Mr H R & Mrs J C & Mr M J Martin

Hollymead House

Inspection report

3 Downview Road
Felpham
Bognor Regis
West Sussex
PO22 8HG
Tel: 01243 868826
Website: www.hollymeadhouse.co.uk

Date of inspection visit: 29 and 30 September and 6 October 2015
Date of publication: 16/11/2015

Ratings

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

Overall summary

The inspection took place on 29 and 30 September and 6 October 2015 and was unannounced.

Hollymead House provides care and accommodation for up to 35 people and there were 29 people living at the home when we inspected. These people were all aged over 65 years and had needs associated with old age and frailty.

Thirty four bedrooms were single and there was a double bedroom which was occupied by one person at the time of the inspection. Thirty bedrooms had an en- suite toilet.

There was a communal lounge and dining area which people were observed using. There was also a conservatory which people were using for craft activities. A passenger lift was provided so people could access the first floor.

The service had a registered manager who was also one of the registered providers. Another staff member was also working in the role of manager but had not applied for registration with the Commission although this was their intention. A registered manager is a person who has

Summary of findings

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. There was an acting manager who had been in post since July 2015 and had not applied to register with the Care Quality Commission.

Staff supervision and appraisal was inconsistent and training in the management of diabetes was not provided for one staff member who took a lead role in this.

People said they were afforded privacy and they were treated with respect but we noted closed circuit television (CCTV) cameras were used to observe and record visitors and people in the car park, the communal lounge and dining areas. Whilst there was a sign at the front door to say CCTV was in operation this did not specify which areas. The use of CCTV in the home had not been discussed with people.

Staff were trained in adult safeguarding procedures and knew what to do if they considered people were at risk of harm or if they needed to report any suspected abuse. People said they felt safe at the home.

Care records showed any risks to people were assessed and there was guidance of how those risks should be managed to prevent any risk of harm.

There were sufficient numbers of staff to meet people's needs. Staff recruitment procedures were generally adequate to ensure only suitable staff were employed.

People received their medicines safely. Whilst staff were trained in medicines procedures this did not include a direct observation of staff handling and administering medicines which was recorded as part of a competency assessment.

The CQC monitors the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Staff were trained in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). People's capacity to consent to their care and treatment was assessed. At the time of the inspection each person living at the home had capacity to consent to their care and treatment and their choices were respected.

There was a choice of food and people were complimentary about the meals. The provider consulted people about the food and meal choices.

People's health care needs were assessed, monitored and recorded. Referrals for assessment and treatment were made when needed and people received regular checks such as dental and eyesight checks.

Staff were observed to treat people with kindness and dignity. People were able to exercise choice in how they spent their time. Staff took time to consult with people before providing care and showed they cared about the people in the home.

People said they were consulted about their care and care plans were individualised to reflect people's choices and preferences. Each person's needs were assessed and this included obtaining a background history of people. Care plans showed how people's needs were to be met and how staff should support people.

There was a wide range of activities for people and a schedule of activities for the week was displayed in the entrance hall. These included arts and crafts as well entertainment from visiting musicians and singers.

The complaints procedure was available and displayed in the entrance hall. People said they had opportunities to express their views or concerns. There was a record to show complaints were looked into and any actions taken as a result of the complaint.

Staff demonstrated values of treating people with dignity, respect and as individuals. People's and stakeholder professionals' views about the quality of the service were sought. Staff views were also sought and staff were able to contribute to decision making in the home.

A number of audits and checks were used to check on the effectiveness, safety and quality of the service.

We found two 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 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?

Good

The service was safe.

The service had policies and procedures on safeguarding people from possible abuse. Staff knew what to do if they suspected any abuse had occurred.

Risks to people were assessed and guidance recorded so staff knew how to reduce risks to people.

Sufficient numbers of staff were provided to meet people's needs.

People received their medicines safely.

Is the service effective?

Requires improvement

The service was not always effective.

Whilst staff were trained in a number of relevant areas, they were not always adequately supervised and their work appraised.

People's capacity to consent to care and treatment was assessed and staff were aware of the principles and procedures as set out in the Mental Capacity Act 2005 Code of Practice.

People were supported to have a balanced and nutritious diet. Special dietary needs were catered for. Health care needs were monitored. Staff liaised with health care services so people's health was assessed and treatment arranged where needed.

Is the service caring?

Requires improvement

The service was not always caring.

Whilst people said their privacy was respected, they were not consulted about the use of CCTV in communal areas and the provider had not followed the guidance issued by the Commission regarding the use of CCTV.

People were treated with kindness and dignity by staff who took time to speak and listen to people.

People were consulted about their care.

Is the service responsive?

Good

The service was responsive.

People's needs were comprehensively assessed and reviewed. Care plans were individualised and reflected people's preferences.

There was a daily activities programme for people.

The service had a complaints procedure and people knew what to do if they wished to raise a concern.

Summary of findings

Is the service well-led?

Good

The service was well-led.

The provider sought the views of people, staff, and, stakeholder professionals regarding the quality of the service and to check if improvements needed to be made.

Staff demonstrated a commitment to treating people with dignity and as individuals.

There were a number of systems for checking and auditing the safety and quality of the service.

Hollymead 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. The inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 29 and 30 September and 6 October 2015 and was unannounced.

The inspection team consisted of an inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We reviewed information we held about the service, including previous inspection reports and notifications of significant events the provider sent to us. A notification is information about important events which the provider is required to tell the Care Quality Commission about by law.

During the inspection we spoke with six people who lived at the home. We also spoke with three care staff, the deputy manager, the acting manager and the registered manager.

We spent time observing the care and support people received in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We looked at the care plans and associated records for five people. We reviewed other records, including the provider's internal checks and audits, staff training records, staff rotas, accidents, incidents and complaints. Records for ten staff were reviewed, which included checks on newly appointed staff and staff supervision records.

We spoke with a community nurse who treated people at the home, a visiting nurse from a local hospice, a visiting activities person and a GP. These professionals gave their permission for their comments to be included in this report.

This service was last inspected on 15 October 2014 and there were no concerns.

Good

Is the service safe?

Our findings

People told us they felt safe at the home and that they received safe care. When we asked people if they felt safe comments included responses such as, "Of course I feel safe," and, "Absolutely." People said there enough staff to look after them and added that staff responded promptly when they asked for help by using the call point in their room.

Staff were trained in procedures for reporting any suspected abuse or concerns. Staff said they would report any concerns to their line manager and knew they could access safeguarding procedures in the home which contained guidance on reporting such concerns to the local authority safeguarding team. The service had policies and procedures regarding the safeguarding of adults, including a copy of the local authority safeguarding procedures.

Risks to people were assessed and recorded. There were corresponding care plans so staff had guidance on how to support people to reduce the risk of injury or harm. These included the risks of falls, the risk of pressure areas developing and risks when moving people. For one person a risk assessment identified the person was at risk of falling out of bed and a bed rail was in place to prevent this. This included guidance for staff on the use of cushioning to prevent the person from possible injuries and we saw this was in place. The risk assessment needed to be expanded to include an assessment regarding the possibility of the person injuring themselves by trying to get out of bed when the rail was being used. The risk assessments showed any risks to people regarding their room environment were also assessed to identify if any preventative action needed to be taken. Care plans, including risk assessment were reviewed on a regular basis so any changes in people's needs regarding risks could be identified.

A dependency tool was not used by the provider to calculate the staffing levels needed to meet people's needs, although the acting manager said the staffing levels were adjusted to meet people's changing needs. The acting manager and staff told us the service aimed to have staffing levels of either four or five care staff from 8am to 2pm plus a senior carer and the acting manager. On the first day of the inspection there were four care staff on duty. From 2pm to 8pm there were at least three care staff on duty and a senior carer. Staffing was organised on a staff roster which showed staffing levels were planned for at these levels.

Night time staff consisted of three staff on 'waking' duty. Staff said they considered there were enough staff on duty to meet people's needs but added that there were times when unforeseen staff absences meant the required levels were sometimes not met. Staff said this did not compromise the standard of care provided to people. The acting manager showed us a system whereby staff indicated when they would be available to provide additional staff hours to cover for unforeseen absences.

Additional staff were provided for cooking, catering, cleaning and laundry.

Health care professionals told us they considered the service had sufficient staff to look after people. One professional commented, "There are always staff around to help people." During the inspection we observed there were enough staff to help people when they needed assistance.

We looked at the service staff recruitment procedures. References were obtained from previous employers and checks with the Disclosure and Barring Service (DBS) were made regarding the suitability of individual staff to work with people in a care setting. We noted one DBS check was not obtained when the staff member started work. The staff member had supplied a DBS check from a previous work place. The acting manager took immediate action to address this and a DBS check was confirmed as being obtained immediately following the inspection. There was a record of staff being interviewed to assess their suitability for the post.

People were supported with their medicines and were able to handle their own medicines if assessed as being safe to do so. For example, one person managed their own medicines and there was an assessment that the person was able to do this safely. This included obtaining confirmation from the GP that the person was able to do this safely. People said staff supported them to take their medicines at the right times.

There was a photograph of each person in the medicines administration records (MARs) so staff knew who to give medicine to. A signature of each staff member was maintained so it could be identified which staff member administered medicines. A record was maintained of any incoming medication stock. The service used a monitored dosage system whereby medicines were supplied by the pharmacist in blister packs instead of containers. The MARs

Good

Is the service safe?

and the blister packs of medicines showed staff administered medicines as prescribed. Staff recorded their signature on the MARs each time they administered medicines. Guidelines were recoded so staff knew the symptoms indicating 'as required' medicines needed to be given.

Medicines classed as controlled drugs were stored appropriately. A controlled drug register was maintained for these medicines where the quantity of medicines was recorded, the amount given and a remaining balance of medicine. This involved two staff who recorded their signature to acknowledge they had handled and administered the medicines. We checked the stock of medicines and recorded balance of controlled medicines and these were found to tally. At the time of the inspection a prescribing nurse from a hospice was assessing a person's medicines for pain relief. This involved working with a staff member from the home in order that any changes in dosage were followed by the staff at the home. The nurse told us the staff worked well with them regarding the person's medicine management and described the staff as "keen and attentive" to people's medicines needs.

The service was found to be clean and free from any odours. Infection control measures included the availability of hand sanitising cleanser around the home which staff were observed to use. Staff had access to, and, used protective gloves and aprons when they needed. Infection control training was provided for staff. The service had a sluice room for the disposal of waste. There were cleaning schedules where staff recorded specific areas of the home were cleaned. Daily checks on cleanliness and infection control in the home were carried out as well as a monthly audit check.

Requires improvement

Is the service effective?

Our findings

Staff were not adequately supervised nor their training needs properly assessed and planned for. Staff gave mixed views on the arrangements for their supervision. One staff member said they were observed in their work and we saw records of this taking place. Another staff member said they had a one to one supervision meetings with their line manager every three months. Two staff said supervision was inconsistent. One staff member said they did not always feel supported in their work, whereas another staff member said they felt supported "100%." Records did not show staff received regular supervision. For example, one staff member had supervision approximately every six months, another had only one supervision in 18 months and a third staff member at a six monthly interval for the last two supervisions. One staff member's supervision records showed this had taken place four times in nine months. The supervision records showed work performance, training and development were discussed and planned for.

Whilst the acting manager and deputy manager said they worked alongside each other and discussed their work they confirmed there were no formal supervision sessions or appraisals of their work by the provider or by a system of peer supervision. There was a lack of systems to formally monitor staff performance and to plan for staff development, even when this was raised with the acting manager by a community health care professional. This had the potential that staff skills may not have been adequately checked and action taken to address areas where improvements were needed.

Records showed staff received an induction when they started work to prepare them for their job. We noted that an induction programme for a staff member who started work 12 weeks before the inspection included a section to acknowledge staff had a demonstration on specific subjects. This was recorded as being completed but a further part of the induction record included a section to state the staff member was assessed in this, which had not been completed. We were not clear if staff had been assessed as part of their induction.

A community nurse said they considered staff were not adequately trained and supervised in specific care procedures, namely the management of diabetes. When issues were raised about omissions in contacting the appropriate health care services when this was needed, the community nurse did not feel these were followed up sufficiently with the staff concerned to ensure they had the right skills and knowledge. We found a senior member of the care staff team who had a lead role in supporting people in managing their diabetes had not completed training in diabetes. This had not been identified in staff supervision with the staff member. This staff member may not have been suitably knowledgeable or qualified to carry out this lead role and ensure safe diabetes care.

Staff received training in medicines procedures. Following the training staff signed a record to say they were trained and confident to handle and administer medicines. The training did not include an assessment by observation and record of the staff member's competency to handle and administer medicines. The acting manager said staff were observed administering medicines for two occasions before completing the task alone. This was not recorded. The service had a copy of the Royal Pharmaceutical Society The Handling of Medicines in Social Care, which includes guidance on assessing the competency of staff in handling and administering medicines which was not followed. Therefore the provider could not be sure that staff who administered medicines were safe and competent to do so.

Staff did not receive appropriate support, supervision, training and appraisal to enable them to carry out their duties. This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were supported by skilled staff who knew how to look after them. People said they were asked how they wanted to be supported.

Staff told us they had access to a range of training courses such as in the moving and handling of people, first aid, the Mental Capacity Act 2005 as well as recognised training in care such as the National Vocational Qualification (NVQ) in care and the Diploma in Health and Social Care. The provider confirmed 22 of the 29 staff were trained to NVQ level 2, 3 or 4. Staff said the training was of a good standard and equipped them for their role. One staff member commented that some of the training was distance learning which they did not consider as effective as face to face training.

We looked at the training records for staff on duty which showed a number of courses were completed, such as in

Requires improvement

Is the service effective?

health and safety, infection control, diet and nutrition, fire safety, equality and diversity and death and dying. At the time of the inspection staff were being instructed in the moving and handling of people.

The service had policies and procedures regarding the Mental Capacity Act 2005 and the associated Code of Practice. This legislation and guidance protects those who do not have capacity to consent to their care and treatment. Staff were trained in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). DoLS authorisations are made by the local authority for those who do not have capacity to agree to their care and treatment and have their liberty restricted for their own safety. The staff used an assessment tool for determining if people had capacity to consent to their care and treatment. These were reviewed on a regular basis. The acting manager told us none of the people at the home lacked capacity to consent to their care and treatment. People told us they agreed to their care and treatment.

People had a choice of food and were asked in advance what they would like to eat. People's dietary and nutritional needs were assessed when they were admitted to the home as well as their preferences. These were recorded and passed to the kitchen staff so they could provide the right food. Regular meetings took place between the home's management team and the kitchen staff in order that people's dietary needs and preferences were catered for. People also had opportunities at the residents' meetings to discuss the menus. Records of these meetings showed people had raised issues about the food, which were acted on by the staff. People told us they liked the food. One person described the food as, "Wonderful. It's first class." Another person said, "The chef is lovely and comes to the dining tables every day to ask if the food is alright. Anything we comment on is put to rights." We observed the chef at lunch as king people if they were satisfied with the food. The food was served to people at dining tables, was well presented and looked appetising. The registered manager and provider said how quality produce was purchased for meals.

Specialist diets such as diabetic diets and softened food were provided where required. People's records detailed any dietary needs and recommended food such as diabetic and gluten-free diets, low potassium diets and diets for diverticulitis. Drinks were available in communal areas and in people's rooms. A drinks trolley of tea, coffee or biscuits was brought round to people in the morning and in the afternoon to ensure people had enough to eat and drink.

People said they were supported to attend appointments with their dentist, their GP and had chiropody services. Records showed people had access to medical services such as community nurses, the optician as well as a GP. Two nurses who visited the home on a regular basis gave differing views on whether people were supported to maintain good health. One nurse said staff were effective in doing this and liaised well with them regarding any changes in people's condition. Another nurse said the staff did not always recognise when medical assistance needed to be sought from a doctor or a community nurse for diabetes management. However, we spoke to a local GP who had responsibility for diabetic patients at the home who said the staff at Hollymead House liaised well with community medical services, sought appropriate advice, and, were cautious in managing diabetes, which they did well. Records showed staff worked closely with community nurses and doctors regarding the management of diabetes. This included medical services being contacted when appropriate.

A hospital discharge summary for one person gave instructions for staff regarding safe blood sugar levels and when medical assistance needed to be sought. These details had not been incorporated into the service's own care plan on how to monitor and manage the person's diabetes. A review of one person's diabetic condition had taken place and was recorded. The acting manager said this involved community nurses, the person's family and staff from the home. The review was recorded on a care plan for a different need and did not state who attended. Although this had not impacted upon effective diabetes management, greater attention was needed to ensure records related to this health condition were accurate and up to date so these provided accurate information when reviewing care needs.

Requires improvement

Is the service caring?

Our findings

Whilst people said their privacy was promoted we found the service used closed circuit television cameras (CCTV) without consulting people and without referring to recent Commission guidance on the subject. CCTV was used to observe and record the car park, outside entrance area, people and visitors in the dining room and in one of the lounges. The provider told us the rationale for the use of CCTV was due to an incident outside the entrance area and was installed for greater security. The impact of this, especially in the lounge and dining areas, had not been fully considered in line with the CQC guidance recently issued on the subject. There was sign at the front door to say CCTV was used but this did not specify which areas. There was no consultation with people about this and there were no policies and procedures about what it was for, nor any assessment of the effects on people's privacy. It was not clear if people were aware of the surveillance in communal areas. The acting manager said the issue may have been discussed with people in the past but was unsure and there were no records of this.

The provider had not ensured the privacy of people was considered. This was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were treated kindly and compassionately by the staff. Comments about the staff included the following: "They are always smiling," "They are kind, understanding and respectful," and, "The staff are excellent. Whatever I want I can have." A community nurse described the staff as kind, adding, "It's a lovely home." Another visiting professional described the staff as "really caring," and that the staff took time to communicate well with people and their families. This same professional said staff listened to people and acted on anything raised.

Staff were observed to talk to people politely and respectfully. We observed the lunch time meal. Staff asked people how they wanted to be helped, if they wanted anymore food and if they wanted something different to eat. People were assisted so they were able to be independent when they were eating. The chef sought feedback about the meal and went to each dining table to ask people what they thought of the food. There were also opportunities for people to discuss the food and meals at resident's meetings. The acting manager showed she was committed to listening to people's views and acting on them.

People said they were consulted about their care and were asked how they wanted to be supported. Care plans reflected people's preferences and background. There was a document called 'Getting To Know Me,' which showed people were able to choose how they spent their time. These included times people liked to get up and their daily routines. People confirmed they were able to choose how they spent their time and this included the times they liked to get up in the morning. The care plans and reviews included space for people's comments to be included and their signature to acknowledge their agreement to the contents of the care plans but these were not completed. This was discussed with the acting manager who said people were consulted but this was not recorded. Care plans showed people were supported to maintain their independence.

The service had policies and procedures in a staff handbook regarding the values underpinning the service such as treating people with respect and helping them to maintain their independence. Staff told us of the importance of treating people with respect, of having time to listen to people and to making choices available. Staff were motivated in their work and found it rewarding to be able to support people well and in the way people wanted.

Good

Is the service responsive?

Our findings

People said they were consulted about how they wanted to be helped and that the care and support they received was based on this. People said their views were sought, listened to and acted on. This included the provision of food and a resident's meetings where people said they could put forward their views. One person, for example, commented, "They listen to whatever you want." People said they knew what to do if they had any concerns by either speaking to the staff or the service's acting manager or the provider. People said they felt confident any issues raised would be dealt with.

There were a range of activities provided for people which they said they enjoyed. These included entertainment from visiting musicians and singer as well as arts and crafts. People also said they were able to attend tai chi exercises and occasional outings. A programme of forthcoming activities was displayed in the entrance hall. This included an activity for each day of the week. At the time of the inspection people were engaged in craft activities with an activities provider from outside the home. This involved knitting, sewing, painting and making decorations. People said how they enjoyed the activity.

People's needs were comprehensively assessed and reviewed. Care needs were reviewed prior to people being admitted to the home so the provider could ascertain whether the person's needs could be met. These included dietary needs, mental health, continence care and moving and handling needs. The records also included assessments completed by referring social services departments so the provider had further information to asses and plan to meet people's needs. People's preferences were included in how they wished to be supported. There were details about any communication needs people had so staff had could find out how people needed to be supported.

Care plans were recorded and gave staff guidance on how people should be supported, such as supporting people with personal care and more specialist care procedures such as supporting people with catheter care. Literature was included in care plans so staff had access to information on specific care needs, such as diabetes and coeliac disease. Records showed care reviews took place on a regular basis. These included moving and handling needs and personal care needs.

People said they knew what to do if they weren't satisfied with the service they received. There were methods of listening and acting on people's concerns and experiences. The complaints procedure was displayed in the home and was also contained in the service user handbook which was provided to each person. The provider told us most issues of concern were dealt with informally usually after being raised at one of the residents' meetings. The acting manager showed us minutes from a residents' meeting where people gave feedback on the quality of food. This was followed up with the kitchen staff so changes could be made. The acting manager told us regular checks were made that people were satisfied with the food. There was a record of one complaint being made in 2014 and there were notes to show this was looked into.

Good

Is the service well-led?

Our findings

People said they had opportunities to give feedback on the service they received. This was by completing a satisfaction survey and/or by attending the regular residents' meetings. Records of the residents' meetings showed people were encouraged to give their views on any aspects of the service. A record was maintained where something was raised and there was a further record to show what action the provider had taken as well as follow up checks that changes were maintained. These were detailed and comprehensive regarding the provision of food. People said the acting manager, provider and staff were receptive to any issues they raised.

The provider used surveys based on the Care Quality Commission domains of Safe, Effective, Caring, Responsive and Well-Led. People, staff and stakeholders were asked to answer questions relating to the key lines of enquiry in each domain. We saw survey responses from people which were positive regarding the attitude of staff and the service's management, as well as there being good communication with the provider. The results of the surveys were summarised and action plans drawn up where the need for changes was identified.

The values of the service were contained in the service user's handbook and the employees' handbook and referred to people being treated with respect and their privacy and dignity promoted. These values were demonstrated by staff when we spoke to them and from our observations of them interacting with people. The acting manager and deputy manager said residents are at the centre of our work and "What we do is to meet their needs and satisfy them."

Staff said they were able to contribute to decisions and said their views were listened to. Regular meetings took place with staff with different responsibilities in the service to discuss their work, any issues and improvements. Records of these were available for us to see.

The home had a registered manager who was also one of the providers who was present in the home each day. There was also an acting manager who had not applied to the Commission for registration as manager, but was intending to do so. The service had a deputy manager and three senior care staff who had responsibility for supervising staff. Staff said they had access to management support during the day and night.

There were a number of systems of audit used to check the safety and quality of the service. For example, cleaning schedules were recorded each day which were handed to the acting manager for monitoring purposes. There were also daily and weekly audits to check that cleaning was satisfactory. Daily and monthly audit checks on infection control were carried out and recorded as well as checks on control of substances hazardous to health (COSHH). Audits of the kitchen and kitchen equipment were carried out as well as a catering audit, and, a kitchen hazard analysis. There were monthly audits of care plans and three monthly maintenance audit checks. A quality assurance check was carried out every three months and recorded. The acting manager told us how these audits were used to check standards were being maintained and to take action where any shortcomings were identified.

Care records showed staff worked in partnership with other agencies. These included community nursing services, specialist nursing services regarding palliative nursing care and local GP services. A specialist nurse who was visiting the service at the time of the inspection was observed working with care staff regarding pain management and medicines procedures. This nurse told us they worked well with the home as did the local GP.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Staff did not receive adequate supervision, appraisal and training as necessary to carry out their duties.** **Regulation 18 (2) (a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The provider had not fully considered and ensured the privacy of service users so they were treated with dignity and respect.** **Regulation 10 (1) (2) (a) (b)**