Care Quality Commission

Care Uk Community Partnerships Ltd

Elizabeth Lodge

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?	Good
Is the service well-led?	Good

Overall summary

We inspected the service on 30 September and 1 October 2015. The inspection was unannounced.

Elizabeth Lodge Care Home provides accommodation for 87 people who require nursing and personal care. The units are situated over three floors. There is one nursing unit on the first floor, two nursing units on the ground floor and one residential dementia unit on the lower ground floor. On the day of our inspection 52 people were using the service. At the time of the inspection there was no registered manager in place however there was an interim manager who was overseeing management of the home until the new manager came into post.

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.

Summary of findings

People that we spoke to were positive about the service they received and the staff who supported them. We saw people being treated with warmth and kindness. Staff were aware of people's individual needs and how they were to meet those needs. Relatives we spoke with were positive about the home and the staff.

The service had a number of systems in place in order to monitor and maintain people's safety. However these were not always being followed. We found that the safe administration of medicines on the lower ground dementia residential unit was of concern. Staff had signed for medicines that had not been administered, several people had significant allergies to certain medicines but this had not been recorded on the medicines administration chart. We also noted two people were administered medicines covertly, but appropriate procedures had not been followed in recording this decision with the appropriate professionals.

We also observed during mealtimes that people who required assistance and chose to remain in their rooms had to wait up to an hour before a member of staff was available to support them.

There was a lack of consistency around the completion and recording of action taken on charts such as food and fluid monitoring, Waterlow recording and topical cream application charts.

People and relatives felt that the staff had the knowledge and skills necessary to support them properly. They told us that staff listened to them and respected their choices and decisions. Concerns were noted about the high usage of agency staff during the summer months and their competency. However people who use the service also confirmed that agency usage had reduced over the last few weeks.

People using the service could not confirm that they knew who the manager was but were confident that they could raise any issues or concerns with any staff member. However relatives who we spoke to knew the manager and the management team and said they were approachable and available.

Staff supervisions were being completed in line with the provider's policy. However the service had not carried out an annual appraisal for any staff member employed by the service.

There were policies, procedures and information available in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) to ensure that people who could not make decisions for themselves were protected. The service was applying MCA and DoLS safeguards appropriately and making the necessary applications for assessments when these were required.

At this inspection there were two breaches of regulation. The first one was regulation 12, which was in relation to safe management of medicines and the other was regulation 18, which was in relation to staff appraisals not have been carried out in over a year. Please refer to the "Safe" and "Effective" section of this report for details. 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 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

Some areas of the service were not safe as medicines were not always being managed safely.

People told us that they felt safe at the home and with the staff who supported them. Staff understood what abuse was and knew how to report any concerns they had to the management.

People's personal safety and any risks associated with their care and treatment were identified and reviewed.

The service had safe and effective systems in place to manage staff recruitment. This included background checks, reference verification, criminal record checks as well as checking that staff were qualified and registered to practice when employed as a nurse.

Is the service effective?

Requires improvement

The service was not always effective. We were told by staff that they did receive regular training and supervision but annual staff appraisals had not taken place.

Staff had clear knowledge and understanding of the Mental Capacity Act 2005 and in relation to how they would not presume a person could not make their own decisions about their care and treatment. Where people were at risk of coming to harm if they left the service unaccompanied, guidelines relating to the Deprivation of Liberty Safeguards (DoLS) were being appropriately followed.

People were provided with a healthy and balanced diet which allowed for choice and preference.

Healthcare needs were responded to properly and quickly with changes to each person's health needs being identified and acted up on.

Is the service caring?

Good

The service was caring and people told us they liked the staff who supported them and that they were treated with kindness and compassion.

Throughout our inspection, staff were observed talking with people in calm and friendly tones, treating them as unique individuals and demonstrating a compassionate nature.

Staff demonstrated a good knowledge of people's character and personalities and conversations were about far more than just care orientated tasks.

Summary of findings

Is the service responsive?

Good

The service was responsive. People and relatives told us that the management team was approachable if they had issues or concerns.

Complaints were listened and acted upon and steps were taken to resolve and learn from issues raised.

Care plans reflected how people were supported to receive care and treatment in accordance with their needs and preferences.

People were observed taking part in activities during the inspection and they were positive about the activities available at the home.

Is the service well-led?

Good

The service was well-led. There was confidence in how the home was managed.

Staff were positive about the management of the home and felt supported in their role.

The service had a system for monitoring the quality of care. Surveys are carried twice yearly with the most recent in June 2015.

Elizabeth Lodge

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 took place on 30 September 2015 and 1 October 2015 and was unannounced.

The inspection team comprised of two inspectors, a specialist advisor practising nurse in dementia care, a pharmacist 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 care service.

Before the inspection we reviewed information we had about the provider including notifications and incidents affecting the safety and well-being of people using the service. We also contacted the local authority safeguarding team for their views about the home.

During the visit we spoke to eighteen people who used the service, seven relatives, seven staff members, the interim manager and the regional director and a visiting community matron. Some people could not tell us about what they thought about the home as they were unable to communicate with us verbally therefore we spent time observing interactions between people and the staff who were supporting them. We used the Short Observational Framework for Inspection (SOFI) which is a specific way of observing care to help to understand the experience of people who could not talk with us. We wanted to see that the way staff spoke and interacted with people had a positive effect on their well-being.

We looked at the care records of nine people who used the services and checked files and records of eight care staff members. Other documents checked relating to people's care included risk assessments, medicine records, relative and residents meetings minutes as well as health and safety documents.

Requires improvement

Is the service safe?

Our findings

Overall good practices were noted with medicines administration on the three nursing units Tudor, Hanover and Windsor. However issues were noted with the administration of medicines on the dementia residential unit Stuart.

Allergy information had not been recorded on the medicines administration record chart (MAR) appropriately. One person on the nursing unit confirmed they were allergic to a particular medicine and had previously suffered serious side effects. However this was not clearly stated on their MAR chart or documented in their care plan. The staff nurse confirmed they would check the resident's allergy status that day and amend the home's records accordingly. Another person also had allergies but this did not correspond with allergy information recorded on the MAR sheet. Issues relating to allergy status of residents had been highlighted on the internal provider medicines management tool audit in August 2015 but had not been actioned.

One person's medicines had been signed for by staff but had not been given and were still in the blister pack. For another person who had been prescribed regular medicines, when the MAR chart, returns information and stock balances were checked the pharmacist was unable to identify the administration history and when highlighted the deputy manager and nurse both also could not identify if this was an administration error or use of medicines which were out of sequence in the monthly blister.

For one person whose medicines were administered covertly the GP had not signed the best interest decision paperwork associated with the Mental Capacity Act 2005. It had been signed by the deputy manager and there was no independent pharmacy advice paperwork. These issues had been highlighted on the internal provider medicines management tool audit in August 2015.

The specialist advisor pharmacist also found that paperwork and old medicines boxes containing personal details from all units had been added to the general bin for disposal.

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

People that we spoke to told us that they felt safe at the home and with the staff that supported them. When asked questions about feeling safe and secure people's comments included "Oh yes I feel safe" and "I feel safe, very safe." Relatives also felt people were safe at the home. Relative's comments included "They're safe and secure" and "Mum is safe."

Staff were aware of what constitutes abuse and the action they must take. The registered nurses and the deputy manager both said that if abuse was reported they would investigate the matter and that this would need to be reported through safeguarding and the local authority. The management had consistently reported any such concerns to the local authority safeguarding team as well as the Care Quality Commission (CQC). Other staff were clear on whom to report safeguarding to internally, and that they could contact senior management where required. Staff understood the term whistleblowing and to whom this must be reported to. Staff were aware that they would need to report this, even if this involved a colleague with whom they worked with. We saw information on display around the home from the provider organisation about how staff could 'whistleblow' if they had concerns about people's care. Staff were confident that the management would take action if they had any concerns.

Staffing levels had been determined by assessing people's needs and this was reviewed regularly. Concerns were noted about the use of agency staff. People who use the service and their relatives stated that agency usage had been high over the summer months although this had reduced recently. One person who used the service stated that "they were unhappy about the use of agency" and gave an example of where the person had to "wait several hours for their dressing to be changed despite asking regularly." The person also stated that "some agency staff did not appear to know how to do the dressing." Another person using the service stated "Agency ones are not so good. They don't know what they're doing and they don't care what they're doing."

People on Tudor unit had to wait for up to an hour for their meal to be served or to be supported with their meal. When we discussed this with the manager and the regional director, they told us they would look at ways to improve this.

The service had safe and effective systems in place to manage staff recruitment. This included background

Requires improvement

Is the service safe?

checks, reference verification, criminal record checks as well as checking that staff were qualified and registered to practice when employed as a nurse. A recruitment tracker was in place which outlined the number of hours recruited to and the number of hours required to be filled.

Risk assessments and care plans were up to date, clearly written and individualised giving information about people's needs and abilities. For example, people had risk assessments on file for wound care, use of plastic cutlery, support with personal hygiene. However some of the risk assessments were lacking detail on how to support the person and in some areas the decision in relation to the risk and the mitigating actions were contradictory.

It was positive to note that in some people's rooms there was advice and guidance for them in relation to swallowing and how to help with communication.

People had call bells to enable them to summon assistance if needed. We saw risk assessments in place for those people who were unable to use a call bell. However on the first day of inspection, in the morning, it was noted that people's call bells had been unplugged without any justified reason. We informed the manager about this and they told us that they would check this and ensure proper use of the call bells.

Standardised tools were used such as Waterlow, to assess pressure risk, food and fluid charts and topical cream application charts. Gaps were noted on cream application charts where the form had not been completed for a number of days and food and fluid charts were not comprehensively completed and totalled to assess a person's intake effectively. We informed the manager who told us they would check all documentation and ensure appropriate action is taken.

We saw accident and incident records which had detailed information about the incident, the investigation that the provider had carried out and what action had been taken as a result. The service also completed analysis on the number of falls in a week, the times and locations of falls to monitor and recorded any patterns emerging.

We saw risk assessments regarding the safety and security of the premises. We spoke with the full time maintenance officer who showed us records of health and safety checks of the building. These included gas, electrical and fire safety systems. Hoists and slings used to support people with transfers were regularly checked. These checks were up to date and included checks of assisted bathrooms. People were provided with individualised slings which were kept in the person's bedroom.

There were clear evacuation plans for all people using the service. Those people who required assistance were identified by colour coded stickers on their bedroom doors. All units had appropriate fire signage and suitable evacuation equipment available.

During our visit we checked communal areas of the service which were all clean and well maintained. There were detailed infection control procedures and staff and nurses demonstrated a good understanding of infection control and Control of Substances Hazardous to Health (COSHH). Staff were observed making use of personal protective equipment efficiently and ample supplies were available.

Requires improvement

Is the service effective?

Our findings

The manager told us that they provided mandatory training in the following areas: dementia awareness, fire awareness, food safety, health & safety, Mental Capacity Act, Deprivation of Liberty Safeguards, moving and handling and safeguarding. In addition to this other topics covered included basic life support, diabetes, pressure care, wound care.

Staff also confirmed that they received regular training and that the knowledge learnt enabled them to do their work effectively. A registered nurse that we spoke to confirmed that they also received training both in house and on line. However when looking at training records they did not always match what we were told. We highlighted this to the manager who agreed to carry out a full audit of the records that the service held.

Records showed that staff were receiving regular supervision and staff members that we spoke to were also able to confirm this. However the home could not demonstrate that staff members had received an appraisal in the last year. The interim manager provided an action plan for each staff member to receive an appraisal by the end of November 2015. They accepted that appraisals should form part of a staff member's development programme which had not taken place.

This was in breach of Regulation 18 (2) (a) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

People told us that staff listened to them and respected their choices and decisions. One person told us "the nurse talks to me and is pretty good in her answers, she guides me." Another person told us "the staff treat me as a woman" and a relative told us "staff here are very positive for asking residents their choice."

Senior staff and care staff understood their responsibilities under the Mental Capacity Act 2005. All staff members had been given pocket sized information cards for quick reference. Senior staff were also aware of the Deprivation of Liberty Safeguards (DoLS). However care staff had little understanding in this area. In terms of the Mental Capacity Act 2005, staff were able to tell us what this meant in terms of their day to day care and support for people.

The senior management team had applied to the local authority for a Deprivation of Liberty Safeguards (DoLS) authorisation for each individual to ensure any restrictions on people's liberty was in their best interest and reviewed on a regular basis.

People had forms in their files to alert staff and other healthcare professionals that if their heart stopped they would not want to be resuscitated or any resuscitation would not be in their best interests. Do not attempt cardio-pulmonary resuscitation (DNACPR) orders were completed appropriately with clear evidence of a multi-disciplinary approach being taken in order to reach this decision especially where a person lacked capacity.

People living at the services had mixed views about the food. One person told us "the food is okay, we have a menu to choose from." Another person commented "food could be better, but breakfast is very nice, the best meal of the day." Another four people using the service said that they were happy with the food with one saying "you get a choice" and another "it was good today."

Pictorial menus were clearly displayed on the main notice board in the entrance and on the tables in the main dining room and on individual units. People were enabled and assisted to make a choice based on the pictorial menu and one person was also given a third choice of a dish which was not on the menu which they were satisfied with.

One person told us about the food "Very nice they cater for what you want although I am not getting enough exercise." Another person told us "Staff are very obliging." She then asked for extra ice-cream with her dessert, which was supplied quickly.

The chef manager was aware of specific diets and was aware of what soft and puréed diets should consist of. Snacks including fruit, biscuits, crisps and drinks were visible around the home and people had access to these however on the second day of the inspection it was noted that at lunch time on the nursing unit there was a lack of drinks available and offered especially for those who were unable to ask for a drink themselves. There were also people at the service who liked having a snack in the early hours of the morning. The chef manager had made arrangements for a snack to be prepared for them on a daily basis.

People's weights were checked regularly and recorded. Staff recorded food and fluid intake where appropriate

Requires improvement

Is the service effective?

however there was a lack of consistency around the completion and recording of action taken on these charts. It was noted that people were not reaching their target intake of fluids for the day and no action was noted to be taken. We highlighted this to the manager who confirmed that they would look into this and check all relating documentation.

Appropriate referrals were made to speech and language therapists (SALT) and dietetic services, when needed, to help ensure that people's nutritional needs were met. Care staff that we spoke to understood what food thickeners were used for and which people were prescribed it as well as what amount of fluid to put with the amount of thickener as per medical advice given.

Care records showed how people's health and well-being were monitored and calls to the GP were made swiftly in response to changes. People and their relatives told us they had good access to healthcare professionals including GP's, opticians, chiropodist and dentists.

One person told us "the staff will get a doctor if I need it" and another person told us "I tell them and they arrange it." One relative told us "If you've got a problem they'll do something about it."

People's bedrooms were personalised with pictures, personal items of interest, photographs, flowers, televisions and radio's. People whose first language was not English had posters on the walls in their rooms outlining key words in their own language so that staff were able to communicate with them effectively. The home had some signage indicating the location of toilets and bathrooms and there were some directional aids. However due to the nature of the building more efforts could be made to enhance the existing signage especially for those people living with dementia.

We have recommended that the service considers obtaining appropriate signage especially in relation to the specialist needs of people living with dementia.

Good

Is the service caring?

Our findings

People told us that they liked the staff who supported them and that they were treated with kindness and compassion. One person told us "I like the nurses, the staff are good to me, I like them." Another person told us "The carers are very good" and in particular spoke about one carer as "an angel without wings."

Relatives who spoke to us told us "The carers talk to people nicely" and also said "if I had to be in a home I wouldn't mind being in this one." Another relative told us "all the staff are lovely, they're good to my relative."

Generally throughout the course of our inspection, we observed staff treating people in a respectful and dignified manner. People's needs and preferences were understood. The atmosphere in the home was calm, quiet and unhurried. Staff engagement was variable. Some staff had a jovial, friendly approach while others were more practical and task focused. Some staff took their time and gave people encouragement whilst supporting them.

The activities coordinators in particular had very good relationships with people, understanding their needs and their characters. Another carer was observed sitting having a friendly chat and a cup of tea with a resident in their room as they waited for transport to a medical appointment. Another person was able to enter the dining room kitchenette and make themself a cup of tea.

Staff were aware of what person centred care was and were aware of individual needs when asked about the care people required. One person told us that they only accepted care from a female carer and that the carers are aware of this and so a male carer would never approach the person to support them with personal care.

Life history work was being undertaken on the dementia residential unit. This gave staff important information about the person's life, their experiences and interests so that staff had a greater understanding of them as an individual. A folder in each person's room contained a one page care plan summary of needs and a life history booklet. However, we were unable to evidence this in the rooms that we looked at on the nursing units.

In Windsor Unit, no one was in the communal areas although we saw that eight people were in their rooms with the door open and either in bed or sitting in a chair. Staff were regularly walking up and down past people's rooms to maintain a check on how people were and entering rooms to speak with them. We looked at the staff allocation list which informed the three care staff on duty which people they should attend to and monitor specifically.

In Stuart Unit we observed two people sitting in the lounge. The television was on and both people were watching it. We found that a staff member regularly came into the lounge to check these people were okay. On one occasion they noticed when one person needed help opening a packet of biscuits and went to help them with this. They also asked people if they wanted their drinks refreshed and offered fruit and biscuits to them. One staff member was also observed having positive verbal interactions with these people, laughing and joking with one person in particular, being courteous and not rushing any of these interactions or tasks they were helping them with. Towards the end of this observation a member of staff was escorting another person into the lounge and was doing this patiently as the person was using a walking frame. They escorted the person to an armchair and observed them until they had sat down safely. They remained alert to whether physical assistance was required but did not overly intervene in order to allow the person to do as much independently for themselves as they were able to.

Staff who were observed assisting people with eating were seen to be kind and gentle. They stayed focused on the person, pulling up chairs to face them and they talked to them throughout the meal. People were not rushed through their meals even though other people were waiting for their food. Some carers were observed having pleasant, often jokey conversations with people. However, it was observed that during lunch on the nursing unit the majority of people were supported with their meals in their own room. We observed that there was not always enough staff to support people and some people had to wait for up to an hour before they were supported with their meal.

We observed staff respecting people's privacy through knocking on people's bedroom doors before entering and by asking about any care needs in a quiet manner. For people being supported with personal care, the staff attached a sign on the door stating "I am being assisted."

One person who was in her bedroom told me the following "They (staff) come when I press buttons, always helpful." Staff respected people's choice for privacy as some people preferred to take their meals in their own rooms.

Good

Is the service caring?

The subject of care came up at the residents' meeting. At the previous meeting, (August 2015) people had asked for carers to be more respectful. A concern had been raised about carers not knocking on doors before entering. People were asked whether this had improved and one person said "it's better, they're knocking on doors – the majority of them." But one person said "These young ones just burst in." The carers running the meeting said they would pass this on to managers and make sure it was communicated to all staff.

One nurse, when showing us the pressure relieving mattress, did not engage with the person on entering their bedroom. The nurse did not knock before entering, although the bedroom door was open.

We were told by relatives that they could visit at any time, and in the privacy of people's bedrooms and this was observed to be the case. Relatives told us they felt involved in care planning and were confident that their comments and concerns would be acted upon.

We were told that there were no people who were on end of life care. End of life information was provided in the care summary information and it included who to contact, the funeral arrangements if any as well as any special requests.

Good

Is the service responsive?

Our findings

People using the service and their relatives told us they were happy to raise any concerns they had with the staff and management of the home. One person told us "if had a complaint I would tell someone in charge" and another person told us "I feel very relaxed to go to a member of staff I have any issues." A relative commented "management are approachable, they deal with complaints and communicate effectively" and another relative said "they do sort out concerns." One relative did state that "I go to the manager if I have any concerns" and another relative stated "the manager is approachable but takes an awful long time to do things."

People's complaints and comments were recorded in the incident log in their care notes and a central complaints file was maintained with records of steps taken to resolve the issue and responses given to the complainant. The records we viewed showed a first response was usually made the same day by a senior staff member. Information about how to make a complaint was on display throughout the home.

Care plans reflected how people were supported to receive care and treatment in accordance with their needs and preferences. Relatives confirmed that they were involved in care planning. However, we were unable to evidence whether people or their relatives had consented and signed their care plan. Care plans were reviewed on a monthly basis or as and when required if there was significant change. A care plan summary was available in each person's room in the dementia residential unit which provided an overview of the care that the person required. However, these were not available for every single person living at the home which meant that staff would not be immediately aware of a person's individual care needs unless they referred to the full care plan.

Pre-admission assessment documents were available on file for people whose care plans we looked at. Prior to admission each person is individually assessed either by the deputy manager or the registered nurse. A standard admission summary is completed which contains useful information about the person, their preferences and wishes. Where possible the service also invites people to the home for a trial visit and families are also encouraged to visit with them.

The home employed two activities co-ordinators who covered six days a week. We observed they had very good relationships with people, understanding their needs and their characters. At the entrance to the home in the main reception there was an activities board outlining activities planned for the week. During the two days of the inspection we saw a quiz taking place with a group of residents, a pictorial quiz during the afternoon, bingo, art work, singing and dancing. We saw photos of recent events, parties and outings displayed around the home and people were observed to be engaging with staff in a positive and happy manner. People were also reading newspapers, completing word searches, spending time with each other, chatting and enjoying each other's company.

One person we spoke to enjoys reading the newspaper and said "the Activity Co-ordinator is lovely and she brings me the paper every day."

The home offered a regular church service which is open to all faiths. A service was held during our visit and several people attended. Volunteers from the catholic church also visit for one to one religious and spiritual guidance with people who belong to the roman catholic faith.

Some people went out of the home on visits including one person who continued to attend activities they used to attend prior to admission to the home.

Good

Is the service well-led?

Our findings

People who use the service told us that they did not know who the manager was but felt comfortable in approaching any staff member if they had any issues or concerns. One relative told us that "management had been useless for the last couple of years but the current manager is approachable." Another relative told us "management are approachable and communicate effectively."

Staff felt they could approach the manager at any time and that they could request training on topics they felt were needed to perform their roles. Staff also told us that they felt the management was supportive. One staff member told us that the manager had been in post three months and was wonderful.

Currently there was no registered manager at the home. However, a person had been appointed to the role and was due to start in November 2015 and they have submitted an application to become the registered manager and a letter confirming this was shown to us at the time of the inspection.

There was a clear management structure in place and staff were aware of their roles and responsibilities. Some of the staff we spoke to had worked at the home for a number of years.

We found that there was usually clear communication between the staff team and the managers of the service. The service held a daily handover sessions when shifts started. Senior managers and nurses held regular meetings. In addition to this senior managers and clinical leads held two weekly clinical meetings which were confirmed by looking at minutes for the last three months.

Staff told us there were regular team meetings which we confirmed by looking at the minutes of the most recent three staff team meetings. Staff had the opportunity to discuss care at the home and other topics.

Regular residents and relatives meetings were also held which was confirmed by the people and relatives we spoke to. On the second day of the inspection a residents meeting took place. The meeting was well run and the facilitators made sure all those present had an opportunity to express their opinions. People were encouraged to voice criticism or concern if they wanted to. It is to be noted that although there were few number of people in attendance, the facilitators said they would take the notes of discussion round to each person living at the home and ask everyone for their thoughts and opinions on the subject raised. Notes would then be circulated to the management.

The service had a number of quality monitoring systems including bi-annual questionnaires for people using the service and their relatives. We saw the results of the most recent survey completed in June 2015 however we were unable to see the actual completed forms as we were told an external company compiled the statistics. The results of this survey were drawn up in an action plan and discussed with people and relatives at the relatives meeting held in September 2015.

The service followed an organisational governance procedure which is designed to keep the performance of the service under regular review and to learn from areas for improvement that were identified. This included looking at areas such as chef managers audit, medicines management, nutrition, infection prevention control, tissue viability and managers monthly quality assurance. We found that the service developed plans to address the matters raised however on occasions issues identified had not always been actioned.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service was not protecting service users from the risks associated with the unsafe use and management of medicines. Regulations 12(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff appraisals were not occurring which meant that staff performance and development was not being effectively reviewed. Regulations 18 (2) (a).