Derbyshire County Council

Beechcroft Care 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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 26 September 2016 and was unannounced.

There is a requirement for Beechcroft to have a registered manager. The provider had notified us about the absence of the registered manager. This period of absence was being covered by another of the provider's managers. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service is registered to provide residential care for up to 40 older people some who were living with dementia. At the time of our inspection 28 people were using the service and one area of the home was closed for refurbishment.

The provider could not demonstrate staff deployment had been planned to meet people's needs. In addition the service could not produce recruitment records to assure us that all staff had been recruited using pre-employment checks designed to ensure staff working with people using the service were suitable to do so. Other records relevant to people's care and treatment had not been made when required or retained. People were supported to use equipment that had not been assessed as suitable and safe for their individual use. Care plans and risk assessments did not always reflect recent changes to people's care and support.

The provider could not demonstrate people always received care and support that followed the Mental Capacity Act 2005 (MCA) and was least restrictive. Although risk assessment identified risks to people staff did not always provide care in a way that helped to reduce risks. People were not asked for their consent to care and treatment before staff provided support.

Staff did not always communicate with people in a way that supported their privacy. For example, on some occasions, staff shouted above the heads of people at dinner time to ask people what they wanted. Not all people received the same amount of social interaction from staff.

Not all staff training was up to date and the manager had put in place actions to make sure staff training was updated.

Some people, but not all, had been involved in planning their care and support. However this care and support had not been regularly reviewed by people, their families and staff.

There was no evaluation as to whether the events and entertainment being organised met people's needs. People's individual preferences for hobbies, interests and pastimes was not recorded and used to plan activities that matched people's needs. Some people were affected by the lack of activities and

entertainment; activities were not to some people's choice and preference. There had been a lack of meetings with people and families to involve them in developing the service. People had not been asked for their views on the quality of services provided. However the manager had plans to involve people more through satisfaction questionnaires and meetings.

Audits had been used to identify shortfalls in the service, however not all shortfalls had been identified and included on an action plan.

People felt safe and felt able to talk to staff about any worries or concerns. Medicines were administered safely and infection prevention and control practices were followed. People had access to other health professionals so as to maintain their good health.

The provider had a system in place to ensure any complaints were investigated to set timescales. The provider had sent in notifications when required. Notifications are changes, events or incidents that providers must tell us about. The service was managed with an open and approachable leadership style.

Some staff had built positive relationships with people and created a jovial atmosphere. People felt staff were caring and felt staff would listen to them.

People had sufficient to eat and drink and most, but not all people, were satisfied with the choices of food available.

We identified four breaches 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.

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 safe.

Staff were not always available to meet people's needs and records to show the provider had made safe recruitment decisions was not available. Risks were identified, however staff did not always follow risk assessments and care plans to ensure they reduced risks to people. Plans were in place to update staffs' knowledge of safeguarding people and staff knew how to report any concerns for people's safety. Medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not effective.

The principles of the MCA were not followed and staff did not check people consented to their care before they provided it. People had sufficient to eat and drink. People received support from external health professionals when required. The manager had identified staff training was out of date and had a plan in place to make improvements.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Not all people were involved in planning their own care. Whilst some staff had built positive relationships with people, not all people received the same levels of social interaction from staff. Staff did not always communicate with people appropriately. Some but not all staff supported people in a kind and considerate way.

Is the service responsive?

Requires Improvement

The service was not responsive.

People had not always been supported to their care planning and reviews of people's care had not been held regularly. People had not been asked about their individual interests, hobbies and pastimes and therefore some people were dissatisfied with the

lack of day to day activities. People had not been asked their views. Systems were in place to manage complaints.

Is the service well-led?

Requires Improvement 

The service was not consistently well led.

Records were not always available as required. The manager understood their responsibilities and had used audits to identify improvements. The service was managed with an open and approachable leadership style.

Beechcroft Care Home

Detailed findings

Background to this inspection

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

This inspection was unannounced and took place on 26 September 2016. The inspection was completed by one inspector.

We reviewed relevant information, including notifications sent to us by the provider. Notifications are changes, events or incidents that providers must tell us about. We asked the service to complete a provider information return (PIR). This is a form that asks the provider to give us information about the service, what they do well, and what improvements they are planning to make. This was returned to us by the service.

We spoke with all 11 people who used the service. Not everyone who used the service could fully communicate with us and so we also completed a Short Observational Framework (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We also spoke with the relatives of three people who used the service. We spoke with three members of care staff, two members of domestic staff, the deputy manager and the manager. We looked at three people's care plans and we reviewed other records relating to the care people received and how the home was managed. This included some of the provider's checks of the quality and safety of people's care and staff training records.

Requires Improvement

Is the service safe?

Our findings

People were not always provided with care in a timely manner. For example, staff told one person sitting in a communal lounge they would help them back to their bedroom. This was so they could change from their pyjamas into their day clothes. The person required two members of staff to assist them to mobilise. Staff told the person on three separate occasions in a 15 minute period they were going to take them to their bedroom, however no second member of staff became available to help assist within this time frame. This meant the person received delayed care as a result of a second member of staff not being available to help.

On another occasion, we observed no staff present in a dining area for a period of five minutes. During this time one person began to attempt to get up on their own without staff assistance. They lifted their walking frame over the head of another person who was still seated. We felt this presented a risk of harm to both people involved. The person attempted to stand with their walking frame and appeared unstable. A member of staff then arrived who shouted to the person, "Hang on; wait for me," as they went to assist the person to leave the room. One relative also commented, "I never see [staff] just sitting and talking with people; sometimes you come and there's no-one around."

One person told us staff were, "Not too long coming to me," when they used their call bell. However other people told us they had to wait for assistance, and particularly at certain times of day. One person told us, "It's a problem at night because I can't get into bed until it's folded back and sometimes you have to wait a long time; they are busy you know, it's not one to one you know." Another person said, "Sometimes you wait a long time in the toilet. It's a shortage of staff, particularly in a morning. They have to get people up and to the toilet and then get breakfast." A fourth person said, "Sometimes it's half past nine before you get your breakfast."

We spoke with the manager about how they worked out the number of staff they needed to meet people's needs at different times of day. They told us the provider calculated the number of care hours required based on the number of people using the service. In addition, the manager told us that extra staff could be brought in to accommodate people who required extra care, such as attending a hospital appointment. Whilst we could see that staff numbers could be flexible to accommodate people's additional needs, we could not see how people's everyday needs had been planned for. For example we spoke with the manager about our observations of a person having to wait when two members of staff were required to assist them to move. There was no plan of how the numbers of staff deployed could provide timely care to people, for example, in a morning or evening, when more people would be requiring the assistance of two members of staff to help them. As such, the provider could not demonstrate sufficient staff were deployed to meet people's needs in a timely manner.

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

One person's moving and handling care plan had been updated and recorded the details of the sling and hoist required to help the person move safely. Staff had recorded their signatures on the care plan to say they had read and understood the updates. We saw staff attempt to assist this person into their sling. This

was not done smoothly and staff frequently changed the position of the person in an attempt to get the sling around their body. Staff did not talk to the person about moving their body before they did so. Staff then changed to use a different sling on the person. The person shouted out in distress whilst this sling was being fitted. The manager told us staff had not used the sling recorded in the person's care plan to finally transfer the person. We were concerned as the sling used had no written assessment completed to confirm it had been assessed as safe to be used with the person. In addition, one staff member we spoke with told us they could not remember reading any updates to the person's care plan. This was despite the manager showing us the records that all staff involved in helping the person to move had signed to say they had read the updates. We saw staff assisted other people to mobilise throughout the day and this was completed without causing distress to people. Some, but not all people, were assisted to move safely.

We saw other people did not always get the correct pressure cushion to sit on to help prevent pressure areas developing. This was because we saw one member of staff place a pressure cushion down for one person to sit on. This resulted in a very high sitting position for the person. The member of staff then picked another pressure relieving cushion and asked the person to try sitting on it. Although the person was now in a lower sitting position, they could still not sit with their feet flat on the floor. This practice did not assure us that staff knew which pressure cushions had been provided to which people. There was therefore a risk people were not receiving the appropriate care to help prevent pressure areas from developing.

The provider had a policy for the safe recruitment of staff and the manager informed us this was followed. However, we could not be assured that care workers had been recruited safely. This was because the recruitment records we requested to see were stored at another location and could not be located during the time of our inspection. This meant we could not be assured these staff had their identity confirmed, their previous work experience verified or had a current Disclosure and Barring Service (DBS) certificate checked.

People told us they felt safe in the home. One person told us, "What's good about the place is that if you fall [staff] are there." Family members we spoke with also shared the view that the home provided a safe environment for people. One of them told us, "[My relative] wasn't safe at home; they fell three or four times and ended up in hospital; I don't think [my relative] has fallen down while here."

People also told us they would feel confident to talk to staff should they feel worried. One person told us, "I could go to staff but they'd know because they do pay attention." Staff we spoke with had been trained in safeguarding adults. The manager had made staff aware of a safeguarding application available for their phones which reminded staff on how to report any concerns. Staff were able to describe to us some of the signs that could indicate a person was at risk from abuse and preventable harm. However, not all staff had completed recent training in safeguarding and were not aware of the different categories of abuse that were now considered under safeguarding. The manager was aware of this training shortfall and was taking action to ensure staff had up to date skills in this area. This meant the provider had taken steps to reduce the risk of preventable harm and abuse to people.

People we spoke with told us staff helped them manage any pain well with medicines. One person told us, "[Staff] look after us. If you've got a headache or something, you just say and [staff will] get you a tablet or whatever." Another person who had a health condition that caused them pain told us, "Some days you could cry with pain; [staff] give me tablets for the pain."

People also told us medicines were given on time, and in a personal way. One person told us they took several medicines and they, "Get it on time." We observed some people being assisted with their medicines. We saw people were asked whether they needed any pain relief and the staff member did not rush people and stayed with them until their medicines had been taken. In addition, where people self-administered

their insulin, we saw staff assisted to prepare this and offered clear and supportive guidance while the person self-administered.

Medicine administration record (MAR) charts showed staff had signed to confirm they had administered people's medicines as required. This included records of topical creams applied in people's own rooms. We saw people had a secure area in their rooms for the safe storage of their topical medicines.

The manager had taken steps to improve practices around preventing and controlling infections. One person told us, while pointing out a staff member serving drinks and biscuits and wearing a hairnet, "You can see the [staff] dealing with the food dress properly." We saw staff wore gloves and aprons when appropriate to do so, for example, when assisting people with any personal care. Domestic staff we spoke with told us they followed a cleaning rota and this ensured all areas were systematically cleaned. They also told us they were able to respond to any additional cleaning needs as and when required. The provider had taken steps to ensure infection prevention and control guidelines were followed in the service.

Requires Improvement

Is the service effective?

Our findings

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 they are appropriately supported to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be made in their best interests and be as least restrictive as possible.

People can only be deprived of their liberty so that they can 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 observed the care for one person who lacked capacity to consent to their care and treatment. We saw one member of staff used their own hands to confine this person's hands and arms during a transfer in a hoist. One member of staff involved with the transfer told us it was not normally necessary to confine this person's hands when they were in the hoist.

There was nothing in this person's care plan to describe this restriction. Without this restriction assessed as necessary in order to prevent the person coming from harm, and that the restriction was reasonable and proportionate to the potential harm, the provider could not demonstrate they had followed the principles of the MCA. Some care staff told us, and records confirmed, they had not had up to date training on the MCA. There was therefore a risk staff would not follow the principles of the MCA and people's care would not be provided in the least restrictive way. We discussed this with the manager who confirmed they would review this person's care.

Staff did not always check that people consented to their care and treatment before they provided it. For example, we saw staff tell a person where to sit for dinner without asking them where they'd like to sit. We saw staff place an apron round the neck of a person without asking whether or not they wanted it on. Another member of staff was seen to cut up a person's food without asking them whether they wanted this assistance.

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

The manager told us five people had been identified for a DoLS assessment and applications had been submitted. However, these applications had not yet been approved by the supervisory body. During this time some people's needs had changed and we could not see how these DoLS applications had been kept under review during this time. We spoke with the manager regarding this who confirmed this would now be done.

We observed some people who were having their breakfast. People were offered the choice of cereal, poached eggs on toast or just toast. We saw people had been provided with a pot of tea. However one person told us breakfast choices were limited to either porridge or toast; or if they were up earlier they were

given cornflakes. They told us, "No choice of a [full] cooked breakfast and I always liked a good breakfast." Most, but not all people were satisfied with the choices of food available.

Most people we spoke with were satisfied with the meals provided. One person told us, "I never go hungry, I get enough to eat. It suits me and I'm finicky." Another person told us the food was, "Very good; a choice of two [different meals]."

People also told us they were given enough to drink. One person told us, "We get our elevenses and we'll get a drink at lunch time." We saw staff with a tea trolley offering people drinks and cakes mid-morning and mid-afternoon.

We saw staff provided flexible mealtimes where people needed to eat at different times throughout the day. We also saw staff stayed with people while they ate where risk assessments had identified this was needed to help prevent the risks associated with choking.

People told us they saw a doctor and other health professionals if needed. One person told us about their hospital appointments. They said, "Sometimes my [relative] takes me but [staff] arrange it at other times and get a car or ambulance." One visiting relative told us, "They hadn't had a dentist for a good while and I had to arrange that but they've got one that visits now. The same with a chiropodist and optician." Records also showed people saw other health professionals. In addition, we saw two health professionals visited people on the day of our inspection. People received support to access healthcare services as required.

Records showed the manager had identified staff training was not up to date. We saw they had identified what training was required and had started to book staff on training courses. The manager had also completed knowledge questionnaires with the staff to identify areas where their skills and knowledge was either as expected or in need of further training. In addition, they had invited other professionals to come and talk to staff to update their skills and knowledge on dementia care. Staff we spoke with had some gaps in their knowledge around safeguarding people and the MCA. The manager was aware of these knowledge and skills shortfalls and had plans in place to update the skills and knowledge of all staff members.

Requires Improvement

Is the service caring?

Our findings

One person told us they had not discussed their care and support with care staff and had not seen a care plan. A relative we spoke with also shared that view. They told us, "I haven't sat down and talked about [person's] care; I haven't seen a care plan." We saw two out of the three care plans we reviewed showed the person had signed to say they had been involved in planning their care. However, there was nothing to record the involvement of the third person in their care plan. People's involvement in their care plans was not consistent.

Our observations on whether staff spoke with people in an appropriate, caring way were mixed. For example, staff would approach some people and ask them what their preferences for lunch were. Then at other times staff would shout across the room to ask people what they wanted. Staff talked to each other above people's heads while they were seated without involving the person in the conversation. We saw one member of staff placed a person's shoe back on their foot when it had fallen off without speaking to them at all. At other times, staff would ask, "Are you alright?" when walking into a room, but not addressing anyone in particular and not waiting for any response before leaving the room again.

Some staff did have warm relationships with people, and shared songs and jokes with them. However, over a twenty minute time period we saw staff initiated social conversations and interactions with some people more than others. We could see people benefited positively from this social contact from staff, for example, they became more talkative or smiled more. However, not all people benefited from the same amount of staff initiated social contact and interactions.

People told us the staff were caring. One person told us, "[Staff] will do anything for you; we get on with them; they are good to us." Another person said, "I love these [staff]." A relative told us the home was, "Very basic, no bells and whistles but [person] is really happy and looked after in a way we couldn't manage at home."

People told us they felt staff listened to them. One person said, "[Staff] will listen to you and if you ask them something they'll tell you." A visiting relative told us, "Staff are obliging; you can talk to them." People also told us staff respected their choices. For example one person told us, "I go to bed when I like; [staff] come round and check on me but don't make me get up; [staff] will save me breakfast."

People told us staff respected their privacy and showed respect to their own bedrooms. For example, one person told us, "[Staff] knock [on my door] and I just say, 'come in'." A relative told us, "[Staff] do knock and as far as I can see [staff] always ask people if they can do things." We saw some staff were kind and considerate when assisting people with their care. We observed one member of staff discretely assisted a person when they needed the toilet. Another person asked staff to keep their bedroom door shut when they were not using it. We saw the member of staff went to shut this person's bedroom door as requested. Some staff supported people with kind and caring attitudes.

Requires Improvement

Is the service responsive?

Our findings

On the day of our inspection a shoe retailer had set up shoes for people to look around and purchase if they wanted. Records showed the service organised an arranged activity approximately once a week, like the shoe sale or an entertainer. Other activities were also recorded as being provided, such as skittles, bingo and birthday celebrations.

However, some people we spoke with told us there was a lack of activities for them to engage with. One person told us, "We're bored; we all sit together and chat but there's not much else to do. All of a sudden you look at the clock and say, 'oh good, its mealtime'." Another person told us they spent their time, "Waiting for dinner," and added, "There's nothing else to do." A third person told us, "There's nothing to do; they promised me they'd take me out on outings, take me here, take me there, but they don't."

We saw other people enjoyed listening and singing along to music. However, again, people's views on the music in the main lounge were mixed. One person said, "It's too loud really," and another person told us, "The music they have is rubbish."

Some other people we spoke with told us they were not concerned about the level of activities. One person told us, they spent their time watching television in their room as, "If I'm in the lounge I do nothing, I'm just sitting here. There's not much going on, but I'm happy with that really." Other people told us they preferred to be in their rooms. One person said, "[People] are all asleep out there, I might as well be in here on my own and watch telly." While another person said, "I go to bed at half past six, because there's nothing else to do out there; I've got my wireless."

Visiting relatives' mostly shared the view the service did not engage people with activities that were of interest to people. One relative told us, "[Person] just sits here or goes to bed sometimes in the afternoon." Another relative told us they had seen some activities such as a singer or someone encouraging exercises. However they also said, "I do feel sometimes they should do a little more with them. Some [people] are quite aware and need something to keep them aware; say arts and crafts. They used to take [people] out on trips but that seems to have stopped. Every time I come in [person] is just sitting in the same place."

People's individual preferences for activities and interests were not recorded, and nor were records kept of what activities or entertainment people participated in. Therefore there was no evaluation of whether the activities available to people met their needs or preferences. Whilst the manager told us this was something they wanted to introduce, the service currently could not demonstrate people were offered personalised interests and activities that met their needs.

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

Care plans had not always been reviewed regularly and when they had been reviewed, people and their families had not always been supported to contribute. One relative told us, "I've not seen anything; I might have signed something when [my relative] first came in, but that's a couple of years back now." The

manager told us they had identified reviews of people's care and treatment had not always been held on a regular basis. As a result the manager was reviewing people's care plans and was involving people and their relatives, when appropriate, in these reviews. The manager showed us a recent review of a person's care plan and we could see their involvement, along with that of their relative.

People we spoke with told us they had not made any formal complaints while using the service. We reviewed the records held of complaints. We saw records were kept of any complaints made and these were investigated in line with the provider's complaints policy. We also saw the service had received compliments and these were shared with staff.

People told us if they raised an issue with the manager it had been investigated. For example, one relative told us, "We've been to [the manager] with issues and [they] were fine and they sorted it."

People and their relatives told us they thought meetings were held with people and their families to discuss ideas and any updates, however no-one we spoke with had attended any meetings. Another person told us the newsletter with what activities had been arranged was not sent out to people and families anymore. The manager told us no recent meetings had been held, however they were planning to re-introduce these meetings.

Requires Improvement

Is the service well-led?

Our findings

During our inspection, we reviewed records relating to the care people received and how the home was managed. The manager had identified records needed updating and we could see that things such as risk assessments had been updated. However, some records we requested were stored at another location. These records were not sent through to for us to review as part of this inspection. The provider could not demonstrate records relating to persons employed at the service were complete. They could therefore not assure themselves that they had protected people that used the service appropriately and carried out all relevant pre-employment checks before people started work. They were also not able to evidence that staff employed by the service were suitable to carry out their work.

Other records were also not available for us to review. We found care records for a person who lacked the capacity to consent to their care stated they refused all their medicine and all their medicine had been stopped in their best interests. There were no details to show what medicine had been stopped, how the best interests' decision had been made and what health professionals and family members had been involved. Shortly after our inspection the manager obtained information on what medicines had been stopped by the GP and the reasons why. However this information was not available in the person's care plan. Records relating to people's care and treatment were not complete.

Another person used additional equipment to help reduce the risks of pressure sores. Whilst we saw this was in place, no care plan had been introduced to cover their use. When we spoke with the manager about this they told us they wrote all the care plans. However due their other responsibilities, changes to care plans could not always be made in a timely manner. There was therefore a risk to people from unsafe care as complete and accurate records of people's care were not maintained.

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

Audits had been completed on various aspects of the service in June 2016. These audits covered various areas, some of which included care files, infection prevention and control, health and safety and medicines. We could see the audits had identified shortfalls and actions had been identified to make improvements. Some of these actions had been completed, for example we could see improvements had been made to infection prevention and control practices. Other improvements were still in progress. For example, care files and staff training. Systems and processes had been used to check on the safety and quality of services.

People we spoke with told us they had not been asked for their views on any of the improvements and refurbishment. Some staff told us people would be able to make choices over the soft furnishings in their rooms. The manager told us some changes to do with the refurbishment had not been discussed with people, for example, choosing the colours in the newly painted communal areas. However, they told us people would be more involved in decisions about their home in the future as more time would be available to plan and involve people. For example, the manager told us they were inviting families to become involved with garden improvements and to contribute their ideas for fundraising.

People's views and experiences had not recently been gathered and used to develop and improve the service. However the manager told us they knew this had not been done and that plans would be made to gather people's views. In addition, the manager told us they wanted to start meetings for people and their families as a way to regularly listen to people's views and experiences.

Beechcroft is required to have a registered manager. The provider had notified us about the registered manager's period of absence and told us management cover would be provided by another of the provider's managers. Shortly after our inspection we received an application from the covering manager to become the permanent registered manager for Beechcroft. The manager was aware of the provider's responsibilities to send statutory notifications to CQC when required. Notifications are changes, events or incidents that providers must tell us about.

The manager was supported by a deputy manager. Both managers demonstrated an open and approachable style of leadership. Throughout the day both managers spent time with people and talking with staff. One person we spoke with said of the manager, "She's very good; she is concerned about us and does care." One member of staff we spoke with told us, "The new manager is a breath of fresh air; they're approachable." The service was being led with an open management style.

Both the manager and the deputy manager were positive and motivated to improve the service. They also recognised and valued their staff team. One manager told us, "There's some brilliant staff and they work so hard." Staff we spoke with told us they enjoyed their role. One staff member told us, "It's lovely here; really nice." Staff spoke highly of the new management team and were supportive of the changes being made. One staff member told us, "We are going to make [the service] better for service users," and, "We are trying to make it more homely." Staff were supportive of the improvements being made.

We saw recent staff meetings provided staff with opportunities to share views as well as receive information on good practice in such areas as controlling and preventing infections and medicines. Other meetings were held with senior care staff and managers. These meetings helped to provide support and reinforce good practice and quality care.

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 9 HSCA RA Regulations 2014 Person-centred care The provider could not demonstrate activities for people were appropriate or met their needs and preferences. 9(1)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's consent to their care and treatment was not always established. 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not always effective as records were not always available. Records of people's care were not always accurate, complete and contemporaneous. 17 (1) (2) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff deployment was not planned to meet people's needs. 18(1)