Care Quality Commission

Adiemus Care Limited

Mundy House

Inspection report

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Ratings

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

Overall summary

Mundy House provides accommodation and personal care for up to 58 people, some of whom are living with dementia.

The unannounced inspection was completed on 5 and 6 February 2015 and there were 57 people living at the service when we inspected.

A registered manager was in 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.

People did not always feel safe or feel that the care and support provided to them was appropriate to meet their needs. The deployment of staff did not meet people's needs, particularly people living with dementia and people who were immobile and spent a lot of time in their bedroom.

Summary of findings

Suitable arrangements were in place to safeguard people against the risk of abuse. Safeguarding concerns and complaints had been managed effectively.

Suitable arrangements were not in place for people to receive their prescribed medications safely.

The dining experience for people was variable and not all people experienced a positive dining experience. Nutritional advice by healthcare professionals was not always followed and the accuracy of some records could not be relied upon.

Staff did not demonstrate a good understanding of dementia and how this affected people in their day-to-day living. Some staff were observed to not communicate effectively with individual people or to provide positive interactions.

Staff were not always able to tell us about the care needs of the people they supported. We found an over reliance by staff on routine and tasks, rather than focussing on people's individual needs.

People's dignity and respect was not always maintained and people's independence was not promoted.

Staff told us that the culture of the service was not always open and staff felt that they could not raise some matters with the manager. Although the provider had a range of systems in place to inform the provider of what was going on in the service, an effective and proactive quality monitoring and assurance system was not in place detailing the actions taken where issues were highlighted. There was a lack of managerial oversight of the service. The manager was unable to demonstrate how they identified where improvements to the quality of the service was needed.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have 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?

Inadequate

The service was not safe.

Appropriate steps had not been taken to ensure that there were sufficient numbers of staff available to support people living at the service.

The management of medicines did not ensure people's safety and wellbeing.

Risk assessments were confusing and gave an inaccurate picture of the risk to the person.

Staff recruitment processes were thorough to check that staff were suitable people to work in the service.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not receive effective training to ensure they had the right knowledge and skills to carry out their roles.

People were not always supported and encouraged to eat and drink enough.

Where people lacked capacity, records showed that decisions had been made in their best interests.

People were supported to access appropriate services for their on-going healthcare needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not routinely involved in making decisions about their care.

People were not helped to maintain their independence so that their skills and abilities could be retained and promoted.

People's dignity was not consistently maintained.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Not all people's social care needs were being properly assessed, planned and delivered.

Not all people's care plans were sufficiently detailed or accurate to enable staff to deliver consistent, personalised care that met people's individual needs.

People told us that staff were not always responsive to their care and support needs.

Summary of findings

Is the service well-led?

Inadequate

The service was not well led.

The provider and manager had failed to implement a robust quality monitoring system that managed risks and assured the health, welfare and safety of people who received care.

Not all staff felt that the culture of the service was open and inclusive.

Relatives spoke positively about the leadership of the service.

Mundy 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.

The inspection took place on 5 and 6 March 2015 and was unannounced.

The inspection team consisted of one inspector, a bank 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 service.

We reviewed the information we held about the service including notifications received from the provider. This refers specifically to incidents, events and changes the provider and manager are required to notify us about by law.

We used the Short Observational Framework for inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 20 people who used the service, 10 relatives, two healthcare professionals, 10 members of care staff, two senior members of care staff, the person responsible for providing activities and social stimulation, the deputy manager and manager.

We reviewed 10 people's care records and seven people's medication records. We looked at records relating to staff support and records relating to how the safety and quality of the service was monitored.

Inadequate

Is the service safe?

Our findings

Medicines were not stored safely for the protection of people who used the service. We found a number of prescribed topical creams in people's rooms. These had not been locked away and posed a potential risk to people who they were not authorised for.

The medication administration records (MAR) for seven out of 57 people who used the service were looked at. People told us that they got their medicines when they needed them however, we found that not everyone had received their prescribed medication as they were 'asleep'. We discussed this with the manager and they confirmed that this had not been discussed with the person's GP so that their medication could be given earlier and before they went to bed. In addition, four people's topical creams were not recorded on the MAR form. The records showed that people had not received their 'topical cream' medication in line with the prescriber's instructions. For example, instead of these being administered twice daily, these had only been applied once daily or not at all on several occasions for two people. This meant that people had not received their prescribed medication as they should.

We found that the registered person had not protected people against the risk of poor management of medicines. This was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's comments about staffing numbers at the service were variable. One person told us, "They don't' have enough staff and so they [staff] can't always come if I need them." They also told us about an incident when they had to wait a long time to be helped with personal care and during this time there had been a 'shift change' and they thought they had been forgotten by staff. They told us that they had taken matters into their own hands and called for help by use of their mobile phone.

Staff did not have enough time to spend with people to meet their needs. For example, we saw that one small lounge was left unsupported by staff on four occasions for approximately 15 minutes, during a 90 minute period of observation. During the 90 minute period two people become anxious and distressed towards one another.

Although guidelines were in place detailing the actions to be taken by staff to provide reassurance to either person, staff were not always available to provide the support required and this placed both people and others at potential risk of harm and an increase in their anxieties.

Staff expressed a concern that many people who used the service were judged as having complex care needs and required two members of staff to care for them. Staff acknowledged that the care and support provided was often routine and task orientated and this was evident from our observations. Staff told us that they felt frustrated and concerned that people sometimes had to wait for care and support to be provided even if their call alarm had been activated. They told us, "I can't leave people alone in the lounge but there's sometimes nobody to go to the person." We discussed this with the manager and although a dependency tool to assess the service's staffing levels was in place, we noted that three different formats were in use and had not been completed at regular intervals or used to determine the staffing levels at the service.

We found that the registered person had not protected people against the risk of inadequate numbers of appropriate staff to meet people's needs. This was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's comments were variable about how safe they felt. Some people told us staff treated them well and they felt safe. One person who used the service told us, "I feel looked after and safe here." One relative told us, "I know my relative is perfectly safe and well looked after when I'm not here." Other people told us they did not always feel safe as a result of a lack of staff available to support them.

Staff spoke of the organisation having a 'zero tolerance' approach to abuse. Staff told us that they would report any concerns to a senior member of the management team. The staff training plan showed that the majority of staff employed at the service had received safeguarding training. However, some staff were not able to demonstrate a good understanding and awareness of the different types of abuse and had a limited understanding of safeguarding and how this should be applied.

The provider's safeguarding and whistleblowing policies and procedures were available to inform staff of their

Inadequate

Is the service safe?

responsibilities to ensure that people were protected from harm. Since July 2014 there had been six safeguarding alerts raised. These had been reported to the local authority and the Care Quality Commission and investigations completed. Where possible people and those acting on their behalf had been involved in the investigation and had indicated that they were happy with the outcome.

Where risks were identified to people's health and wellbeing such as the risk of developing pressure ulcers, nutrition, manual handling and falls, risk assessments were in place to guide staff on the measures in place to reduce and monitor those risks during delivery of people's care. Risk assessments were not always reviewed each month or as circumstances changed and in some cases the information was not accurate. This was particularly evident in relation to some people's nutritional risk and meant that they were at risk of not receiving the care and support they needed. For example, some people were identified as a medium and high risk on different documents within their care records for the same time period. This meant that the assessment was confusing and gave an inaccurate picture of the risk to the person.

Risk assessments relating to the premises and equipment were not routinely completed. For example, there was no Control of Substances Hazardous to Health (COSHH) risk assessment in place, despite concerns being raised about the security of COSHH items and the risks posed specifically to people living with dementia. Risk assessments for people who had bed rails in place were not always completed detailing the potential risk of injury to the person. Staff told us that they had sufficient manual handling equipment to meet people's needs. Although the manager had recently identified that a large sling and two slide sheets were urgently required, these had not been ordered.

Shortfalls in relation to fire safety were identified. Essex County Fire and Rescue Service had issued an enforcement notice in November 2014 detailing the required improvements needed. Additionally, the provider had requested an external company complete a fire safety risk assessment in December 2014. This highlighted a significant list of actions, some of which repeated the shortfalls noted in the fire authority notice. Although the provider had requested an extension until 1 April 2015 to address the works needed, the manager had not worked on the action plan to show the actions taken and where the service was in relation to the shortfalls and continued risk. This meant that people, those acting on their behalf and staff could not be fully assured that adequate fire safety measures were in place.

The provider had a safe and robust system in place for the recruitment and selection of new staff. Required checks were undertaken to ensure that staff were suitable to work with vulnerable people. This ensured that staff were appropriate to carry out their role.

Requires Improvement

Is the service effective?

Our findings

Our observations of the lunchtime meal showed that the dining experience for people within the service was not always positive and flexible to meet people's individual nutritional needs. Although the vast majority of people were able to eat independently, with staff occasionally offering to cut food up for them where appropriate, others required assistance from staff to eat and drink. Where people had not eaten their meal, the plates were removed by staff without asking the person why they had not eaten or provided an alternative to the menu. The records showed in two cases, that staff had recorded that two people had eaten a meal when they had not. This meant that the latter could not be relied upon to provide an accurate account so as to determine if the person's dietary needs had been met or were satisfactory.

The nutritional needs of people were identified and where people who used the service were considered to be at nutritional risk, we found that an appropriate referral to a healthcare professional such as GP, Speech and Language Therapist and/or dietician had been made. Staff were inconsistent in ensuring that people were weighed at regular intervals in line with their specific care and support needs. For example, where weekly weights were requested, this had not always been completed. Where dietetic advice had been given, for example, on the need to lose weight to improve one person's mobility, not all staff followed this.

We found that the registered person had not protected people against the risk of adequate nutrition and hydration. This was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had received regular training opportunities in a range of subjects and this provided them with the skills and knowledge to undertake their role and responsibilities and to meet people's needs. We spoke with one newly employed member of staff and they confirmed that they had received an 'orientation' induction to the home environment and completed a number of 'shadow' shifts whereby they shadowed a more experienced member of staff. However, we found examples of poor staff practice which indicated a lack of learning from training provided to staff.

People were at various stages of their dementia condition ranging from early onset to advanced stages. Some staff did not demonstrate an understanding of dementia and how this affected people in their day-to-day living. Some staff were observed to not communicate effectively with individual people or to provide positive interaction. For example, staff spent little time talking with one person to ensure that they received the meals of their choice and liking. The person indicated that they were frustrated by staff's lack of understanding of their needs. We discussed this with the deputy manager and they confirmed that a pictorial communication book was available for this person. No reason was provided as to why this had not been used during the two day inspection. Some staff were unable to tell us how they could support people to reduce their anxieties. Others lacked knowledge about people's backgrounds and past history which would have enabled them to understand more about the person they were supporting.

The deputy manager had recently identified shortfalls in some of the staff's manual handling practices, which was putting people at risk. This was reflected in recent safeguarding alerts raised. As a result action was being taken by the management team through communication with staff, use of quick reference guides and staff training to improve staff's practice. However, prior to our inspection records showed that staff were still undertaking incorrect manual handling procedures and this was still placing people at risk.

Staff told us that they received regular supervision and an annual appraisal of their performance and development needs. They told us that supervision was used to help support them to improve their practice. Records confirmed what staff had told us.

Staff confirmed that they had received Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) training. However, staff spoken with showed a variable level of understanding of MCA and DoLS with some staff demonstrating a good knowledge and others not being sure what they meant. Appropriate assessments had been carried out to assess people's capacity.

Comments about the quality of the meals provided were variable. One person told us, "The food is OK but nothing special." Another person told us, "The meat is so tough and it takes a long time to chew. I give up." Staff confirmed that the meat was often too tough for people to manage. We

Requires Improvement

Is the service effective?

discussed the above with the chef and they told us that it was not a regular occurrence for them to go out and talk to people about the meals provided or the quality of the meals. They told us that this would be something they would consider in the future to inform their menu changes and to make any required improvements.

A list of people who required a specialist diet, for example, diabetic or soft diet was recorded. However, we found that the list of people who required a high calorie diet because of weight loss, was out of date and had not been up-dated since June 2014. Staff spoken with were unsure exactly who should be on the list. This meant that people who required a high calorie diet were at risk of not having their nutritional needs adequately met.

Relatives told us that staff contacted them if they were concerned about their family member and if there had been any changes in their healthcare needs.

People had access to healthcare professionals as required. Healthcare professionals visiting the service spoke positively about their working relationship with the staff team and told us that they raised concerns with them promptly and that communication was good. The local district nurse team outlined a recent initiative that the staff team had trialled with them that helped to identify people at risk of developing pressure ulcers. They confirmed that this had helped reduce the incidence of pressure ulcers at the service. However, a monthly pressure ulcer audit showed that two people had developed significant pressure ulcers in recent months and whilst these were healing well now, prevention and interventions had not been effective. The development of pressure ulcers had been raised previously as a safeguarding concern.

Requires Improvement

Is the service caring?

Our findings

People did not consistently receive a service that was caring or compassionate. People's comments relating to the quality of care received at the service was variable. One person told us, "The staff are caring and they do listen but they are often unable to solve issues that you raise with them." Another person told us, "Some of the staff are very nice to me, but some [staff] are a bit abrupt. I wouldn't say they are rough, but they don't talk to me very much. I suppose they don't have the time." A third person told us, "Some [staff] are very good, some are not so good. They can seem a bit uncaring sometimes, especially if they're short staffed." Relatives told us that staff were kind.

Staff were not always able to tell us about the care needs of the people they supported. The responses of staff often related to tasks carried out and staff were unable to tell us about people's personal life history or preferences. Care staff had access to people's daily care records and these were kept in one folder for ease of access. This meant that care staff rarely accessed people's full care plans and therefore did not see the records of people's personal life history, so as to help them to relate to them better as individuals and to be able to have a more caring approach. Informative life histories were in place for some people however, others did not have this level of information available.

We were also concerned about staff's lack of communication and interaction with people at mealtimes. For example, two members of staff were seen to assist two people with their meal. Both members of staff were observed to look bored, disinterested and gazed around the dining room as they assisted both people to eat their lunchtime meal. Neither member of staff spoke to the people they supported and when each person had finished their meal, both members of staff got up, took the plates into the kitchen and left without any verbal or visual communication with those that they had supported. No-one was asked if they had enjoyed their meal or if they would like any more. In addition, people's plates were removed without asking people if they had finished their meal. Condiments were not readily available to people other than in the dining room and the availability of condiments within the service had been previously raised at the 'residents meeting' in January 2015. This showed that staff did not always support people to meet their eating and drinking needs with sensitivity and respect for their dignity and ability.

People confirmed that they were not routinely involved in making decisions about their care. Three people when asked if they were involved in decisions about their care or if they had had sight of their care plan, told us they had not. Relatives told us that they had not been asked to be involved in the planning of their relative's care other than at the initial pre-assessment stage.

The majority of people told us that they were offered choice in relation to the time they got up in the morning, choice of clothes to wear for the day, whether they participated in social activities or not and the time they went to bed. Staff were seen and heard to offer some people choice in relation to where they sat during the day or where they had their meals. Some choice was offered in relation to meal choices but often the information was heard to be basic, for example, pork or beef and not explaining or showing people living wih dementia what the meal choices actually were.

Staff were polite to the people at the service. Staff talked to them in passing and discussed what was going on in the service. However, improvements were needed as good practice relating to respecting and promoting people's dignity was not consistent. For example, consideration had not been given as to how people's dignity could be maintained and independence promoted. Throughout the inspection we found that people were not supported to maintain their dignity through personal grooming, in that their fingernails were uncut and/or dirty, their glasses were not clean or smear free, some people's eyes had not been washed properly and several men were unshaven. One person told us that when they wished to use the toilet some staff did not like them asking for assistance. They told us, "They want me to sit here until it suits them [staff]." Another person told us that they were frustrated by staff's inability to spell their name correctly and although they had discussed this with staff they did not feel listened to. This did not show respect for people or demonstrate good practice.

People were not always helped to maintain their independence so that their skills and abilities could be retained and promoted, for example, with personal grooming, and having tea pots available so that some

Requires Improvement

Is the service caring?

people could pour their own tea. People told us, “The staff do everything.” Promoting independence was not highlighted within people’s care plans reviewed. Since our last inspection in April 2014, a new unit for up to eight people living with dementia and who were purportedly more independent had been opened. However, our observations showed that the people who lived within the unit were not independent or more able than those living within the main part of the service. Although there was a small kitchen available for people to make a drink or snack, staff told us that none of the people were safe to undertake this task without staff support.

We saw that staff protected and upheld people’s privacy. We saw that staff knocked and waited before entering people’s bedrooms and that care and support was offered discreetly. Staff were observed to address people respectfully by using the term of address favoured by them. We also saw that staff ensured that people were appropriately dressed and that their clothing was arranged properly so as to preserve their modesty and to promote their dignity.

People were supported to maintain contact with family and friends and relatives told us that they were always welcomed and that there were no restrictions on visiting times. Relatives told us that they were always made to feel welcome.

Requires Improvement

Is the service responsive?

Our findings

We looked at people's care plans and found that these were not fully reflective of people's care needs. Where a person's needs had changed the care plan had not always been updated to reflect the new information. For example, the care plan for one person recorded that they were at high risk of developing pressure ulcers. The person's care plan had not been updated since December 2014 to reflect that since this time further pressure ulcers had developed. We discussed this with staff and they confirmed that the latter information was accurate. No reason was given as to why the person's care plan had not been updated.

Staff told us that there were some people who could become anxious and distressed. The care plans did not provide sufficient information detailing people's reasons for becoming anxious and the steps staff should take to reassure them. Staff we spoke with had a basic understanding and awareness of how to support people during these times. The daily records for two people showed that inaccurate information had been recorded by staff on the first day of our inspection following a period of distress and anxiety between both people. Both people were observed to be anxious and distressed towards one another for some considerable time and staff had had to intervene. This was not recorded within either person's records. This meant that the information recorded could not be relied upon to provide an accurate account of events or be relayed to healthcare professionals if required.

Our observations showed that several people were permanently cared for in bed. Some people had been cared for in this way for many years with no evidence of poor skin integrity. However, there were people in bed who had severe contractures which required particular attention paid to their skin integrity. Two people were found to have poor hand and nail care putting them at risk of poor skin integrity and/or infection. This was raised with the deputy manager at the time of our inspection. An assurance was provided to us that the issues raised would be addressed immediately.

People told us that the person responsible for activities was very good. Throughout our inspection we observed the person responsible for activities interacting with a large number of people in the main communal lounge. In the morning a game of bingo was enjoyed and in the afternoon a trolley laden with different seafoods was offered for people to sample. We noted that no other members of staff supported the person responsible for activities. From our discussions with the person responsible for activities, they expressed concern that social activities for people living with dementia or for people who remained in their bedroom were limited as there was only one activities person employed at the service. Our observations showed that the latter was accurate. For example, people in two small lounges on the ground and first floor received no social stimulation other than the television. The care plans relating to people's individual hobbies or interests did not evidence how these were to be enabled or supported. For example, the care plan for one person detailed that their interests included, reminiscence and beauty therapy. No information was recorded as to how this was to be facilitated. In addition, we saw no items available to aid stimulation or provide comfort and reminiscence such as 'objects of reference' and memory boxes for people living with dementia.

We found an over reliance by staff on routine and tasks, rather than focussing on people's individual needs. We observed long periods of inactivity where people were either sleeping or disengaged. Staff in the main were focused solely on tasks, for example, people were only offered drinks at set times and personal care was provided at set times of day, rather than staff concentrating on people's individual needs. Our observations during the two days showed that staff gave more time and attention to those people who were able to verbally communicate with them. People who were more reserved, introverted and not able to engage easily without a lot of staff input, received little verbal interaction and support outside of set tasks.

People told us they knew how and who to raise any concerns or complaints to. Most people told us that they felt able and happy to raise concerns and to speak about issues that bothered them, telling us that staff listen, "If they've got time." Relatives told us that they felt listened to and that their concerns were taken seriously. Appropriate steps had been taken by the provider to ensure that people who used the service and those acting on their behalf could be confident that their complaints had been acted upon and investigated.

Inadequate

Is the service well-led?

Our findings

There was no consistent approach to quality assurance to ensure effective development and improvement of the service. There was a lack of managerial oversight of the service as a whole and the manager was unable to provide an assurance or demonstrate how they identified where improvements were needed across the service. Systems for improving the service through auditing and monitoring were not effective and it was unclear in some areas as to what actions had been taken. For example, whilst an analysis of incidents including falls did take place this was not robust. We found from looking at people's accident records for the past two months that approximately 50% of the accidents occurred late in the evening. There was no evidence to show that the manager had monitored these to reassure themselves that effective action had been taken.

Although there were arrangements in place for assessing and monitoring the quality of service provision, these had not highlighted the areas of concern we had identified. For example, the provider did not have an effective system in place to review staffing levels and to ensure that the deployment of staff within the service was suitable to meet people's needs. The impact of this on people was that the deployment of staff within the service was poor and did not always meet their needs. The quality assurance system did not identify that there were gaps in people's care plan documentation or ensure that information was accurate and included the care and support to be planned and delivered to meet people's needs. In addition, the quality assurance system had not identified that there were gaps in the management of medicines. Whilst risks to people's safety and wellbeing had been identified, not all strategies to minimise these risks had been implemented or were effective.

The manager was unable to tell us what the aims and objectives of the service were or how they ensured that these were met. Staff we spoke with were not aware of the service's aims and objectives. The manager told us that they were not fully aware of the organisations 'mission' statement and how this should be applied to the service. This relates to a written declaration of an organisation's core purpose, focus and values.

We found that the registered person had not protected people against the risks of inappropriate or unsafe care, as there was no effective system in place to assess and monitor the quality of the service provided. This was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although some staff felt supported by the management team, senior care staff and other members of care staff, some staff felt that the culture across the service was not open and inclusive. Some staff felt that cultural and ethnicity differences at times between some members of staff created an undercurrent of bad feeling within the service and that some staff received preferential treatment. Staff told us that there was no value in raising these issues with the manager as they did not feel that these would be dealt with or that the manager was able to address these.

The manager told us that staff meetings were held at regular intervals so as to enable staff to express their views. Actions to address the issues raised, to problem solve or drive improvement were not recorded and it was not clear if the actions highlighted had been dealt with.

The manager confirmed that the views of people who used the service and those acting on their behalf had been sought in November 2014, December 2014 and January 2015. All of the comments received to date were noted to be positive and raised no issues for further corrective action. One person commented, "We cannot find one fault with Mundy House." Relatives told us that the manager made themselves available to discuss any matters. One relative told us, "They [manager] do ask us if everything is ok." Another relative told us, "I've spoken to the manager occasionally about issues, and I've always felt they understood and cared. They will listen and act if they can."

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 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that the registered person had not protected people against the risk of poor management of medicines. This was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing We found that the registered person had not protected people against the risk of inadequate numbers of appropriate staff to meet people's needs. This was in breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs We found that the registered person had not protected people against the risk of adequate nutrition and hydration. This was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the registered person had not protected people against the risks of inappropriate or unsafe care, as there was no effective system in place to assess and monitor the quality of the service provided. This was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.