Benoni Nursing Home Limited

# Benoni Nursing Home Limited

## 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** |

# Summary of findings

## Overall summary

This unannounced comprehensive inspection took place on 28 April and 3 May 2017. The last inspection took place on 20 August 2015 when we found one breach of the regulations regarding the management of medicines.

Benoni is a nursing home which offers care and support for up to 25 predominantly older people with physical health needs, some of whom have a form of dementia. At the time of the inspection there were 25 people living at the service. Bedrooms were arranged over three floors. There was a communal lounge and a dining area on the ground floor. A lift assisted people to access the upper floors.

The service did not have a registered manager in post; however, the current manager had made an application to become registered with CQC. 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.

There were not sufficient staff available to meet people's needs. We heard call bells ringing frequently throughout the day and observed lengthy periods when staff were unable to attend to people who had called them. For example, one person told us, ""I've asked for the commode over half an hour ago and I'm still waiting."

People who used the service and staff who worked at Benoni all commented there were not enough staff to meet people's needs. Comments included, "The staff are all very nice. But I do think they are understaffed. They are running around covering what they have to do but you won't find many have time to stand and chat with you", "The staff are very nice but very very busy" and "They are always short staffed it appears. Call bells are ringing all morning on and off."

We had concerns with the way medicines were managed by the service. We found incidents when medicines had been signed as being given which were not in stock.  For example, a person was prescribed one dose of a medicine which had been signed as being administered twice. Management told us this had taken place because the staff member had not referred to the medicine administration records while administering medicines. This meant the MARs records were not an accurate reflection of the medicines people had received.

Handwritten entries had not been signed by a member of staff or witnessed by a second member of staff. The strength of one medicine for a person had been crossed out and a handwritten amendment had been added. There was no authorisation or explanation for this change and the amendment was not double signed as a checking mechanism. This meant there was a potential risk of errors and people might not receive their medicines safely.

Where people were prescribed pain relieving patches we saw body maps were included with prescribing information. However, these were not consistently being used to indicate where patches had been placed. This meant there was a risk that concurrent patches could be placed on the same site which is not medically recommended.

Carpets in communal areas throughout the ground floor were badly stained and in need of replacement. We saw there were maintenance issues throughout the service. For example, there was damage to wood work around the walls in one person's room, in another room a double electric plug socket was broken but still being used. We saw a rusty wall mounted corner unit in a bathroom and brown water stains on the ceiling in the lounge and two people's bedrooms.

Care plans were personalised to the individual but did not consistently give clear details about each person's specific needs For example, there was a lack of clear guidance about diabetes management recorded in care plans.

Details recorded in care plans about how people liked to be supported were not always consistent with what people told us. For example, one person said they would like to be able to be more mobile during the day. We looked at the care records for this person where it was recorded "Likes to stay in bed watching tv, has problems sitting out in chair – slides off." This meant care plans did not always accurately and consistently reflect people's choices.

Care plans were generally reviewed monthly or as people's needs changed. We saw some care plan reviews had fallen behind the service time frame for review. People had not signed their care plan to state they consented to the contents.

Risks were not consistently identified, assessed and monitored for any changes. For example, we found one room had water at a temperature above what would be considered safe. There was no risk assessment in place for this.

People living at the service did not have access to sufficient meaningful activities to occupy their time. The service offered some activities such as music for health and armchair exercises on a monthly basis, however, people told us there were not regular activities offered. There was an activity board outside the lounge but this did not record any activities as planned for the week. There were no activities offered to people during the two day inspection. We observed people spent time in the communal lounge reading or watching television or in their rooms.

Staff were clear on how to report any concerns they may have regarding the safeguarding of people at the service.

Staff had recently been supported with supervision and appraisals. Staff said they felt supported by the manager. Comments included, "[Name] will fight your corner. She is supportive."

Staff had attended mandatory training such as safeguarding, infection control and first aid. Nurses received clinical training for example about tissue viability. Some training specifically for nurses such as medication administration updates were required. Fire warden training had also been identified as being required.

The service was not entirely meeting the requirements of the Mental Capacity Act 2005, including the associated Deprivation of Liberty Safeguards. Where it was recorded that people living at the service did not have capacity to make their own decisions, it was not evidenced how staff came to this conclusion. We

found people did not have mental capacity assessments in place and people had not routinely signed their consent to their care package. We found there was confusion about the correct process to follow when a person was unable to provide their consent. In some cases family members had signed in place of their relative without having the legal authorisation to do this. The manager told us they were aware that systems required further work in this area.

We had concerns about aspects of infection control management. The service had not followed the guidelines of their policy and procedure regarding replacement of liquid hand-wash that required the use of replacement sealed liquid soap cartridges. Staff told us they did not use single use cartridges and regularly topped up soap dispensers. This meant there was a risk of bacteria developing within soap dispensers and posed an infection risk.

Benoni did not have appropriate systems in place to assess, monitor and improve the quality of the service. Quality assurance audits were out of date. We found the fire safety regulations highlighted in a fire safety inspection in July 2014 had not been fully met.

We identified breaches of the regulations. You can see what action we have told the provider to take at the back of the full version of the report.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not safe. There were not sufficient staff available to meet people's needs.

Medicine management systems were not robust.

Risks to people were not being adequately assessed or addressed to keep people safe.

### Is the service effective?

**Requires Improvement**

The service was not effective. The requirements of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards were not fully met.

There were maintenance requirements throughout the service.

People were provided with a nutritious diet with a choice of options and regular hot and cold drinks were offered.

### Is the service caring?

**Good**

The service was caring. However, details recorded in care plans about how people liked to be supported were not always consistent with what people told us.

People said they liked the staff and were generally satisfied with the care they received.

Staff provided care and support in a calm and caring manner. Interactions between staff and people living at Benoni were caring and staff spoke to people respectfully.

### Is the service responsive?

**Requires Improvement**

The service was not consistently responsive. Records in relation to people's risks, care and treatment were not reliable.

People who wished to move into the service had their needs assessed to ensure Benoni was able to meet their needs and expectations.

The service's complaints procedure provided people with information on how to make a complaint.

## Is the service well-led?

**Requires Improvement**

The service was not well led. Staff told us morale at the service was low.

Quality assurance procedures were not adequately monitoring how the service was operating.

Records relating to the running of the service including care plans were not securely stored.

# Benoni Nursing Home Limited

**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 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 28 April and 3 May 2017. The inspection was carried out by one adult social care inspector on the first day and two inspectors on the second day of inspection.

Before the inspection we reviewed the information we held about the service. This included past reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with eight people who lived at Benoni. We spoke with six care staff, three nursing staff, and the manager. We spoke with a visiting healthcare professional, and one relative.

We looked around the premises and observed care practices. We looked at care documentation for five people living at Benoni, medicines records for 20 people, five staff files, training records and other records relating to the management of the service.

Requires Improvement

# Is the service safe?

## Our findings

There were not enough staff available to meet people's needs. Five carers and one nurse were available in the morning from 8am to 2pm to support up to 25 people. On the ground floor, two carers supported ten people,. However nine of these people required two carers to support them with their mobility. Staff told us, "Carers here genuinely care but there are simply not enough staff available when you take into account the high level of needs of people here" and "It's physically hard and we all think there should be more staff."

We saw that staff were continually occupied in carrying out tasks and we heard people repeatedly call out from the lounge and from their rooms for staff support without being responded to.People told us and we observed that staff did not always respond to people's calls for assistance promptly. We heard call bells ringing frequently, and not being promptly responded to, throughout the day. We spoke with one person whose bell had been ringing for over 10 minutes. They told us no-one had come to attend to them. Another person commented, "I've asked for the commode over half an hour ago and I'm still waiting." This was brought to the attention of a carer at the time who then helped the person with their needs.

People who used the service and staff who worked at Benoni all commented there were not enough staff to meet people's needs. Comments included, "The staff are all very nice. But I do think they are understaffed. They are running around covering what they have to do but you won't find many have time to stand and chat with you", "It shouldn't be so difficult to be made heard in the night. I know we have the call bells but I do think people who can't get out of bed should not be so far away from staff", "The staff are very nice but very, very busy" and "They are always short staffed it appears. Call bells are ringing all morning on and off."

The service had conducted a dependency audit of peoples' needs in March 2016 that had highlighted a discrepancy between the number of nursing staff hours delivered and the hours required, amounting to 64 hours in deficit.

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

We had concerns with the way medicines were managed by the service. We found incidents when medicines had been signed as being given, when these medicines were not in stock in the service and therefore not available to have been administered. For example, a person was prescribed one dose of a medicine which had been signed as being administered twice. Management told us this had taken place because the staff member had not referred to the medicine administration records while administering medicines. This meant the MARs records were not an accurate reflection of the medicines people had received.

Staff had handwritten prescribing information for some people on to the medicine administration record (MAR) following advice from medical staff. Usually prescribed medicines are printed on the MAR sheet at the beginning of the period, unless items are prescribed during this period, when they are then handwritten on to the MAR by staff. Handwritten entries had not been signed by a member of staff or witnessed by a second member of staff to confirm the entry was accurate. One person had a handwritten amendment to the

strength of their medication. There was no record of who had authorised this on the MARs. This meant there was a potential risk of errors and that people might not receive their medicines safely.

Where people were prescribed pain relieving patches, which are patches placed on the skin to deliver a specific dose of medication, we saw body maps were included with prescribing information. However, these were not consistently being used to indicate where patches had been placed. This meant there was a risk that concurrent patches could be placed on the same site which is not medically recommended.

Some people had been prescribed creams and these had not been dated on opening. This meant staff were not aware of the expiration date of the item when it would no longer be safe to use.

Medicines audits were not conducted as outlined in the service policy, which stated an audit would be carried out monthly: the last audit had been carried out in November 2016.

Staff training records showed that staff who administered medicines had not received appropriate training updates. Four out of five nurses required medicine administration updates.

The service held medicines that required stricter controls and these were in place. We checked the records for these items against the stock held and they were accurate. Refrigeration temperatures for medicines that required cool storage were recorded.

Risks to people's health and welfare had not been consistently identified, assessed and monitored and there was a lack of sufficient guidance to help staff safely manage risks. For example, we found hot water coming from a tap in a person's room at a temperature above 50 degrees Centrigrade. This meant the person using this tap was at risk of potential scalding. . The temperature of water in other rooms did not exceed temperatures considered safe for domestic use. Another person did not have any hot water available from the hot tap in their room.  Staff told us this had been the case for some time and they brought hot water into this person's room when they required to attend to the person's personal care needs. We also saw a large fan, without a guard, that was in regular use at the top of a flight of stairs. It was possible to touch the active fan. This posed a risk to people who could catch loose clothing in the fan.

At the last fire inspection by Cornwall Fire and Rescue Service in July 2016 the service were deemed to be "Not fully complying with the legislation to continuously monitor and review the effectiveness of your fire risk assessment." The fire and rescue inspection report stated, 'You should ensure that staffing levels are sufficient and available at all material times to facilitate the movement of your residents to safety. You should not depend on the fire and rescue service to evacuate people." The last internal fire risk assessment was conducted in October 2015 and was a general fire risk assessment did not reflect the current situation at the service. For example, it stated that four fire wardens were available to safely evacuate people in the event of an emergency. The manager confirmed there was currently one trained fire warden at the service. This meant the service did not have sufficient trained and competent staff to follow the guidance of the fire and rescue report.
The fire and rescue service had found there was a failure to carry out sufficient evacuation procedures and drills for staff to follow in the event of an emergency. We spoke with the manager about this who was unable to be clear about whether this issue had been dealt with and was not able to find the service action plan that followed the fire inspection stating, "We just can't find some stuff."

Following the inspection we contacted the Cornwall Fire and Rescue Service and informed them of our findings.

We had concerns about aspects of infection control management. The service had not followed the guidelines of their policy and procedure regarding replacement of liquid hand-wash that required the use of replacement sealed liquid soap cartridges. Staff told us they did not use single use cartridges and regularly topped up soap dispensers. This meant there was a risk of bacteria developing within soap dispensers and posed an infection risk. We saw an open bag of continence pads left in a communal bathroom with one opened continence pad left on top of a wall mounted dispenser. This posed an infection control risk.

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

The service checked to ensure new staff were safe to work with older people. Recruitment systems were robust and new employees underwent the relevant pre-employment checks before starting work. This included Disclosure and Barring System (DBS) checks and the provision of two references.

Staff knew how to recognise and report signs of abuse. They knew the correct procedures to follow if they thought someone was being abused. Accidents and incidents were consistently recorded.

Requires Improvement

# Is the service effective?

## Our findings

As well as talking with people we used our Short Observational Framework for Inspection tool (SOFI) in communal areas during our visit. This helped us record how people spent their time, the type of support they received and whether they had positive experiences.

The premises were not in good order. We saw maintenance issues throughout the service. For example, there was damage to wood work around the walls in one person's room, in another room a double electric plug socket was broken but was still being used. We saw a rusty wall mounted corner unit in a bathroom and brown water stains on the ceiling in the lounge and two people's bedrooms. The service employed a maintenance person who we observed carrying out maintenance tasks. However, the service was in need of more extensive maintenance works and refurbishment.
Carpets in communal areas throughout the ground floor were badly stained and in need of replacement.

People's bedrooms were not marked with the person's name or pictures that would be meaningful to the person. There was no pictorial signage throughout the service indicating bathrooms and toilets. This did not help people, who required additional support to easily and independently find their way around the building. Providers must make reasonable adjustments in accordance with the equality Act 2010 and other current legislation and guidance.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The service employed two cleaning staff and we saw they worked hard to ensure cleaning standards were high. There were no malodours present.

Staff had been supported with supervision and appraisals. Staff told us they felt supported by the manager and said they could approach management for additional support if they needed to. Comments included, "The manager is very approachable and does fight your corner."

We had concerns about how staff disciplinary procedures were managed. We saw records relating to supervision and management of a staff disciplinary matter conducted in 2016 that had not been appropriately followed up after the last manager left the service. This meant management could not be confident that issues addressed by the previous manager were being formally monitored to ensure the staff member in question was meeting service policies and procedures. We spoke with the manager about this and were reassured that action plans regarding disciplinary procedures would be more closely monitored in future.

People told us they were happy with the choice and quality of the food they were served and were able to choose when they ate their meals and whether they ate together or in their bedroom. We saw people eating breakfast in the lounge and saw there were a range of hot and cold drinks available throughout the day. Comments included, "The food is good. You can have what you ask for pretty much. I can have a cooked breakfast if I want" and "Someone comes round each day and tells you what the options are and you can

ask for something else if you don't fancy it. The food is pretty good on the whole."

The catering staff had a good knowledge of people's dietary needs and catered for them appropriately. For example, soft, pureed and vegetarian diets. A white board in the kitchen detailed people's medical conditions where these were relevant to their diet. For example, if a person required a low sugar diet due to diabetes this was recorded to ensure staff were aware of this.
People were asked for their meal preferences each day by the cook. We saw kitchen staff used a card recording system to record people's preferences, likes and dislikes. We saw records stating, 'likes white tea in china mug' and 'dislikes egg sandwiches'.

The Food Standards Agency had awarded a 5 star rating in July 2016. We observed the standard of cleanliness in the kitchen was good and all required recording and temperature checks for fridges and freezers had been completed to ensure compliance with health and safety regulations. Catering staff had attended relevant training.

People were able to make choices about what they did in their day to day lives. For example, when they went to bed and when they got up and who they spent time with. We saw one person had chosen to get up early and sit quietly reading their newspaper in the lounge. Staff told us this was something they liked to do most days.

Relatives told us they had been involved in the admission of their family member to the service and staff ensured they found out as much information as was relevant about their family member so that they could get to know them, their likes, dislikes and interests. We saw this was reflected in life history information for each person. This gave staff a better understanding of each person's past and how it could impact on who they are today.

Staff had a basic knowledge of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). People were asked for their consent before care and support was provided. However, people's consent to care and treatment was not recorded in line with legislation. Where it was recorded that people did not have capacity to make their own decisions, it was not recorded how staff came to this conclusion. People who did not have capacity to make decisions for themselves did not have mental capacity assessments in place. In some instances a relative, without the appropriate legal authorisation, had signed consent on behalf of a person. We discussed this with the manager and found there was some confusion about the requirements of the Mental Capacity Act (MCA) and associated Deprivation of Liberty Safeguards (DoLS) in this regard.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA , and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the service had made the required applications.

It is recommended the service follow the requirements of the Mental Capacity Act (2005).

Newly employed staff were required to complete an induction before starting work. This included training

identified as necessary for the service and familiarisation with the service and the organisation's policies and procedures. The service had a planned induction which was in line with the Care Certificate. It is designed to help ensure care staff that are new to working in care have initial training that gives them an adequate understanding of good working practice within the care sector.

The service had a record of staff training which showed that most required staff training was up to date. Staff had attended mandatory training such as safeguarding and infection control. Nurses received clinical training such as tissue viability. Some training specifically for nurses such as medication administration updates were required. We spoke with the training officer who showed us a documented plan to address current gaps in staff training.

People had access to healthcare professionals including district nurses, GP's, opticians and chiropodists. Care records contained records of any multi-disciplinary notes. Care staff kept daily notes of people's care needs and any changes in their health. A visiting healthcare professional told us they were confident in the care provided at the service.

Good

# Is the service caring?

## Our findings

On the day of our inspection there was a friendly atmosphere at the service. People had good and meaningful relationships with staff and staff interacted with people in a caring and respectful manner. People appeared to be well cared for and spoke positively about the care they received. Comments from people included that staff were "kind" and "The staff are good, always whistling and singing." People told us they liked the staff and were generally satisfied with the care they received, "The only issue I have really is how long it can take for staff to come when you call them."

We saw that when staff supported people they were kind and compassionate. Staff acknowledged the time pressure they were under in order to meet people's needs and told us they believed, "The core of this home is really wonderful."

Care plans were personalised to the individual but did not consistently give clear details about each person's specific needs For example, there was a lack of clear guidance about diabetes management recorded in care plans.

Details recorded in care plans about how people liked to be supported were not always consistent with what people told us. For example, one person said they would like to be able to be more mobile during the day. We looked at the care records for this person where it was recorded "Likes to stay in bed watching tv, has problems sitting out in chair – slides off." This meant care plans did not always accurately and consistently reflect people's choices.

Care plans were generally reviewed monthly or as people's needs changed. We saw some care plan reviews had fallen behind the service time frame for review.

People's privacy was respected. Staff knocked on bedroom doors before entering, gaining consent before providing care and ensuring curtains and doors were closed.

Visitors told us they visited regularly at different times and were greeted by staff who were able to speak knowledgeably with them about their family member.

People said they liked their bedrooms. Bedrooms were decorated and furnished to reflect people's personal tastes. People had their own personal effects including pictures of family members, past activities and interests. When people are living with dementia it is particularly important to them to have things around them which were reminiscent of their past.

Requires Improvement

# Is the service responsive?

## Our findings

Records in relation to people's risks, care and treatment were not reliable. A monthly nutrition report recorded an overview of everyone using the service. This overview recorded any weight loss, (Body Mass Index) BMI, nutrition risk and dates of specialist referrals and was last completed in February 2016. We found one person's care record noted a weight loss of 15 kgs over a time period of eight weeks. This had not been highlighted as a concern and no action plan was in place to address this. Following the inspection we were contacted by the manager who clarified that the weight loss was inaccurately recorded. However, the lack of auditing procedures in this area meant that concerns of this nature were not identified and checked appropriately.

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

The service employed an activities coordinator, who had produced personalised activities folders for people which included activities they enjoyed. We were shown people's activities folders that demonstrated that some activities such as painting flower pots and crafts activities were offered. The manager told us outside agencies visited monthly to do movement classes and various other activities.

There was an activities board in the hall way but this was blank and we observed there were no activities offered to people throughout the two day inspection. We spoke with the manager about this who told us the activities co-ordinator had reported absent at short notice and this had affected the availability of planned activities during this time.

People who wished to move into the service had their needs assessed to ensure Benoni was able to meet their needs and expectations. People who moved to the service had met with the manager prior to admission to ensure the service would be able to meet their care needs. Relatives were also consulted to ensure their views on what support the person needed were obtained.

The manager was knowledgeable about people's needs and balanced decisions about new admissions with the needs of people already living in the service. Staff had a good knowledge of the histories of people who lived at the home. Staff were able to tell us detailed information about people's background and life history from information gathered from family and friends.

The service's complaints procedure provided people with information on how to make a complaint. The policy outlined the timescales within which complaints would be acknowledged, investigated and responded to. It also included contact details for the Care Quality Commission, the local social services department, the police and the ombudsman so people were able to take their complaint further if they wished.

We asked people who lived at the service, and their relatives, if they would be comfortable making a complaint. People told us they would have no hesitation in raising issues with the manager or staff. All told

us they felt the manager was available and felt able to approach her, or staff with any concerns.

Requires Improvement

# Is the service well-led?

## Our findings

We heard how the previous registered manager had left the role in April 2016 and a subsequent manager had stayed at the service for the intervening months before leaving in September 2016. The current manager came into post in October 2016. It was acknowledged this had caused the service to fall behind as regards recording procedures. For example, quality assurance and policies and procedures were found to be in need of updating. Staff told us, "It's a bit like trawling through treacle at the minute because lots of things have fallen behind (over the) last year."

Records were not maintained securely. We saw personal care records were left unattended in a communally used room. We also found records relating to the running of the service including care plans were left in an unlocked room which could be easily accessed by the public.

The service did not have an effective quality assurance process in place, to regularly assess and monitor the quality of service that people received. We saw the service had previously used a wide range of audits to check the effectiveness of systems such as medicines management, care planning and infection control. However, audits had not been carried out for at least six months, which was outside of the frequency for auditing processes stated in the service's quality assurance policy. For example, the last audit of care plans was carried out in January 2016; the policy stated these should take place monthly. The last audit had highlighted areas for action which had not been completed such as ensuring care plan content pages were completed for everyone living at Benoni. The last fire risk assessment was conducted in October 2015 when the service policy stated these should take place on a six monthly basis.

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

Management and staff at the service were clearly committed to providing good quality care to people who lived at Benoni. However, staff told us they were stressed by what they felt were increasing demands on them with little support from the provider. Comments included, "Morale is on the floor here", "It's all stick and no carrot," "Things aren't good here. Morale amongst the staff is low."

Benoni is required by law to have a registered manager employed to manage the service. The current manager had submitted an application to the Commission which was being processed at the time of the inspection.

The service had requested the views and experiences of people who used the service. However, there was no date to evidence when these had been done and the majority of responses held only ticks against questions. We were told staff had assisted people to answer the questions. Residents meetings were held to provide an opportunity for people to share their views with staff.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 15 HSCA RA Regulations 2014 Premises and equipment<br><br>Premises were not in good order. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Records in relation to people's risks, care and treatment were not reliable.<br><br>Records were not maintained securely.<br><br>The service did not have an effective quality assurance process in place, to regularly assess and monitor the quality of service that people received. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The service did not have sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to meet people's needs. |

This section is primarily information for the provider

# Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Risks to people's health and welfare had not been consistently identified, assessed and monitored and there was a lack of sufficient guidance to help staff safely manage risks.<br><br>The service had not followed appropriate systems for the proper and safe management of medicines.<br><br>The service had not appropriately assessed the risk of, took measures to prevent, detect and control the spread of infections, including those that are health care associated. |

**The enforcement action we took:**

WN against Reg 12.