Avery Homes (Nelson) Limited

Oban House

Inspection report

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Ratings

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

Overall summary

Our inspection took place on 21 and 22 July 2015 and was unannounced. At the end of the first day we told the provider we would be returning the next day to continue with our inspection.

This was the first inspection for Oban House under the new provider of Avery Homes (Nelson) Limited.

Oban House provides nursing care for up to 50 people, some of whom are living with dementia. Accommodation was located over three floors with a passenger lift. Bedrooms were single occupancy and had en-suite facilities. On the day of our inspection 38 people were using the service.

The service had a registered manager. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

People were given their medicines at the right time by registered nurses. However, we found areas of concern with regard to how people's medicine was being stored, recorded and managed.

Although staff had received training in safeguarding adults some staff we spoke with were unsure about the types of abuse people could face and what to do if they

Summary of findings

wanted to report their concerns. We found one example when an incident should have been reported as a safeguarding concern and was not. We were not assured that the systems and processes in place to prevent and detect potential abuse were effective therefore leaving people at risk of potential abuse.

The provider was aware of the requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS) to help ensure people's rights were protected. However, staff training and knowledge were limited in this area. Some people's mental capacity assessments were not fully completed or details were not clear. When a person was found to lack capacity there were no decision specific mental capacity assessments in place and the reasons for making decisions on people's behalf were not clearly recorded

People told us they felt safe living at Oban House. They said staff were kind, caring and respected their privacy and dignity. They thought that the care they received was good and that staffing levels met their needs, although sometimes people felt staff did not have enough time to speak with them. The recruitment procedures were appropriate at the time of our inspection.

People were mainly positive about the meals served at the service and we observed how people were given a choice of something different if they asked for it. People's specific dietary needs were catered for.

There was an activities programme at Oban House and the type of activities available for people were improving. We heard about the plans the service had to ensure people had the opportunity to be involved in meaningful pastimes to help stop them from feeling lonely or isolated.

People's care records were person centred and focused on people's individual needs, their likes, dislikes and preferences. People's care was assessed and reviewed regularly and people and their relatives felt involved in this process.

We have recommended that the service refers to current best practice guidance around activities for people living with dementia.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the management of medicines, safeguarding people from abuse and protecting their rights. You can see what action we told the provider to take at the back of the full version of this 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 aspects of the service were not safe. People told us they felt safe at Oban House. However, some staff did not fully understand what types of abuse people could experience and how to report it. Systems to report incidents and potential abuse were weak and staff failed to report all incidents to managers.

People's medicines were not always being stored, recorded and managed safely.

Staffing numbers were adequate and satisfactory recruitment procedures were in place.

Is the service effective?

Requires improvement

Some aspects of the service were not effective. The provider knew the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) to help ensure people's rights were protected. However, some staff's knowledge was limited and some people's MCA assessments did not contain enough information about why decisions had been made in people's best interest.

Staff had received the basic training or skills they needed to deliver safe and appropriate care to people.

People were supported to eat and drink sufficient amounts of well-presented meals that met their individual dietary needs.

People's health and support needs were assessed and this was reflected in care records. People were supported to maintain good health and access health care services and professionals when they needed them.

Is the service caring?

Good

The service was caring. People said staff were kind and caring and treated them with dignity and respect. People's diversity and spiritual needs were identified and respected by staff. Staff knew about people's life histories, interests and preferences, which allowed them to provide more person centred care.

People and their relatives told us they were involved in the planning of their care and making decisions about the care and support provided at the home.

Is the service responsive?

Requires improvement

Some aspects of the service were not always responsive. Efforts were being made to make available a range of meaningful activities so people could be supported to follow their interests and prevent people from feeling isolated or lonely.

Summary of findings

People's care records were person centred and focused on people's individual needs, their likes and dislikes and preferences.

People and their relatives felt able to raise concerns or complaints and knew how they should complain, the service responded to and investigated complaints appropriately.

Is the service well-led?

Some aspects of the service were not always well-led. Systems were in place to regularly monitor the safety and quality of the service people received and results were used to improve the service but sometimes these internal reporting mechanisms were weak and serious incidents concerning people's safety were not always reported to managers.

People and staff spoke positively about the managers at the service. Regular staff and managers meetings helped share learning and best practice so staff understood what was expected of them at all levels.

Requires improvement

Oban House

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.

Our inspection took place on 21 and 22 July 2015 and was unannounced. The inspection team consisted of two inspectors, a specialist advisor with expertise in people's medicines and dementia care 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.

We spoke with 10 people who used the service, eight relatives, nine members of staff and the registered manager. We observed the care and support being delivered 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. We looked at nine care records, three staff records and other documents which related to the management of the service such as staff training records and policies and procedures and quality audits.

Requires improvement

Is the service safe?

Our findings

We looked at how the service managed people's medicine so that they received them safely. People received their prescribed medicines at the right times and these were administered by registered nurses. However, during our inspection we found several areas of concern with regard to how people's medicines were stored, recorded and managed.

The temperature of the medication room and fridges were regularly recorded. We found the temperature in one medication room was recorded higher than the recommended limits for 13 out of 22 days in July 2015 with the highest temperature recorded at 32c. Although we were told the issue had been reported no action had been taken to reduce the temperature. It is important to keep temperatures within the recommended guidelines as medicine can be easily damaged if exposed to excessively low or high temperatures.

We looked at people's medicine administration records (MAR) charts. We noted when people's medicines were booked in they were not always countersigned by a second member of staff in line with the service's policy. Sometimes the information on the MAR charts were not always clear. For example, one person's MAR chart had been pre-populated by staff in advance of when their medicine was due as there were long gaps between doses. Some of these entries had been incorrectly marked which may have resulted in that person not receiving their medicine when they should. In addition, some MAR carts had been signed and later crossed through as refused or destroyed which indicated MAR charts were being completed at the point of preparation and not after administration as recommended by in the National Institute for Health and Care Excellence (NICE) guidance. Nursing staff told us they had been booked on training for the safe handling of medicines and hoped this would help them make improvements to their record keeping.

Although we saw some guidance in place for 'as required' or PRN medicines this was missing in some cases. One PRN medicine for pain relief had been hand written on the MAR chart to be taken at set intervals through the day. This information was different to the pharmacy advice on the label. The person was living with the later stages of dementia and had been prescribed medicine to be given if they suffered additional breakthrough pain. We asked staff how they monitored a person's pain when they may not be able to verbalise their feelings. Staff were unclear about the use of monitoring non-verbal signs of pain to support people living with dementia. We did not see any guidance alongside people's medicine records to help staff recognise when people were in pain.

Some people using the service received covert medicines. (Covert is the term used when medicine is administered in a disguised way without the knowledge or consent of the person receiving them.) However, we found no evidence in people's current care records as to why this decision had been made. There were no specific mental capacity assessments relating to covert medicine or records of the decision making process taking into account the person's best interests. We were unable to source specific recommendations by the supplying pharmacy to how the medicines were prepared or to what foods they could be added. It is important to record the advice of a pharmacist because adding certain medicines to food or breaking and crushing medicines to hide them can alter the way they work.

We saw one person had prescribed creams in their bathroom which were freely accessible to any other person who entered the room. Staff told us they did not think this risk had been identified. One tub of cream was without a lid and another was over a year old. The cream was being used for one person who was at high risk of pressure sores. We spoke to staff about our concerns regarding the risk if cross contamination. The creams were immediately taken away and replaced with new, sealed pots.

These incidents amounted to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe living at Oban House. One person commented, "I trust the staff to take care of me." Another said, "I feel safe here." The service had a safeguarding policy and contact details for the local authority safeguarding teams were on notice boards around the service.

Records showed that most staff had received training in safeguarding and we were told the local authority's safeguarding lead had recently visited the service to raise awareness of safeguarding issues and was due to return soon. We spoke to staff about what they would do if they suspected someone was at risk of or being abused. Most

Requires improvement

Is the service safe?

staff knew what to do if safeguarding concerns were raised. This included reporting their concerns to managers within their organisation, however, other staff were unsure about the different types of abuse people may face and did not know how to access the local authority's safeguarding team if they needed to.

During our inspection we found staff had been recording events relating to one person's behaviour, we were concerned that in some instances the serious nature of these events should have resulted in an incident report and a referral to the local safeguarding team. We spoke with the manager about our concerns who told us they were unaware of the situation, but they would act immediately. Later that day we received confirmation that our concerns had been reported to the local safeguarding team and the manager had put processes in place to protect the person concerned and other people using the service.

Although mangers acted as soon as they became aware of the situation we were concerned that the systems and processes in place to prevent and detect potential abuse were not effective therefore leaving people at risk of potential abuse. This was a breach under Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had systems to manage and report accidents such as falls. Accident reports were monitored and analysed to help identify any patterns so future risks to people could be reduced. Details of 'significant events' were recorded together with action taken at the time, who was notified, for example relatives or healthcare professionals and what action had been taken to avoid any future incidents. We noted the accident reporting forms did not contain the same level of detail as the significant event forms. We spoke to the manager about how additional information may help them when they reviewed the accident forms and help give them assurance that the correct procedures were being followed.

Risk assessments were in place for people covering aspects such as falls, pressure ulcers, choking and malnutrition together with guidance for staff on how to reduce the risk. For example, one person was at risk from choking, there was guidance for staff about the type of food the person should have and how they could assist the person by using specialised equipment.

The service followed safe recruitment practices. Staff files seen contained a checklist which clearly identified all the pre-employment checks the provider had obtained in respect of these individuals. This included an up to date criminal records check, at least two satisfactory references from their previous employers, photographic proof of their identity, a completed job application form, a health declaration, full employment history, interview questions and answers, and proof of eligibility to work in the UK. .

People and their relatives told us they thought there was enough staff although some people felt they were always short of time and there had been a lot of recent changes. Comments included, "There are lots of different members of staff lately", "Different staff lately…to some extent unsettling. Now it's a little better" and "All the original nurses have gone." Staff told us there had been changes, but they thought there were enough of them to meet people's needs.

The manager showed us the duty rotas for June and July 2015. Areas where additional staff were needed had been identified. Internal bank staff were used to cover annual leave and sickness and agency staff were only used if the situation was urgent.

Requires improvement

Is the service effective?

Our findings

The service had policies and procedures in relation to the Mental Capacity Act 2005 (MCA) and the provider had issued a directive concerning Deprivation of Liberty Safeguards (DoLS) to give staff basic guidance. The provider was aware of the implications that resulted following the Supreme Court Judgement in relation to DoLS and the manager was in the process of identifying those people who may be affected. The service was in liaison with the local authority to ensure appropriate assessments were undertaken so people who used the service were not unlawfully deprived of their liberty. An overview of the MCA Act had been given to staff during group supervision. However, from provider records it did not demonstrate that most staff had received specific training in the MCA or DoLS. When we spoke with staff their knowledge of MCA and DoLS was limited, one senior staff member explained they had not worked at the service for long so did not know anything about DoLS applications.

People's records contained mental capacity assessments relating to a person's ability to contribute towards the planning of their care, however, we found examples where these assessments were not fully completed or details were not clear. When a person was found to lack capacity there were no decision specific mental capacity assessments in place. For example, when bed rails were in use, when people were receiving covert medicines or when do not attempt cardiopulmonary resuscitation (DNACPR) decisions were in place. When we looked at people's care records in these examples there was either none or very little recorded rationale in place explaining why the decision was made in each person's best interests and little recorded evidence of best interests meetings being held or reviewed.

This was a breach under Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

A new provider had taken over the service in November 2014. The manager explained that all staff were required to undertake the new provider's mandatory training regardless of what training staff had received from the previous provider. They told us and records confirmed that they were currently working through a schedule of training to ensure this happened. Training undertaken by staff was monitored centrally, records confirmed most staff had received their statutory training in subjects such as safeguarding adults, moving and assisting people, health and safety, infection control, and fire safety. Training had been booked for staff to attend the Control of Substances Hazardous to Health (COSHH), first aid and palliative care. We noted from records that additional more job specific training, such as dementia awareness, mental health awareness, pressure ulcer preventions and end of life care were still to be completed by most staff. We spoke to the manager as we felt once staff had received this additional training it would help them when providing day to day care to the people using the service. We saw future training events had been booked in the coming weeks and the manager explained that the priority had been for all staff to complete their mandatory training and that all staff would have completed all of their training programs by the end of the first 12 months of the service being in operation. We will look at staff training again during our next inspection to ensure full completion.

New staff completed an induction when they started working for the service. This covered subjects such as the service's aims and objectives, safeguarding adults, person centred support and health and safety awareness. The manager explained a new induction had just been introduced in line with the new care certificate framework and this was due to begin during August 2015.

Staff told us they felt they had enough training to meet people's needs. Some staff were unsure when they last received supervision or an appraisal. Records indicated that staff attended regular supervision but this was sometimes group supervision which covered general subjects, such as infection control, the mental capacity act and the risk of falls. The manager explained as the service had been running less than a year under the new provider, staff appraisals had not taken place yet, however plans were in place to complete these over the coming months.

We observed staff supported people appropriately when their behaviour challenged the service. Staff told us how they helped people when they became upset or distressed and we observed one situation when staff supported a person when they were unhappy. Staff remained calm and attentive they allowed the person space while still being observant of their needs. People's care records contained details of their likes and dislikes, for example, too much talking or shouting made one person unhappy and staff recorded events when people became angry or upset or

Is the service effective?

acted out of character. However, we saw limited written information in people's care records to inform staff about possible triggers for certain behaviour and strategies to help them manage this. This type of guidance would be particularly useful for those staff who were new to the service and did not know the person directly.

People were supported to have sufficient amounts to eat and drink and maintain a balanced diet. People's comments included, "The food is good, I'm well fed", "It's fairly good…I don't always get what I ask for", "I mostly make a choice the day before" and "I always have loads to eat."

People told us they were brought a cup of tea and biscuits at least twice a day and we saw staff offering drinks throughout the day. Fruit juice and water was available in the main lounge areas all day and we observed people in their rooms had water within easy reach.

We observed the service during lunchtime and saw staff were kind and attentive and supported people when they needed assistance. The atmosphere was relaxed although quiet. People were offered a choice and alternatives, staff comments included, "Have you finished, would you like anymore?" and "You haven't eaten much. Would you like to try the fish?"

People who had special dietary requirements were catered for, for example, some people were served soft or pureed food, the food was presented well and looked appetising. When people were experiencing weight loss they had their meals fortified with higher calorific food. We spoke with the chef who had a good knowledge of people's dietary needs including cultural preferences. Alternatives to the menu were available for people and we were shown the process in place to order different options. When people wanted something different on the day we were told how staff did their best to cater for them. For example, one person wanted a salad for lunch and the kitchen provided this. People's weight and fluid intake were monitored and where necessary nutritional screening tools were used to identify people's needs and involve other healthcare professionals as necessary.

People using the service were supported to maintain good health and have access to healthcare services and support when required. Staff told us the local GP visited every week and more frequently if needed. We saw records of visits from healthcare professionals in people's care records including visits and advice from the tissue viability nurse and the community psychiatric nurse.

Good

Is the service caring?

Our findings

People told us that staff were caring. They said, "The staff are lovely, they look after me" and "The staff are nice, I'm happy here". Relatives told us, "[My relative] is happy so we are happy…so far I'd give this place 10/10", "Can't do better than this home. I always appreciate what [the staff] do" and "Some of the new carers are extremely good, helpful and kind. I can't praise them enough."

People's diversity was respected, for example, people's spiritual needs were understood and supported. During our inspection a local church visited to sing some hymns with people. We spoke with a volunteer from the church who told us they came every other week and explained that they found people preferred to sing the older style hymns. People's cultural and spiritual preferences were recorded in their care records.

We observed staff supported people in a kind, caring and sensitive way. Staff had knowledge of people's preferences and personal histories and we saw how they made people feel involved. For example, one member of staff was talking with a person about their wartime experience and another was having a conversation about one person's birthday celebrations. We observed staff asking people if they would like tea or coffee and if the temperature was alright for them.

People told us staff respected their privacy and dignity and we observed staff knock on people's doors before entering and closing doors when they were supporting people with personal care. People were clean and well dressed, we saw many were wearing their chosen accessories such as jewellery and hair bands. One person told us about the bracelet they were wearing and we observed staff were careful to keep their handbag in reach so the person had access to the things that were important to them.

Care records were centred on people as individuals and contained detailed information about people's diverse needs, life histories, likes, dislikes and preferences to how they would like to be cared for. For example, one person preferred to eat their meals in the room, they liked to watch television or listen to the radio if the volume was not too loud. They wanted to be told about the activities so they could choose if they wanted to join in or not.

There was a call bell system in operation and we observed the staff response time and found staff came quickly. Call bells were within easy reach of people and when a person was unable to use a call bell this was noted in their care records together with alternative arrangements, For example, one person was unable to use the call bell so arrangements had been made for staff to check on that person at regular intervals.

Oban House was in the process of re-applying for recognition with the Gold Standards Framework (GSF) which is a system of training and accreditation in end of life care which enables front line staff to provide a 'gold standard' of care for people nearing the end of life. The manager explained they were receiving support from a local hospice and that they had identified areas where they could improve and provide additional training to help develop staff knowledge and confidence.

Requires improvement

Is the service responsive?

Our findings

People we spoke with were mostly unaware of their care plans, however, relatives told us they felt they were involved with the assessment and planning of care. One relative said, "I always ask the nurse when I come, if there have been any changes to [my relative's] care. They always let me know." Another relative said, "[The staff] tell us about things… they probably know [my relative's] needs better than me."

The service had introduced 'resident of the day' system and this enabled staff to review people's care records monthly. One person had a photo on their wall wearing a resident of the day red sash. We asked them about this and although they could not remember much about the event they were pleased to have been a focus for a while and enjoyed looking at their photograph. Resident of the day allowed people and their relatives to meet with senior members of staff, their keyworker, housekeeping and maintenance. This gave an opportunity for any issues to be highlighted and rectified. It allowed for a review of care needs and the opportunity to improve things that mattered to that person. For example, food, activities, maintenance issues and looking at peoples' healthcare needs. Although records of these meetings were not complete at the time of our inspection the manager told us plans were in place to change the forms used so they could highlight the issues raised and evidence how the service had made things better for people.

People's care records were person centred and focused on people's individual needs, their likes, dislikes and preferences. For example, one care record gave information about a person's food preferences, how they had a small appetite and needed encouragement from staff to eat. A relative told us how their family member now had a bed that was lower to the floor and had a crash mat in place, they told us they felt relieved as their relative was having problems during the night and this change should help.

People had mixed views about the activities available at the service. Comments included, "There aren't any activities", "I get involved in the activities and I go out with my family", "I would like to go outside in the garden by myself but they won't let me", "No-one comes and says '[person's name] how are you today.' It's all a bit miserable" and "I like to watch the activities …they drag you in sometimes" One relative told us, "It would be nice if they took [my relative] to the garden sometimes to get some fresh air." Another told us, "The activities could be better, there used to be lots going on with outside entertainers nearly every day, now there is very little." Some people told us that they just wanted to have a chat but felt staff had little time for them while they worked, people told us, "None of the staff comes to sit and chat, I'd prefer that to playing bingo", "I used to say good morning to [staff] but they don't answer, so I don't say it anymore" and "One [staff member] comes and gives care, but doesn't talk to me while she is working."

We spoke to the newly appointed activities co-ordinator and talked about how they intended to include everyone in meaningful activities while understanding and respecting each person's personal preferences. They told us their plans for the future, for example, baking cakes, days out and social events and how they were trying to coordinate events on each floor so everyone could join in if they wanted to. They were also looking at ways to involve the outside community and were speaking with a local school to provide volunteers to come in and chat with the residents. We were told that two people like gardening so they had brought some flowers for the people to plant and care for. We observed one person going out with staff to water their flowers during our inspection.

We observed people having a hand massage as part of new program introduced by the manager. Staff told us this gave a good opportunity for staff to sit and engage with people. During the afternoon some people were sitting in the garden while afternoon tea was served. We were concerned however that not everyone had something to fill their time and some people may be at risk from social isolation. One person we spoke with was sitting in their room, they told us they didn't know about the activities going on at the time, they relied on staff to tell them what was going on and help them to the lounge. We spoke to the manager about how they and other staff could support the activities coordinator to help improve people's day to day lives. We will look at this again during our next inspection.

People told us they would speak to someone if they were unhappy and relatives told us they felt listened to by the manager and staff. One relative told us, "I would go to the manager if I had any problems" The service had a procedure which clearly outlined the process and timescales for dealing with complaints. Complaints were logged and monitored at provider level. The manager

Requires improvement

Is the service responsive?

confirmed there had been two complaints since the new provider took over the service and relatives were encouraged to raise any issues directly with the manager or during relatives meetings.

We recommend that the service refers to current best practice guidance around activities for people living with dementia such as the resource toolkit for living well through activity in care homes produced by the College of Occupational Therapists.

Requires improvement

Is the service well-led?

Our findings

Regular audits were undertaken to assess internal standards at the service. We spoke with the maintenance staff and were shown detailed daily, weekly and monthly checks and audits covering equipment, fire checks and safety audits. A monthly self-audit programme was undertaken by the manager in subjects such as, moving and handling, fire and maintenance. The provider conducted home visit reports these looked at areas of care, record keeping and staffing issues in the home. Audit reports confirmed an improvement in staff training and recognised there was more to be done, there were also recommendations for improving the activities for those people living with dementia. The manager told us he found the feedback from these reports useful as it gave them targets to work towards.

Although we found the above audits were in place and noted how they help drive improvement in the service, we were concerned that some audits were not thorough enough. For example, the monthly medication audit did not highlight the errors we found in people's medicine records. There did not appear to be an effective system in place for reporting any medication errors and incidents so it was hard to see how managers could monitor progress, learn from events and improve standards. We found that internal reporting mechanisms were weak and serious incidents concerning people's behaviour were not always reported to managers. For example, the manager was unaware of one incident we brought to his attention. Clear and transparent reporting processes for staff would help reduce the risk to people using the service and allow managers to act quickly to meet people's needs and ensure their safety.

This was a breach under Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

People and their relatives were positive about the way the service was managed and generally felt things were improving. They said, "The new manager is good. He is cracking on with things, there are no problems", "The present management, present staff are much better" and "I'm very happy, new management is absolutely excellent. The whole way the home is run, staff are more dedicated. [The manager] takes a personal interest."

Regular relatives' meetings were conducted to ensure views were listened to. We saw records of these and noted concerns that had been raised had been addressed. For example, one relative was concerned about items left in their relative's room that could cause them harm. This was noted and a risk assessment was completed resulting in these items being removed.

The service had not conducted a resident and relatives' survey at the time of our inspection as it had been operating for less than a year under the new provider. We asked how the manager gained people's views or knew that people were happy. He told us relatives meetings were a good source of information and that he encouraged feedback from relatives and staff.

Regular staff meetings were held. Senior staff including nurses, housekeeping and maintenance attended a daily meeting with the manager. This provided the opportunity to discuss the needs of people who used the service, share information, raise any concerns and identify areas for improvement. Staff meetings helped share learning and best practice so staff understood what was expected of them at all levels. Minutes from the staff meetings covered information such as infection control, confidentiality and general employment issues as well as feedback from the relatives meeting which included improvements for people's care, activities and the relative's thoughts on how things could be better.

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 **Regulation 12 (2)(g) People's medicines were not always being stored, recorded and managed in line with policy, procedure, current legislation and guidance.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Regulation 13 (2) (3) The provider did not have robust processes and procedures in place to make sure people were protected from abuse.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Regulation 11 (1) (2) When people were found to lack capacity staff did not always follow the requirements of the Mental Capacity Act 2005 and associated code of practice.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 (2) (a) The provider did not always have systems in place to identify where quality or safety were being compromised and did not always have access to all necessary information to improve the quality and safety of the services provided.**