Foxholes Nursing Home Limited

Foxholes Care Home

Inspection report

Pirton Road
Hitchin
SG5 2EN
Tel: 01462 410767
Website: www.foxholescarehome.com

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Ratings

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

Overall summary

This inspection was carried out on 15 October 2015 and was unannounced.

Foxholes Care Home provides accommodation and personal care including nursing care for up to 110 older people. At the time of the inspection there were 62 people living at the home. There was a manager in post, who was not currently registered with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

When we last inspected the service on 04 September 2014 we found them to be meeting the required standards. At this inspection we found that they were in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The Care Quality Commission (CQC) is required to monitor the operation of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are put in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of the inspection some applications had been made to the local authority in relation to people who lived at the service. However not all applications were submitted as required by the recent changes of the Deprivation of Liberty Safeguards legislation.

Staff obtained people's consent before providing the day to day care they required. We found that processes to establish if people had lacked capacity for certain decisions were followed in line with the MCA 2005, however staff had no clear guidance in how to ensure the care delivered was in the person's best interest. There were no best interest meetings organised to develop an effective plan of care for vulnerable people. This meant that it was a risk that the care people received was not in their best interest.

People were accommodated in a purpose built environment which was clean and well maintained. Bedrooms were personalised and had an-suite facilities whilst still providing specialist bathroom facilities, several communal areas, dining rooms, orangery room, a shop, hairdresser room, quiet lounges. People were able to choose where they wanted to spend time.

People were not always protected from harm, two people developed pressure ulcers whilst they were living at the home. We found that people were not repositioned as it was recommended by professionals and this increased the risk of more pressure ulcers developing and delay in the healing process.

People told us that they felt their needs were not met safely at all times. They had to wait to use the toilet at times as staff took a long time to answer call bells. We also saw on one occasion when staff gave reassurance to a person in distress and promised they will come back to help them; we waited for 15 minutes however they did not return. Relatives told us they were happy with the care people received however they felt it was a need for them to visit daily and `keep an eye` on things.

The provider was monitoring people`s dependency levels and they recently adjusted staffing levels for nights as they recognised that people`s needs were not met safely. They also monitored how long it took for staff to answer call bells.

Staff had received training in how to safeguard people against the risks of abuse. They were able to describe what constitutes abuse and the reporting procedure they would follow to raise their concerns.

People had their medicines administered by staff who was trained, however we found when we reconciled medicines for people there were more tablets that there should have been or less. This meant that people had not received their medicines according to the prescriber`s instructions. People had access to health care professionals, there were regular visits form GP however some senior staff said they had to ask managers to for a second opinion if they wanted to ask for a GP visit outside the regular visits days.

People were concerned about staff leaving the service and the high number of newly employed staff members. They expressed mixed views about the skills, experience and abilities of the staff who supported them. We found that staff had received training relevant to their roles. Staff had regular supervisions to discuss and review their performance and professional development.

People told us that the standard of food provided at the home was good. We saw that the meals served were hot and that people were regularly offered a choice of drinks. Staff monitored food and fluid intake for people who were at risk of losing weight; however this was not done consistently. Most people told us staff was kind and respectful however they were concerned that staff was changing constantly and they were not able to develop long standing relationships.

People expressed mixed views about the opportunities available to pursue their social interests or take part in meaningful activities relevant to their individual needs. We saw that where complaints had been made they were recorded and investigated. However, there were no records to show that positive lessons had been learnt or that service delivery was improved from the complaints raised.

Staff was complimentary about the leadership of the home and they felt well supported in their role. There

Summary of findings

were several audits carried out regularly by the provider and the manager of the home; however the action plans developed following these audits were not revisited to ensure the outstanding actions were completed.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staff was able to tell us how they were safeguarding people form abuse. They were knowledgeable about reporting under the whistleblowing procedure to local authority or the Care Quality Commission.

Risk to people`s health and wellbeing was not always managed safely by staff and people developed pressure ulcers.

People felt there were not enough staff to meet their needs on some occasions.

People`s medicines were not managed safely.

Is the service effective?

Requires improvement

People felt due to high turnover, staff were not skilled and knowledgeable enough to meet their needs effectively.

People were asked to consent before staff delivered care.

People who lacked capacity to consent had no best interest decision made in their favour to ensure the care they received was in their best interest.

People were provided with a varied menu and encouraged to have a healthy balanced diet however the monitoring of food intake for people at risk of losing weight was inconsistent.

Staff received regular supervision and training. They felt supported in their role by managers.

Is the service caring?

Requires improvement

The service was not consistently caring.

People were treated with kindness and respect by staff.

People had not developed long standing relationships with staff due to constant changes in staffing. They felt newly employed staff had not had a good understanding of their needs.

People`s interest who lacked capacity to be involved in decisions about their care was not always represented by an advocate.

People's dignity and privacy was promoted.

Is the service responsive?

Requires improvement

The service was not always responsive.

People did not always receive personalised care from staff.

Summary of findings

People were provided with a range of activities. However some people felt these were only suitable for a particular age range and they were not provided with anything to stimulate or occupy their time.

People told us they were able to raise concerns and complain, however they were not confident in any positive outcomes following their complaints.

Is the service well-led?

Requires improvement

The service has not always been well led.

Systems used to quality assure services, manage risks and drive improvement were not as effective as they could have been.

People were aware of the management arrangements at the home but felt that it was a high turnover of staff and managers which unsettled them.

Staff told us they understood their roles and responsibilities and had confidence in taking matters to management.

The provider had not submitted notifications to the Care Quality Commission for all the pressure ulcers developed at the home as required.

Foxholes Care Home

Detailed findings

Background to this inspection

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

The inspection was carried out on 15 October 2015 and was unannounced. The inspection team consisted of two inspectors, a specialist pharmacist and an expert by experience. An expert by experience is a person who has personal experience of having used a similar service or who has cared for someone who has used this type of care service.

Before the inspection we reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we spoke with 20 people who lived at the home, four relatives, 8 staff members, one nurse, a team leader, the home manager, the deputy manager and the provider.

We looked at care plans relating to seven people who lived at the home, and three staff files. We also carried out observations in communal lounges and dining rooms and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us due to complex health needs.

Inadequate

Is the service safe?

Our findings

People had mixed feelings about what safety meant for them. One person said, "I feel safe now dear. I have to call them [staff] for help. They [staff] don't respond very quickly; I had a fall on the bathroom floor because they did not come; I banged my head. I have rails now on the bed and I have to call them to help me to the bathroom." Another person said, "Yes I suppose I feel safe; I don't think about it." Two relatives told us they felt their loved ones were safe in Foxholes; however they felt the need to visit daily to `keep an eye on things. ` One relative said, "[Person] is safe here, they settled very well. We [family] keep a close eye on him. We [family] visit every day."

People told us that were not enough staff to meet their needs safely. One person said "I have to plan when I go (to the toilet) around when staff are available; it's worse at night". Another person explained that they were sometimes unable to shower when they wanted to as staff were not always available. We also observed a staff member giving reassurance to a person in distress in their bedroom. They promised they will come back soon, however we waited 15 minutes, they did not return. This person told us, "Staff is keep telling me they will be back. I am kept waiting but they are not coming back."

Most staff told us they thought there were enough staff available to meet people's needs. One staff member said, "Staffing is better than in some other places I worked." Another staff member said, "Sometimes when staff goes off sick it`s hard." Another staff member explained to us that they did not always have time to spend talking with people. They told us that they knew this was important for people who spent a lot of time in their rooms as they felt isolated and lonely. They also said that on occasions records were not completed because staff were rushing and missed things.

We found that the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as they did not ensure that there were sufficient numbers of suitable staff to meet people`s need safely.

Staff were able to tell us their responsibilities to safeguard people from abuse and avoidable harm. Staff knew the signs and indicators that could suggest abuse and how to raise any concerns that they may have. One staff member said, "Safeguarding refers to every vulnerable person who is over 18. We [staff] have a duty to report any concerns we have to our seniors and report under the whistleblowing procedure to Local safeguarding teams or the Care Quality Commission."

People were not always safe because risks to their health and well-being had not been managed effectively. For example we saw a person who was cared for in bed and had developed a pressure ulcer on their foot. The risk assessment identified the high risk of developing pressure ulcers, the pressure equipment which was used and the fact that the person should have been turned regularly. We found that the specialist nurse who visited this person recommended one to two hourly turns however the management had instructed staff to turn the person every two to three hourly. The person had developed another pressure ulcer due to ineffective pressure care management and their poor health.

Staff were unable to tell us when and how another person had developed a pressure ulcer. We looked at the care records for this person and found that they were contradictory about when the wound developed and did not reflect what the nursing staff told us in terms of whether it was healing. The records made by staff showing how often they helped the person change position in bed showed gaps in excess of what the assessment and care plan stated was needed.

Staff knew which people needed assistance to change position however they were inconsistent with their knowledge about how often this should happen for each person. One staff member said, "We turn people usually in the morning, lunchtime and supper time. Then night staff takes over." When we asked the nursing staff how they establish how often people should be turned they said this was established upon assessing the risk however they were not able to describe the assessment criteria. They said, "Depends if people are immobile or not we will re-position two to three hourly or three to four hourly." Turning charts were not completed regularly and staff was not always allocated to be responsible to turn people. One staff member said, "Sometimes we are allocated to turn people, sometimes not."

We observed a person who was in bed on their right side were assisted to eat their lunch by a staff member. We asked the senior staff if that was the correct way to assist the person. They said, "Staff meant to get me to turn them

Is the service safe?

but they didn't, they should be upright when they eat to make sure they don't choke." We found that this person was referred to a specialist speech and language therapist to assess their swallowing as they were observed keeping medicines in their mouth.

We found that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as they did not ensure that the identified risks to people's health and welfare were sufficiently mitigated to keep people safe.

We looked at how information in medicine administration records and care notes for people living in the service supported the safe handling of their medicines. Medicines were stored safely for the protection of people who used the service and at correct temperatures. Staff authorised to handle and administer people's medicines had received training and had been assessed as competent to undertake these tasks.

Medicine records did not confirm that people were receiving their medicines as prescribed. When we compared medicine records against quantities of medicines available for administration we found discrepancies. This included records for the administration of insulin by injection for the management of diabetes mellitus.

Some medicines were not administered because they were unavailable. This placed people's health and wellbeing at risk. For example, a person who was scheduled to have sodium valproate tablets administered for the prevention of epileptic seizures had not been administered them because they had not been obtained in time. We observed staff administering medicines and found that they followed safe procedures and talked to people about their medicines. However, the length of the morning medicine round was excessive so people did not always get their medicines at the times scheduled and intended by the prescribers.

For one person who preferred to take their own medicines unsupervised, medicines were left out in their room for them to take. However, the service had not considered the risks relating to this. For another person who managed their own medicines, where a risk assessment had been completed in July 2015, there had not since been a review.

Supporting information was available alongside medicine administration record charts to assist staff when administering medicines to individual people. There was personal identification and information about known allergies and medicine sensitivities. There was information and charts in place to record the administration of anticoagulant medicine to record the application and removal of skin patches but there were unexplained gaps in all these records. There were charts to record people's blood glucose levels; however, there were also gaps in these records.

When people were prescribed medicines on a when required basis, there was sometimes but not always written information available to show staff how and when to administer these medicines. For example one person who was prescribed a medicine on a when required basis, records showed the medicine was administered each day and not only when required. However, for another person, there was written information available, when the medicine was not prescribed in this way. Therefore people may not have had their medicines administered appropriately.

We saw that a person with limited mental capacity to make decisions about their own care or treatment was having their medicines administered to them crushed in food (covertly) without their knowing. However, there were no records showing best interest decisions had been made on their behalf, no written guidance for staff to refer to about administering medicines to the person in this way or records about consultation with other healthcare professionals or relatives. Therefore this person may not have been administered their medicines in a way that was appropriate and in their best interests.

We found the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as they had not ensured the proper and safe use of medicines.

Requires improvement

Is the service effective?

Our findings

People were offered choices and we saw staff asking people's consent before providing care and support. One person explained, "Staff asked how I wanted to be helped". However, another person told us some staff did not always respect their independence and helped them with things they would rather do themselves. They explained "When I am washing I can do a lot for myself."

For people who lacked capacity to take decisions regarding some aspects of their life consent was not always appropriately sought. People had consent forms in their care records to consent to specific aspects of their care; however these were not agreed by them. For example we saw one form had been signed by the person's relatives with no details of why they had signed on behalf of their relative. Staff were not able to tell us whether the relative had power of attorney or any other authority to make such decisions. Staff told us that another person's relative did have power of attorney but they were unable to tell us whether this was for care or financial decisions. This meant that people were at risk to receive care in a way which was not in their best interest.

Deprivations of liberty safeguard applications were not submitted to the local safeguarding team by the management for every person who was at risk of being deprived of their liberty. For example, there were key codes for the doors and some people needed constant supervision and were not able to leave the home unsupervised.

Staff told us that they had the necessary training to enable them to care for people and meet their needs. Two new members of staff explained that they had received an induction which included working alongside experienced staff as well as attending training courses. However we found that staff had not demonstrated good knowledge in some areas like pressure care and record keeping. This was an area which needs improvement. Staff told us that they received supervision and were given feedback from senior staff. All staff said that they felt supported by the management of the home.

People were offered a choice of menu options and mealtimes were unhurried and taken at a pace to suit people. People spoke positively about the food saying it was good and there was a good choice. One person said, "The food is very good, I need to cut down on it as I am not moving a lot." Where people were able to eat in the dining rooms we saw that meal times were sociable occasions. Where people spent mealtimes in their bedrooms we saw staff offered assistance as needed.

We observed on the day of the inspection staff were not monitoring people`s nutritional intake. We saw that two people who were at risk of losing weight had not eaten their meal; however this was not reported or logged promptly. We saw that one person had lost significant amount of weight over a four week period, they were weighted weekly and their food intake should have been monitored closely. In addition we found that five other people who were assessed for staff to record and monitor their food and fluid intake were not done for the day. This meant that there was a risk that people could get malnourished because staff did not report or record the fact that they had insufficient amount to eat.

People received visits from a GP who visited the home twice a week. One person said, "If I want to see a doctor I am told that they [staff] will put me on the list for when he calls, but then sometimes you still don't get to see him." One staff member said, "If a person or relative asks to see a GP we [staff] will tell them the days they call Tuesday and Friday (it used to be Sunday). If the person believes it to be urgent, I would refer the matter to my manager who would provide a second opinion before a GP is called. If it is felt necessary a GP will be requested to make a home visit."

This meant that people`s wishes and request could have been overruled by management if they felt the person did not need the GP. Chiropodist, optician and dentist visited the home regularly and offered their services to people.

Requires improvement

Is the service caring?

Our findings

People responded positively to staff who were polite, kind and caring in their interactions with people. One person told us, "I cannot complain about any of them. None of them speak badly to anyone that I have seen." One relative told us, "The girls are lovely here; the main problem is that there is not enough of them."

We saw staff checking on people's well-being and giving explanations and reassurance as needed. For example in the morning we saw a person who was crying and were anxious. Staff approached them and engaged them to deliver the newspapers together. This had a positive impact on the person who calmed down and relaxed. Staff told us, "[Person] is very distressed in the morning so we take her with us to deliver the papers. She used to do this with her grandchildren when she was at home."

One person explained that they had been involved in putting their care plan together and in reviewing it. However, they told us that staff often did not follow the care plan in terms of their preferred time to get up in the morning or in helping them pursue activities they enjoyed. We saw a person`s preferred time to get up in the morning was 7-8am, however at 11 am we observed the person very anxious in their night wear asking for staff assistance which was promised but delayed as reported under Safe. One person told us that they currently had involvement from an advocacy service to assist them with a specific situation.

People`s dignity and privacy were promoted. We saw staff acted on people`s preference to have their bedroom doors closed or open if they wished. We saw staff closing bedroom doors if personal care was delivered. Staff did refer to people by their first name and people were relaxed in their company. One person told us, "The staff are good and respectful of my dignity."

We saw that people were asked to think about end of life plans and it was documented if they had any wishes or they refused to talk about this matter when they moved in to Foxholes Care home

We found that the majority of the people whose care plan we saw had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) directive. However some were not completed to indicate if the decision was indefinite or not and if the people involved in the decision had the right to do so. For example one person had a DNACPR form on their file which stated they did not want to be resuscitated if they had a cardiac arrest; however this had been completed while the person was in hospital and it had not been reviewed to make sure it still reflected the person's wishes now they were living in the care home.

Another person who had a DNACPR record in their care plan had not been included in the decision making process. They had a capacity assessment carried out and established that they had capacity to make this decision. However their family member took this decision without consulting the person. Staff could not tell us that the family member had the legal right to take this decision. This meant that people were at risk of staff acting in a way which was not agreed by them and not necessarily in their best interest.

We found that the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because decisions were made regarding care and treatment for people without their or an appropriate person`s consent.

Requires improvement

Is the service responsive?

Our findings

People had mixed views about the care they received. One person told us, "I would like to know someone is looking after me and knows about my needs. No problems with cleaning or smells all pristine but you have to look beyond the surface of the lovely new building." Another person explained that although they had been provided with a special chair for sitting in at the table staff did not help them to sit in it. They told us "Staff tell me I should ask, but they should know I need help".

Some people and relatives told us they had been involved in reviewing their plan of care; for others we saw that the change in their needs did not trigger a review. For example one family member said they were very much involved in the care plan of their relative which had been reviewed three times since they moved in the home at the beginning of the year. For another person who`s mobility changed there was no review of their care plan.

We saw in several instances where the care and support people received did not reflect what was in their care plans. One person's care records noted that staff must support the person "as quickly as possible" when they need to use the bathroom however the person told us they often had to wait and on occasion this had led to them being incontinent. The person explained to us how being incontinent upset them for the whole day. Another person said, "It is difficult to get anyone to cut my nails. I can pay someone who comes in to do it but staff doesn't have time."

People had access to activities which were organised by two engagement staff members. Activity plans were displayed on notice boards around the home and each person had a copy in their rooms. People could join in baking sessions, word games, ladies clubs, bingo, and craft sessions. However some people thought the activities were not varied enough. They said, "There are limited activities that I can do, there is a knitting group but I can't knit."

The environment was generous and provided many areas where people could sit and enjoy activities like reading newspapers, listen to music, had conversations. Throughout the day we saw that people were moving from area to area depending on their preference. People told us they would like more outings and community involvement in the home. We saw that there were various meetings for people where improvements to activities, menus and other issues were discussed however the only action seen was to inform people on what was to happen in the home and not involving people in improvements or decisions about how the home was run.

People had mixed views about how and to whom they could complain or raise any issues. One person said, "If I want to make a complaint, I would speak to the staff." Another person said, "I would complain to that lady down there on the corridor. Mind you she can be a bit abrupt if you complain. I don't want any trouble but I want to be treated with respect." One family member told us they had made a complaint because their relative`s personal hygiene was not at their standard. They said, "We [family] were satisfied with the outcome of the complaint but we come every day to keep a close eye on things."

We overheard a person complaining to a staff member about two other people who were sitting next to the person and they were talking about them. The person said, "I have complained about this before, nothing gets done here about it, they need to be spoken to. The trouble is they have got their favourites here that is the trouble with the staff here." All relatives spoken to said they knew how to make a complaint but were unaware of any written policy being shared with them when their relatives came into the home. We saw that recently the management created individual complaints folders for each area of the home to ensure staff recorded people`s and relative`s complaints and where possible solved the problems.

Requires improvement

Is the service well-led?

Our findings

The majority of people living in the home and all the family visitors were able to tell us who the floor team manager was and that the manager and the deputy were visible most days and they were approachable. Staff spoke well of the manager and the deputy and said they felt supported to carry out their jobs and were aware of the expectations the management had of them. One staff member said, "Managers and seniors are very nice, they talk to us."

Staff told us that they felt the leadership in the home was better since the new manager joined and they felt it was more stability. One staff member said, "I have seen different managers come and go and a regular turnover of care staff in that time. In the last couple weeks it seems to have settled down a bit." Another staff member said, "I feel supported by the manager. They are hands on when we need help. There have been many changes of managers but it is more stable now." Staff explained that the senior staff in the home met each day to discuss any issues that had arisen as well as having weekly meetings where they reviewed whether the necessary actions identify in the previous week had been completed.

The manager told us they completed a range of audits, generally by sample checking on each area within the home. However we saw that there were anomalies between what was recorded in people's care plans as the care they required; what staff told us people needed and what staff recorded as the care they had delivered. For example, two people were assessed as requiring regular help to change position to reduce the risks of developing pressure ulcers. Records detailed gaps of several hours where there was no record of this assistance being given. We discussed with the team leader, nurse and senior staff on the unit how they checked to make sure people were receiving care in line with their assessed needs. Although they told us that they checked daily care records they were unable to explain why the anomalies we found had not been identified and addressed. We discussed this with the manager who told us he was introducing a system where the nursing staff would sign off the records to ensure care was being delivered in line with people's needs.

The manager had identified some areas in need to improve in various audits like health and safety, infection control, care plan audits, however the actions to improve the service were not effective, timely or they were not followed through to ensure the quality of the service improved. For example we saw a health and safety audit carried out in June 2015 identified that staff needed more training, however we saw that this had re-occurred in the audit carried out in September 2015 and there was no action plan developed to detail if this was completed or not. We also seen a medication audit done in July 2015 which identified similar issues with medication as we identified during the inspection; however there was no indication that the issues were actioned and what was the impact on a person who had not been supplied with medication in time.

We saw that there was some consultation with people living in the home and relatives about how the service was run. Dates for meetings were posted on the lounge walls but the majority of people and relatives we spoke to were unaware of these meetings and had never attended. The manager explained that attendance to meetings were encouraged and were held every six weeks and minutes were sent to all the relatives.

We saw that the manager had monitored falls and people were referred to falls clinics in case they had recurrent falls. Complaints were also monitored and held centrally by management however there was no analysis of any trends and patterns to ensure these were investigated and positive lessons learned to prevent those happening again.

Due to lack of accurate recordings, lack of systems to identify shortfalls of the service provision and the lack of responsiveness to improve the quality of the service provided we found the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider failed to ensure there were sufficient numbers of suitable staff to meet people`s needs safely at all times.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider did not ensure that the identified risks to people`s health and welfare were sufficiently mitigated to keep people safe at all times.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider had not ensured the safe and proper use of medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider failed to ensure that decisions made regarding care and treatment for people were made with their consent or by a rightful representative.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

The provider failed to implement efficient systems to identify and improve any shortfalls of the service provision. The provider failed to ensure care plans and risk assessments were contemporaneous and records were completed in a timely manner.