Westgate Healthcare Limited

Kingfisher Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 04 April 2016 and was unannounced.

Kingfisher Nursing Home provides residential nursing care for up to 22 older people, some of who may live with dementia. There were 13 people accommodated at the home at the time of this inspection.

We last inspected the service on 11 April 2014 and found the service was meeting the required standards that we inspected at that time.

There had not been a registered manager at Kingfisher Nursing Home since the service had registered with the Care Quality Commission (CQC) under the Health and Social Care Act 2008 in February 2011. A new manager had been in post for six weeks at the time of this inspection and had started the process of applying to become registered with CQC. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

We found the service to be in breach of the Health and Social Care Act (Regulated Activities) 2014 Regulations. You can see what action we took at the back of our report.

People felt safe living at Kingfisher Nursing Home. Staff knew how to keep people safe however, they were not always clear of how to report any concerns to outside agencies. Risks to people's safety and well-being were identified however, we found that some areas of identified risks did not have management plans in place to mitigate risk and promote safe care and treatment. People's medicines were not always managed safely.

People and their relatives were not satisfied with the opportunities for engagement and stimulation that were provided. This matter had been raised with the management team by relatives however, had not improved. Record keeping in the home did not support staff to provide safe and consistent care.

The home was calm during the day of the inspection and people's needs were seen to be met in a timely manner. People told us that their needs were met in a timely manner during the daytime when there were more staff available; they were less satisfied with the staffing levels during the night. The provider operated robust recruitment processes which helped to ensure that staff members employed to support people were fit to do so.

Staff had the skills and knowledge necessary to be able to provide people with safe and effective care and support. Staff received regular support from management which made them feel supported and valued. People were supported to make their own decisions as much as possible. People received support to eat and drink sufficient quantities. People's health needs were well catered for because appropriate referrals

were made to health professionals when needed.

People were complimentary about the care and kindness demonstrated by the staff team. Staff were knowledgeable about individual's needs and preferences and people were involved in the planning of their care where they were able. Visitors to the home were encouraged at any time of the day and people's privacy and dignity was promoted.

The provider had arrangements in place to receive feedback from people who used the service, their relatives, external stakeholders and staff members about the services provided. People were confident to raise anything that concerned them with staff or management. The manager was new in post so people could not confirm to us at this time if they felt confident they would be listened to.

The provider had arrangements in place to regularly monitor health and safety and the quality of the care and support provided for people who used the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People's medicines were not always managed safely.

Staff were able to describe what constituted abuse and said that they would not hesitate to escalate any concerns however, they were not all were clear about how to report safeguarding concerns to external agencies.

Risks to people's health and well-being had been identified however, management plans had not always been developed to guide staff how to provide safe care for people and mitigate the identified risks to their health and well-being.

There were sufficient numbers of staff on duty during the day time to meet people's needs. However, people raised concerns about the call bell response times in the evening and night time when there were just two staff on duty.

People who used the service told us they felt safe at Kingfisher Nursing Home.

The provider operated robust recruitment processes.

Is the service effective?

Requires Improvement

The service was effective.

People received care and support from staff who were appropriately trained and supported to perform their roles.

People were supported to enjoy a healthy, varied and balanced diet.

People were supported to access a range of health care professionals to help ensure that their general health was maintained.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect.

Staff demonstrated a good understanding of people's needs and wishes and responded accordingly.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not always supported to engage in a range of activities to provide them with engagement and stimulation.

People's concerns were listened to and acted upon but not always in a timely manner.

People's care was planned and kept under regular review to help ensure their needs were met.

Is the service well-led?

Requires Improvement

The service was not always well led.

There had not been a registered manager at Kingfisher Nursing Home since the service had registered with the Care Quality Commission (CQC) under the Health and Social Care Act 2008 in February 2011. A new manager had been in post for six weeks and had started the process of applying to become registered with CQC.

Record keeping in the home did not support staff to provide safe and consistent care.

The provider had a range of systems in place to assess the quality of the service provided in the home.

Kingfisher Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider met 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 under the Care Act 2014.

This inspection took place on 04 April 2016 and was unannounced. The inspection was carried out by one inspector 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 service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we observed staff support people who used the service, we spoke with seven people who used the service, three relatives, three care staff, the home manager and two members of the provider's senior management team. Subsequent to the inspection we spoke with three relatives by telephone to obtain further feedback on how people were supported to live their lives.

We requested feedback from representatives of the local authority social working team and other external professionals involved with the care of people who used the service. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed care records relating to three people who used the service and other documents central to people's health and well-being. These included staff training records, medication records and quality audits.

Requires Improvement

Is the service safe?

Our findings

People's medicines were not always managed safely. Entries on the medicine administration records (MARs) were consistent and handwritten entries were countersigned. However, we checked a random sample of six boxed medicines and found that three did not contain the amount of tablets indicated in the MAR. For example, there were either too few or too many tablets in the box which meant that we could not be confident that people had received their medicines in accordance with the prescriber's instructions. We discussed this with the manager who expressed surprise at our findings and reported that an audit had been undertaken the previous week where no issues had been identified.

Risks to people's health and well-being had been identified in such areas as falls, moving and handling, skin integrity and the use of bedrails. Moving and handling care plans stated how many staff were required to provide support, what sling was required for mechanical transfers and where sliding sheets were required to assist people to re-position in bed. However, we noted that management plans had not always been developed to guide staff how to provide safe care for people and reduce risks to their health and well-being. For example we reviewed records for two people with pressure ulcers that had developed in the home and found they did not have a care plan in place to support staff to promote their skin integrity. This meant that there were no written guidelines for staff to follow to help ensure that the person received consistent care and support they required to manage the existing pressure areas and to help prevent further pressure areas from developing.

A further person who lived with diabetes did not have a specific care plan to support staff to care for them safely and reduce the risks associated with diabetes. For example, there were no written guidelines for staff to follow in relation to the specific symptoms or signs of hypoglycaemia that the person could experience or information on how to treat hypoglycaemia if it occurred. There was no specific dietary plan for the person and no clear arrangements to screen regularly for diabetes related complications, such as diabetic foot ulcers. There was no information about the level and intensity of blood glucose monitoring required and who will take responsibility for reviewing blood glucose readings and altering treatment accordingly. The manager reported that the person's blood sugar levels needed to be checked twice daily however, we noted that this was not common practice. This meant that there were no systems in place to mitigate the risks associated with diabetes.

Due to the concerns relating to the management of medicines and the absence of risk management of pressure area care and diabetes care this was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) 2014.

People who used the service told us they felt safe at Kingfisher Nursing Home. People's relatives said that people safe and cared for. One relative said, "I think it is brilliant here, [relative] is absolutely safe, so relaxed and so happy." Another relative said, "My relative is definitely safe, no problem there."

We spoke with staff about protecting people who lived at the service from abuse. All the staff we spoke with were able to describe what constituted abuse and said that they would not hesitate to escalate any

concerns they had to their line manager. Training records confirmed that 12 of the 18 permanent staff members had received up to date training in this area, three staff members were due for refresher training and three had not received any training in this area. However, staff members were not clear about how to report safeguarding concerns outside the organisation despite posters being available in the communal areas of the home to signpost people to the local authority adults safeguarding team. This means that there were gaps in their knowledge which had the potential to leave people at risk of abuse.

We observed people being supported to move from armchair to wheelchair by means of a mechanical hoist. Staff provided re-assurance to people, spoke kindly and steadied people checking that they were at ease with the move.

People who used the service and their relatives shared mixed views about the availability of staff. Some people said there were plenty of staff available whilst others were less positive. A person told us of their experience of using the nurse call bells, they said, "If you want any nurse it's a job to get them." A further person commented, "When I need help from a nurse it's quite a few minutes."

One relative told us, "I feel that staffing may be a bit low because nearly everyone needs two people to assist them. Having said that though, the care given is very good, the staff are brilliant." A further relative said, "It used to be better when the staff team was stable. The staff levels seem to be fine during the day but it is a worry that there are only two staff on duty at night. What happens if more than one person wants attention at a time, they all have to wait." Another relative raised a concern about the constantly changing staff team, they told us, "Since [relative] has been there staff seem to constantly come and go. This is disturbing for us and [relative] because they become attached to people and feel sad when they leave."

People's concerns about the call bell response related to the evening and night time when there were just two staff on duty. The manager told us that staffing levels were the same regardless of the amount of people who were accommodated at the home because the provider had a policy of staffing for full occupancy. The management team undertook to monitor staff availability at this peak time of day in relation to the dependency of the people who used the service. During the course of the inspection we noted that call bells were responded to in a timely manner and that people's needs were met. We noted that the atmosphere throughout the home was calm.

A member of the provider's senior management team explained to us that the service had experienced an unexpected churn in some of the key long term staff and which had resulted in some negative impact on the service. However, the senior management team had taken all reasonable steps to support the service. The manager told us that there were just two vacancies at the home at this time for registered nurses. The service used a regular agency to cover vacancies where needed so that people who used the service benefitted from regular staff who knew their needs. The manager and provider were able to demonstrate that they were actively working to recruit and that the HR department was supporting the manager with recruitment initiatives for new staff.

We reviewed recruitment records for two recently recruited staff members and found that safe and effective practices were followed to ensure that staff did not start work until satisfactory employment checks had been completed. Staff we spoke with confirmed that they had to wait until the manager had received a copy of their criminal record check before they were able to start work at the home. This helped to ensure that staff members employed to support people were fit to do so.

Requires Improvement

Is the service effective?

Our findings

People gave us mixed feedback about the food provision, one person said, "The food is alright. Again my taste has probably changed. Sometimes it's good. Sometimes not so tasty. Salt is not on the table but I ask for it. I'd probably like to change the food." Another person told us, "The food is pretty good but does vary." Relatives told us that people seemed to enjoy the food provided for them, one relative told us, "The food is not too bad. [Relative] enjoys the Sunday lunch, they have still got a good appetite."

We observed that one person hardly touched their food and the plate was taken away without an alternative being offered. Another person was served sweet and sour pork and rice and immediately expressed that they did not want it. Nevertheless, a staff member persuaded them to try a bit which they kept in their mouth, clearly hating it, and was eventually told to take a drink to wash the food down. Staff persevered and provided another alternative for the person of which they ate a small amount.

People were not clear about what was going to be served for them to eat at lunchtime. The meal choices had been offered to people the day before and they told us that they had forgotten what they had chosen. One person told us "I order in advance and I don't remember what I ordered. I think they give me something I didn't order." The menu was handwritten on a small white board and was out of sight. A member of the senior management team advised us that the lack of menus had been identified as an area for improvement and was 'work in progress' at this time. An action plan developed as a result of a satisfaction survey showed that the manager was targeted with discussing the menu with people during care plan reviews, discussing this with the chef and to introduce photographic lunch menu to support people to make meaningful choices.

People's weights were routinely monitored in order to identify emerging risks of poor nutrition. We noted that where people had been assessed as being at risk of poor nutrition and hydration external professionals such as dieticians and GPs had been involved and supplements were recommended. The manager told us that staff increased the calorific value of people's foods by introducing milk shakes and adding cream and butter to foods where appropriate.

During the lunch service we saw that people took their meal where they chose. For example, some people chose to eat in the communal dining room whilst others chose to eat their meal in their rooms. Staff sat with people encouraging them to eat where needed.

People who used the service told us they thought the staff carried out their roles well. One person said, "Care assistants are all lovely, so kind and the food is lovely, too." Another person told us, "I like the place and the people. They look after me very well. I'm quite satisfied."

Relatives of people who used the service told us that they felt the staff understood people's needs well and had the skills necessary to care for people. One relative said, "They really do care for my [relative]." Another person told us, "The staff appear to know what they are doing. They say they have had more training

recently."

People were looked after by staff who mostly had the knowledge and skills necessary to provide safe and effective care and support. Records showed that there had recently been a shortfall in refresher training for the staff team. It was clear from discussion with the senior management team that this had been identified and was being addressed. However, two of the four care staff on duty on the day of this inspection were relatively new to the service and had not undertaken basic core training such as moving and handling, safeguarding vulnerable adults and infection control. The manager reported that training had been booked.

New staff members were required to complete an induction programme and were not permitted to work unsupervised until assessed as competent in practice. One new staff member was on duty at the home on the day of this inspection and was working with an established staff member. The manager reported that a three day induction had been booked for this staff member. Staff members told us that they had received 1:1 supervision from the manager and told us they had been able to discuss any aspect of their role and any training requirements which made them feel supported and valued.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager demonstrated awareness of when it was necessary to apply for an authority to deprive somebody of their liberty in order to keep them safe. They demonstrated an understanding of what steps needed to be followed to protect people's best interests and how to ensure that any restrictions placed on a person's liberty was lawful. At the time of the inspection two applications had been approved by the local authority in relation to people who lived at Kingfisher Nursing Home. The manager was aware that further applications needed to be submitted for consideration and told us that this was work in progress for them and the newly recruited clinical lead at this time.

Staff demonstrated an understanding of the MCA and communicated with people to gain their consent prior to support being provided giving people time to respond and express their wishes. Staff told us that they always asked people's consent to personal care. We noted from records that 14 of the 18 staff employed to work at Kingfisher Nursing Home had received training about the MCA 2005 and DoLs.

People's health needs were well catered for. We saw that chiropodists, dentists and opticians visited the home when people needed them and people had easy access to their GP. Relatives told us that they were satisfied with the health care people received. We noted that referrals had been made to external health care agencies.

Good

Is the service caring?

Our findings

People's personal and private information was stored at the nurse's station in a communal space. The filing cabinets were not secured and therefore we could not be confident that people's personal and private information was kept confidential at all times.
People who used the service and their relatives told us that the staff team were kind and caring. One person said, "They're very lovely, the people here, they really are." They went on to say, "They are good tempered. You don't see them until I squeak! Someone pops their head round and they say OK?" Another person said, "People are very kind. No-one just bangs the thing down in front of you and goes. I enjoy being here I really do. I don't feel I'm ill." Relatives generally gave us good feedback about the staff however, one relative said, "The permanent staff are great but the agency staff do not have the same attitude and compassion."

We observed some good examples of caring interaction between staff and the people who used the service. For example, we saw a staff member gently approach a person to ask if they would like to have some pain relief, they patiently explained to the person that they only had to ask, they didn't need to be experiencing pain. We also observed during the lunch service that staff offered people clothes protectors and gave help to put these on where needed.

Staff were knowledgeable about people`s individual needs and preferences in relation to their care and we saw that people had been involved in discussions about their care where practicable. We noted that staff gave people enough time to respond and then acted upon the choices people made. Throughout the course of the inspection we heard staff provide people with choices about what they wanted to drink, where they wished to sit in the dining room and lounge areas and what they wanted to do with their day.

Relatives and friends of people who used the service were encouraged to visit at any time and on any day. A relative told us, "They always let us know what is going on, they keep us up to speed."

We saw staff knock on doors and allow people time to respond before they entered their bedrooms. When people required support with using the toilet or with personal care needs, they were supported discreetly to ensure they received support in private and with their dignity intact.

People had access to information about advocacy services should they need additional support to make decisions about any aspects of their lives.

Requires Improvement

Is the service responsive?

Our findings

People told us that they were not completely satisfied with the activities provided at Kingfisher Nursing Home. One person said, "Someone used to come and organise games, nothing happens now." Relatives we spoke with shared this view and one person said, "The events co-ordinator is absent and no-one is covering. There used to be a really good event co-ordinator who used to play backgammon with people, put films on for people, there used to be a different activity on each day of the week to keep people stimulated. There used to be singers, concerts and outside entertainers brought into the home but this isn't happening anymore. People who have capacity are not being stimulated. They seem to sit in front of the TV staring into space." Another relative told us, "There used to be a person there who did their best to provide opportunities for engagement and stimulation but they have left and now there is nothing. The radio is always on blaring out pop music and the TV is always on with daft quiz programmes which no-one actually watches."

Relatives told us that there had been a meeting that they had been invited to attend to share their views recently. One relative said, "There was a meeting held a few weeks ago but I was only told about it very last minute so I was not able to go." We saw minutes of a meeting held for relatives of people who used the service in February 2016. Three relatives had attended and amongst other topics discussed they shared their concerns about the lack of engagement and stimulation provided for people.

The provider had submitted the 'Provider Information Return' (PIR) in March 2016 which stated that there was, "An activity coordinator whose role it is to encourage residents to take part in activities for their enjoyment and stimulation." We discussed this with the senior management team who confirmed that the dedicated staff member had been absent from the home for some time however, they told us that care staff incorporated engagement opportunities into their daily role. We noted that a care staff member did try to engage one or two people with some simple table games during the course of the morning however, there was no evidence of the cookery or arts and crafts activities that were advertised. Staff told us that they were not able to provide the level of engagement previously offered by the activity co-ordinator because they did not have enough time to do so.

People did not have sufficient opportunities to take part in meaningful activities and engagement according to their personal preferences and individual needs. This was a breach of regulation 9 of the Health and Social Care Act (Regulated Activities) 2014.

Some people told us they had been involved with planning their care and where people lacked the capacity to contribute to their plan of care we saw that relatives had been involved on their behalf where appropriate. Care staff responded to people in an individualised manner and it was clear when we asked them that they knew what the people`s personal care needs were.

We saw a selection of compliments cards from relatives of people who used the service praising the staff team for the kindness, compassion and thoughtfulness shown to people and their families. A relative told

us, "Very good here, no complaints at all." People and their relatives told us they would be confident to raise anything that concerned them with staff or management team. However, one relative said, "There have been so many changes lately. I would be confident to raise issues with the manager but it is too early to say that I am confident they would be sorted. It is early days." Another relative told us, "I wouldn't know who to complain to because I don't know who is who there anymore."

Requires Improvement

Is the service well-led?

Our findings

Record keeping in the home did not support staff to provide safe and consistent care. The provider had submitted the 'Provider Information Return' (PIR) in March 2016 and this stated that wound care plans were in place where required. This was not our finding during this inspection. We reviewed records for two people who had developed pressure ulcers and the manager agreed there were no care plans in place to assist staff in providing consistent care. Risk assessments identified those people who were at high risk of developing pressure ulcers but care plans had not been developed to support staff in maintaining their skin integrity.

The PIR also stated that care plan documentation was currently under review so that the paperwork across the home was consistent and reflected person centred care by the end of 2016. With just 13 people accommodated at the home at this time we consider that the timescale for this important piece of work is excessive.

There were arrangements in place to support people and their relatives to share their views and talk about any improvements they would like. However, people who used the service and their relatives told us that they were not confident that actions would be taken as a result of them sharing their views. For example, people told us that they had raised concerns via the quality assurance survey relating to the lack of engagement and activity provided for people. We viewed the action plan that had been developed in response to this concern and we noted that one target of action was, "Daily activity and quality of life to improve for the residents." The target date for achieving this outcome was 03 April 2016. At this inspection we found that people's satisfaction levels had not improved. This example demonstrated that people's views had not been acted upon. People told us that they acknowledged that the manager had only been in post since February 2016 and they felt that it was early days for them to have achieved the necessary improvements. However, people said they were disappointed that the provider had not provided more support in this area.

The manager undertook a range of audits, checks and observations designed to assess the performance all aspects of the service delivery. These included areas such as medicines, health and safety, the environment, accidents and incidents and infection control. Information about the outcomes of these checks, together with any areas for improvement identified, was reported to the provider each month. There was a comprehensive service improvement plan in place that incorporated actions from the manager's internal audits, the provider audits, quality assurance surveys and feedback from people who used the service and their relatives. The plan had dates for action and was kept under review as part of the provider's quality monitoring process. However, we noted that this was not always effective. For example, the action plan developed in response the quality assurance survey stated, "Daily activity and quality of life to improve for the residents." The date for this action to be completed was 03 April 2016. The activity coordinator had been absent from work however, no alternative effective arrangements had been made to provide stimulation and engagement for people.

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

There had been no registered manager at Kingfisher Nursing Home since the service had registered with the Care Quality Commission (CQC) under the Health and Social Care Act 2008 in February 2011. There had been many appointments to the post during this period however due to many and varied reasons managers had not registered with CQC. The newly recruited manager had been in post for six weeks at the time of this inspection. They told us that their Disclosure and Barring Service (DBS) check was almost complete and they undertook to submit their application to register as manager of Kingfisher nursing home as soon as the completed DBS was received.

The manager reported that they had undertaken a robust induction process when they started to work with the organisation and had received good support from their line manager and from peers. A clinical lead had been recruited to support the manager in their role.

The manager operated an open door policy and encouraged people to walk in at any time with suggestions, concerns or complaints. Relatives gave positive feedback about the manager, one relative said, "The manager is very good. They are kicking on and getting things moving, it is coming together."

Daily handover sheets were completed by the nurse in charge at each shift and the information from these fed into the manager's weekly reports. The manager undertook a daily 'walk around' and maintained records of these to contribute to their overall quality assurance processes. For example, on one record we viewed the manager had identified that breakfast was still on going at 11am. This may have been a concern for people because there would only be 1 ½ hours between breakfast and lunchtime and they may not have the appetite to eat the main meal of their day. The manager dealt with this by exploring the reasons for the delay with staff and monitoring practice over the following days to ensure that this did not recur.

The provider had a range of systems in place to assess the quality of the service provided in the home which included regular quality monitoring visits undertaken by members of the provider's senior management team. Areas of performance reviewed included accidents and incidents, complaints, deaths, infections, safeguarding concerns, training, medicines errors, pressure sores, staff sickness, room enquiries, admissions and local audit outcomes. The provider's operations manager had an overview of all issues relating to the home and used these to inform the regular provider visit audit. The operations manager acknowledged that the service had recently experienced an uncharacteristic drop in performance and was able to evidence that the senior management team had been monitoring the key indicators at Head Office. We found that the provider's quality monitoring systems were effective in identifying areas that required improvement. For example, the February audit had identified a significant shortfall in staff training and the March audit showed that action had been taken towards improvement whilst continuing to indicate some shortfall.

Providers of health and social care are required to inform the Care Quality Commission, (CQC), of certain events that happen in or affect the service. The manager had informed the CQC of significant events in a timely way which meant we could check that appropriate action had been taken.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not have sufficient opportunities to take part in meaningful activities and engagement according to their personal preferences and individual needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's medicines were not always managed safely. Management plans had not always been developed to guide staff how to provide safe care for people and reduce identified risks to their health and well being.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Record keeping in the home did not support staff to provide safe and consistent care.