at four people's care plans in relation to medicines.

We observed two meals in the communal area and one person being supported to eat in their room. We used the principles of SOFI, or short observational framework for inspection, which is a way of observing the care interactions for people who may not be easily be able to communicate verbally with us about their experience. We used the principles of SOFI because we wanted to capture the detail of some of the concerns we had. We spent time in the communal lounges and dining area and saw an organised activity take place.

We looked at care records for four people, this included risk assessments, care planning and daily records. We checked to see if the care as described in their care plans was taking place. We looked at a further two people's care records specifically regarding the management of incidents.

We also looked at policies and procedures the service used and records for people's weights, kitchen records, quality assurance and audits.

After the inspection we spoke with a further five professionals, and were sent information we requested from the service at the time of inspection.

Inadequate

Is the service safe?

Our findings

People were not safe and not protected from avoidable harm.

Supporting people to stay safe from harm and abuse.
• For one person who was at an identified, ongoing risk of abuse, there was no risk management plan in place. We felt this person was at risk of harm and on the first day of inspection asked for an urgent risk assessment to be put in place and this be communicated to staff. On the second day of inspection we saw the risk assessment had been written and signed by the office staff and management team. We witnessed an incident and saw that care staff had not been effectively communicated with as to how to keep the person safe. The person had potentially been placed at avoidable risk of harm. We fed back the level of our concern to the service and reported our concerns to the local safeguarding authority and the police as we felt this person was not being kept safe.
• Staff had been supported to attend training on safeguarding. However, managers did not understand when an issue should be reported to the local authority safeguarding team or a notification of abuse made to us. Further, we saw senior staff did not know how to act to support the person in a situation when they were at immediate risk of harm. This lack of knowledge included failing to identify when a crime was being committed and when the police should be called.

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

Assessing risk, safety monitoring and management, learning lessons when things go wrong and managing medicines safely.
• Risk assessments for people's health and care needs were not always up to date or in place. This placed people at risk of inappropriate care and avoidable harm.
• Two of the upstairs windows did not have restrictors. This placed the person whose bedroom it was at avoidable risk of harm of a fall from a height. We fed this back to the service and they fitted restrictors that day. There were no systems in place to monitor the safety of windows and restrictors and a lack of understanding regarding why this was important for people's safety.
• Records showed that people who required checks hourly to see if they were safe were not getting them and there were gaps in recording for repositioning charts and totals for daily fluid intake for people at risk of dehydration. This showed people's safety was not being monitored and managed.
• The service could not demonstrate it had learned from incidents and made care safer for people.
• Records showed multiple instances of unwitnessed falls with no evidence that measures were put in place to reduce the risks to people. For example, one person was found to have fallen from their bed onto a 'crash mat' in October 2018. One month later in November 2018 the same person was found to have fallen on to the crash mat again. 999 was called due to a 'squashed nose' and swollen eyes. Nothing had been put in place after the first fall to alert staff should the person fall again, so they could respond quickly and minimise the risk of injury to the person. On the first day of the inspection, the person was observed to be in bed with bed rails up. However, this was not reflected in the care plan which still detailed the use of a crash mat, and no bed rails risk assessment was in place. This fall, and need for emergency medical attention was

potentially avoidable.
• Records showed one person's limbs had become entrapped under their bed rails on four occasions between June 2017 and 1 December 2018. The last incident report from December 2018 said the person was found 'distraught and shouting out with both legs trapped under the bed rails causing pain'. On this occasion the staff member documented 'we need something to put down the sides to stop (person's name) being able to get their legs under' and 'this is not the first time (person's name) has done this to themselves'. On the day of inspection, we observed the bed sides were not fully covered with a bumper to prevent the person becoming entrapped again. The handover document for staff contained information to ensure bed rails were covered but care staff had not completed this action and it had not been checked by any senior member of staff or manager.
• People were placed at repeated risk of harm; care staff were reporting incidents but there was inadequate management oversight to ensure preventative actions were put in place and completed to ensure the management of risks people faced.
• Medicines were not managed safely. Some people had 'Just in Case' medicines for use by the community nurse to relieve symptoms at the end of their life. There was no information in people's care plans about when these medicines might be used or what symptoms a person may demonstrate. The controlled drugs contained in these just in case packs were not stored securely or recorded according to The Misuse of Drugs Act. We asked a senior carer to store and record these medicines appropriately.
• For medicines that required topical application, such as creams, there was no guidance in place in the form of a body map showing staff where to apply the creams.
• There was no guidance in place for people receiving medicines prescribed 'as and when'. For example, if a person required pain relief or a medicine to alleviate their distress staff had no guidance on how to judge if a person who could not communicate verbally was in pain, or what approaches to try before giving medicines that affected mood or behaviour. The outcome of the use of as required medicine was not always recorded so it could not be shown how effective the medicines were.
• Staff told us and care plans showed, that some people had medicines given covertly (without the knowledge of the person taking them, often hidden in food or drink). There was no guidance to help staff give medicines covertly in a way that was safe and effective, for example, whether a medicine could be crushed. It was not possible to tell from medicine administration records (MAR) which medicines had been given covertly.
• Not all staff administering medicines had been assessed as competent to do so.

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

• We saw staff supported people to take their medicines in a patient and thoughtful way. Staff were recording the administration of medicines on MAR. Medicines were in date, and stored at the right temperature.

Staffing levels.
• There were not enough staff to keep people safe. People were left for long periods of time to wander around the home or in communal areas with trip hazards which placed them at risk of avoidable harm. We saw one person fall and hit their head with no staff present to witness or prevent it.
• There were high numbers of agency staff working in the home. The service tried to book agency staff who were familiar with people's needs but this was not always possible.
• Relatives told us some people entered their family member's room and took or damaged their belongings. Often there were no staff around to help because they were so busy.
• People's needs were assessed using a scoring tool that did not consider the complexity of their need, especially for those people with advancing dementia.

• We saw people trying to leave multiple times, in a confused and distressed state, with no staff around to comfort them.
• Staff told us it was a struggle to meet people's needs. One staff member told us, "I'm scared for the people here, for their safety."
• Two people told us they felt forgotten and only saw staff when they dropped in their meals. One person said they had to remind staff to provide them with food and personal care because staff were so busy.

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

Systems and processes.
• There were recruitment processes in place. However, they were not always operated effectively. Documents told us one person started work before an enhanced disclosure (police checks) had been obtained, and gaps in staff employment history were not always established and explored. Reasons why a previous position in health and social care ended were not always obtained. This meant the service could not be sure new staff were suitable to work with people who may be vulnerable.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection.
• Staff knew how to keep people safe from the spread of infection by using gloves and aprons. We also saw two people being 'barrier nursed' where staff used extra infection control precautions when supporting them.
• Open bags with soiled continence aids were in a bin with an easily openable lid in the garden.
• The home was clean and mostly odour free. Most of the soft chairs in communal areas were visibly stained with dried urine down the front and on the cushions. We fed this back to the providers and they said they would look into this.

Requires Improvement

Is the service effective?

Our findings

People's care, treatment and support doesn't always achieve good outcomes, does not always promote a good quality of life and is not based on best available evidence.

Effectiveness of care, treatment and support: outcomes, quality of life.
• Three professionals that we spoke with said their best practise guidance was not always followed, or it took a long time for staff to follow it. This affected health outcomes for people. For example some skin integrity issues could potentially have been avoided.
• People were smartly dressed and had clothing that fitted and matched. However, some people had hair that needed washing or nails that needed cleaning.
• The recording tools that staff had to use were not used effectively. Fluid charts were not always totalled, repositioning records had large gaps and one person's bowel chart had no entry for 39 days. This told us records were not accurate and could not be used confidently to monitor people's health and wellbeing. The providers told us a new recording system was being implemented in January 2019 which would improve recording.
• People were having only their very basic needs met. This impacted on their quality of life.

Ensuring consent to care and treatment in line with law and guidance.
• 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 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
• DoLS applications were made for people but had not been recently followed up.
• We did not see records for best interest decisions for bed rails or movement sensors for some people, which meant people were having their liberty restricted by the service and the principles of the MCA 2005 were not being followed.
• Some people received medicines covertly and had been assessed under the Mental Capacity Act 2005, as lacking the capacity to make complex decisions. However, there were no records that showed the decision, to give medicines covertly, had been made in the person's best interest or in conjunction with a family member or advocate.
• Staff did not always ask for consent from people before delivering care.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law.
• One person had not received a full assessment of their needs before moving to the home, this resulted in several incidents that could have been avoided. We asked the provider about this and they said there had

not been a robust pre-assessment process in place before they took over and this had now been implemented.

Staff skills, knowledge and experience.
• A comprehensive induction programme had been introduced in August 2018. Staff told us they had enough training but it could be more in depth. The providers had booked in additional dementia training for staff.
• A new supervision system had been introduced and some staff had received recent face to face supervision. Since the inspection the providers sent us additional evidence to show supervisions were taking place.

Eating, drinking, and a balanced diet.
• We saw people being offered drinks and in rooms people had drinks within reach. In the dining area there was a jug of squash. We asked one person if they liked squash and they said, "I don't get asked, I probably wouldn't choose it as I'm not used to it but its ok."
• Staff were aware of which people needed thickened fluids or a soft diet and prepared their drinks and food accordingly. For a person who required their food pureed the chef pureed each food item separately to make it more appealing.
• There was a balanced menu of food on offer. Information was available on people's allergies.

Staff providing consistent, effective, timely care.
• Care staff said they tried hard to meet everyone's needs but sometimes it got very busy.
• We observed on one of our inspection days the shift was not organised so that care staff knew which people they were supporting. This led to needs not being met and people having to wait for assistance with continence.
• Daily monitoring was not effective or learned from. Staff were over recording for some people who did not need it and there were gaps in some people's daily recording where they were at risk of dehydration or their skin integrity breaking down. There was ineffective oversight of daily recording.

Adapting service, design, decoration to meet people's needs.
• There was a stair lift in the home on one of the sets of stairs for people to move between floors.
• The providers were seeking advice on making adaptations to the property and redecorating communal areas so they were homelier and dementia friendly.
• There was some signage in the home but it was not consistent for people with dementia so they may not have been able to find their way to the toilet or communal lounges.
• People were not always able to locate their bedroom. There were no identifying features on bedroom doors.
• The home had a large conservatory that was used as a dining area, this had far reaching views out to the sea but the blinds were drawn most of the day, obstructing the view for people in communal areas. At certain times during our inspection there was bright sunlight coming in the ceiling and windows in patches causing confusion for some people with dementia.

Requires Improvement

Is the service caring?

Our findings

The service does not always treat people with compassion, kindness, dignity and respect.

Ensuring people are well treated and supported.
• Every person we spoke with said care staff were kind.
• Care staff were patient with people and where we saw they had time for a brief interaction, these were gentle and used humour and eye contact to engage with people.
• Relatives told us care staff were caring and made them feel welcome.

Supporting people to express their views and be involved in making decisions about their care.
• There was a consultation on what colour to paint the communal areas but we saw little evidence of other input into the running of the service by the people living there.
• Care plans were not discussed with people. In some instances, relatives had been asked for their input.
• Some people were not asked about decisions relating to their care and weren't offered choices they were able to contribute to, such as what hot drinks they wanted, what position they wanted their bed in, or whether they would like the radio on.

Respecting and promoting people's privacy, dignity and independence.
• People were not supported to rehabilitate or be more independent. We did not see anyone encouraged to help with meal preparation, other domestic chores, or make themselves a warm drink. One person said they had had very little support in trying to be more physically independent, and had not been asked about what their support should look like to that effect.
• People's confidentiality was not always respected. When we arrived on the first day of our inspection we saw the service's daily recording notes and care files for people on a trolley in the communal area. This was unattended by care staff. Files contained personal details about people's health and history and their names and photographs were visible. We asked a care staff member about it and they moved the trolley out of the communal area.
• On the first day of inspection one person was asleep with their bedroom door open. Their bed covers were off and nightwear pulled up exposing their body to people walking past their room. We mentioned this to care staff and they closed the door to cover the person up. It was not clear how long the person had been like this. This did not demonstrate respect for this person's privacy and dignity.

Inadequate

Is the service responsive?

Our findings

People did not receive personalised care that responded to their needs.

Personalised care.
• Care plans contained some personal information about people's histories and preferences. However, for some people the information was minimal and some sections regarding preferences were left blank.
• Where preferences were specified, care staff were not always meeting them. For example, one person was offered tea throughout the day when they liked coffee. A radio was left playing loudly when the care plan specified loud continuous noise was a source of distress for this person. We intervened and turned the radio down and the person visibly calmed.
• One person had their hair tied up in a ponytail. They kept pointing to it and trying to say something to staff. Care staff said to the person "It looks lovely", but when a family member visited they took the pony tail out as the person did not like them.
• We saw three people continuously walking around the home on the first day of inspection. All three were confused and upset at regular intervals and were not having their emotional needs met. This was despite their care plans saying they needed gentle reassurance when upset.
• A staff member mistakenly thought a person had dementia when they had a cognitive impairment. This showed they had not read the assessment and were making decisions about their needs based on an assumption and resulting in inappropriate advice to a relative about dementia led behaviour.
• Activities provision was very poor. People were not kept busy which was described as a need in their care plans. We saw one activity where people were sat in a semi-circle around a musician. One person was collecting other people's belongings from around the home and arranging and rearranging them because they had a desire to keep busy but were not receiving support to do so.
• The service was unable to tell us how they had supported people specifically around a protected characteristic. There was an equality and diversity policy and the provider told us future training was going to be booked in this area to raise awareness in the staff team.
• People were not supported to access the local community or facilities that were on offer in the area. One person said, "We don't do anything here but I don't want to complain as they do try."

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

Improving care quality in response to complaints or concerns.
• Some complaints were recorded. The providers were implementing a new complaint recording system.
• Relatives said they could feed back to the service but weren't sure who to go to.
• One person told us they "Get told off" by staff if they complained. We fed this back to the management team.

End of life care and support.
• There were several people who were cared for in bed and were very frail and needed support to

communicate, eat, drink and move.
• The service did not consistently engage people in discussions about end of life care and their wishes. End of life wishes were recorded for some people but for others the relevant section in their care plan had been left blank.
• Care staff had not all attended end of life training. There was inadequate training in human rights and equality and diversity. This meant care staff may not have known how to meet people's diverse needs at the end of their lives.
• There were not instructions on how to and when it would be appropriate to use the 'just in case' bags prescribed for people when they came near to the end of their lives.

Inadequate

Is the service well-led?

Our findings

Leadership and management do not assure person-centred, high quality care.

Leadership and management.
• The service was going through a period of change, it had been in administration for three years, with a provider changeover in May 2018 and several changes in management. People and relatives were not always clear who was in charge.
• The provider gave support and resources to the service. There were lots of plans for embedding internally identified improvements. However, improvements were slow to take place and the provider acknowledged this.
• The providers and senior team were not aware of the level of issues within the service and did not have an understanding of how people were being placed at risk.
• An audit of recruitment files had been completed for all staff and work was ongoing to obtain information in retrospect. However, this audit did not identify all the information we found to be missing, so we could not be confident it was thorough.
• Incidents were reported by care staff but not followed up or actioned by managers so no learning had taken place on how to prevent future avoidable harm and risks were not appropriately mitigated.
• An internal audit of care plans showed that one person had only 10% of their care plan complete and the most complete care plan were only 47% complete.
• Records were not always, accurate, up to date or stored securely.
• Daily records and key monitoring documents had sections to evidence a manager had checked and signed the records. These were often not filled out and had not had management oversight to check they were filled out accurately or actioned.
• The service was not aware they had a responsibility to protect people from the risk of a fall from height and had not restricted all of their upper floor windows. There were no checks in place to monitor the window safety.
• People's needs and rights were often overlooked because there was a lack of understanding and leadership around how to promote an equality agenda for older people with sensory, mobility and dementia needs.

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

Regulatory requirements.
• There was a lack of understanding regarding when it was appropriate to send notifications to us. We were not always informed when there was an incident of suspected abuse or an occurrence where the health, safety or welfare of people was affected.
This was a breach of the Care Quality Commission (Registration) Regulations 2009: Regulation 18.

Continuous learning and improving care.
• The service was unable to demonstrate how it was learning to improve care. There was no evidence staff

were encouraged to reflect on their practice. Knowledge about best practice in dementia care was limited to one staff member who told us they researched it in their spare time.

Working in partnership with others.
• Professionals fed back the service did not listen to their professional advice. Some professionals told us people were placed at avoidable risk of harm.
• The providers told us they were willing and open to working with the local authority and other agencies to drive improvement in the service. After the inspection the providers have been very responsive, open and willing to make improvements.

Engaging and involving people using the service, the public and staff.
• The providers had made recent efforts to engage family members and staff through the use of social media. People were starting to be engaged in the running of the service through meetings and their opinions were sought on some matters.
• Staff felt supported and said recently they felt more listened to.

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	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to report to the Commission allegations or incidents of abuse. Regulation 18R, (1) (2) (e) (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service failed to gain consent for care and treatment from the relevant person and act in accordance with the Mental Capacity Act 2005. Regulation 11 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not established or operated effectively to ensure staff had relevant experience and information as detailed in Schedule 3 was not available. Regulation 19, (2) (3) (a)