Runwood Homes Limited

Humfrey Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on the 12 October 2016 and was unannounced.

Humfrey Lodge provides accommodation and personal care support to 48 people including people living with dementia. On the day of our inspection there were 47 people living at the service.

At the last inspection the service was rated as requires improvement. The provider sent us their action plan where they told us what they would do to meet regulatory requirements. At this inspection we identified several areas of improvement. However, as further action was required to ensure the provider met requirements the service remained as requires improvement.

Since our last inspection in February 2016 the previous manager has left the service and a new manager employed within the last four months. The current manager had applied to be registered with the Care Quality Commission (CQC) and their application was currently being processed. 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.

The provider had systems in place to ensure people were protected as far as reasonably possible from abuse. Staff were trained in identifying acts of abuse and knew what steps to take to reduce the risk of people experiencing abuse. Staff had been provided with procedural guidance in steps they should take to report issues of concern through safeguarding and whistleblowing processes in place.

Improvements had been made with the implementation of systems in place to audit, risk assess and protect people from the risk of cross infection. Actions had been taken to improve the standard of hygiene appropriate for the purposes for which the premises were being used, in line with current legislation. However, further work was required to ensure the risks of acquiring health related infections were mitigated through a regular audit of mattresses and bedding to check cleanliness and ensure replacement of items took place as and when required.

The provider had established and operated effective procedures for the management of people's medicines.

The provider had system in place for safe staff recruitment processes such as disclosure and barring checks as well as references obtained from the most recent employer prior to their starting work at the service to reduce the risk of employing unsuitable staff. However, we found staff recently employed who were unable to speak, write and understand the English language. We observed this impacted on people's ability to be heard, understood and put people at risk of not having their care and treatment needs met.

Staff were supported with regular supervision and staff meetings. Staff worked well as a team, and had a good relationship with the manager.

Since our last inspection staffing levels had been increased. However, there continued to be a significant number of vacant staffing hours. This meant there was a high number of agency staff in use. Feedback from staff and people who used the service told us this had the potential to put people at risk of not receiving consistent care from staff knowledgeable about people's individual care and support needs.

Steps had been taken to make sure that people were supported to receive adequate nutrition and hydration, and that people at risk of weight loss and, or dehydration were monitored and had access to specialist advice. However, staff did not always accurately record the food consumed by people. This meant that monitoring of people's nutritional intake was ineffective. However, people's weight was regularly monitored and action taken to refer to people to specialists for advice and support.

The manager had a good understanding of their roles and responsibilities with regards to the Mental Capacity Act 2005 (MCA) and demonstrated an awareness of the requirement to assess people's capacity to consent to their care and treatment and to consider people's best interests when supporting them to make decisions.

Staff received training, supervision and staff meetings. This provided them with opportunities to discuss their work performance and plan their training needs. However, for newly appointed staff there was limited evidence to show they had received sufficient induction training to enable them to carry out the roles for which they were employed.

Staff were positive about the new manager and their leadership of the service. The manager demonstrated clear vision for continuous improvement and caring values which were observed in their conduct and discussions with staff, relatives and people who used the service. People told us they were confident to raise any concerns they might have with the management and the staff. The provider had systems in place to address any complaints in a timely manner with a system of audit recording outcomes and actions.

There were improved governance systems in place to regularly assess, monitor and mitigate risks relating to the health, welfare and safety of the people who used the service. However, the provider had recognised the need to sustain further improvement in the monitoring of the service and to sustain effective recruitment and retention of staff and to ensure sufficient staffing levels were maintained at all times.

During this inspection we identified a number of 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 the report.

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 consistently safe as there was a shortfall in the management of recruitment and selection processes in place to ensure staff employed had been sufficiently checked for their competency and skilled to undertake the roles for which they were employed.

Risks to people's safety had been assessed and staff provided with actions to mitigate the risks to people's health, welfare and safety.

The provider had established and operated effective procedures for the management of people's medicines.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not always accurately record the food consumed by people. This meant that monitoring of people's nutritional intake was ineffective. However, people's weight was regularly monitored and action taken to refer to people to specialists for advice and support.

Staff received training, supervision and provided with the opportunity to attend staff meetings. This provided them with opportunities to discuss their work performance and plan their training needs. However, for newly appointed staff there was limited evidence to show they had received sufficient induction training to enable them to carry out the roles for which they were employed.

The manager had a good understanding of their roles and responsibilities with regards to the Mental Capacity Act 2005 (MCA).

Is the service caring?

Requires Improvement

The service was not consistently caring as interactions between staff and people were mixed in their ability to empathise and respond appropriately to people living with dementia

People's privacy and dignity was maintained in supporting people with their personal care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Whilst we found some improvements had been made since our last inspection we found continued shortfalls in the planning and provision of care for people.

People were confident to raise concerns they might have with the management and the staff. The provider had systems in place to respond to people's complaints and these were dealt with promptly and appropriately with action taken evident.

Is the service well-led?

Requires Improvement

The service had not been consistently well led. However, there was a recently employed new manager in post. The current manager had applied to be registered with the Care Quality Commission (CQC) and their application was currently being processed.

There were improved governance systems in place to regularly assess, monitor and mitigate risks relating to the health, welfare and safety of the people who used the service. However, the provider had recognised the need to sustain further improvement in the monitoring of the service and to sustain recruitment and retention of staff to ensure sufficient staffing levels were maintained at all times.

Staff were in the main positive about the new manager and the leadership in the service. They were provided with regular supervision and annual appraisals. The manager demonstrated clear vision for continuous improvement and caring values observed in their conduct and discussions with staff, relatives and people who used the service.

Humfrey Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 10 October 2016 and was unannounced.

This inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience had experience of providing care and support for an older person.

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 improvements they plan to make.

We reviewed information available to us about the service, such as statutory notifications. A notification is information about important events which the provider is required to send us by law. We also reviewed information of concern received prior to our inspection regarding staffing levels provided and concerns regarding the cleanliness of the service.

Some people living at the service were unable to tell us, in detail, about how they were cared for and supported because of their complex needs. However we spoke with 10 people who were able to verbally express their views about the quality of the service they received and three people's relatives. We observed the care and support provided to people and the interactions between staff and people throughout our inspection. We also used the short observational framework for inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with nine members of care staff, the cook, one domestic staff, the activities coordinator, deputy manager, the manager and the operations director. We also spoke with a visiting health care professional.

We reviewed care records for five people. We also reviewed records in relation to medicines management, staff rotas, staff training, staff recruitment and other care records related to the quality and safety monitoring of the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in February 2016 we found insufficient staffing levels to meet the assessed needs of people who used the service. At this inspection we found the provider had made some improvement by increasing by one member of staff on each shift.

We observed there to be sufficient staff available to respond to call bells in a timely manner and support people one to one where required during the midday meal. People told us for the majority of time staff responded in a timely manner to call bells. One person told us, "Sometimes they are quick and other times not but they have a lot of people to see to." Another told us, "They always come when you call for help; you don't have to wait too long."

There continued to be a significant number of vacant staffing hours. The manager told us they currently had weekly 132 staffing hours remaining vacant and were finding it difficult to attract and retain staff. The provider was actively recruiting staff from overseas to fill the gaps as well as employing the use of agency staff. We found there was a high number of agency staff in use. Staff and people who used the service told us this was not ideal as this had the potential to put people at risk of not receiving consistency of care from staff who knew them well. They also lacked the required knowledge to meet people's individual care and support needs as they did not have easy access to care plans. For example, relatives told us, "There is a constant change of staff with lots of agency staff around but staff do their best." And "There are some good staff here. Most are kind and pleasant. My only criticism is they are taking on staff who cannot understand or speak English. They appear to be kind but if I don't understand them how is my [relative] supposed to understand them and even more importantly they don't understand what [relative] needs."

We noted from a review of staff files that the provider had carried out pre-employment checks, including having obtained references from the most recent employer and carried out Disclosure and Barring checks (DBS) to reduce the risk of employing unsuitable staff. However, we found a number of staff recently employed from overseas who we observed to have limited ability to speak, understand and grasp the English language as well as lacking the ability to record in care records.

We observed on one unit communal lounge, for a period of 30 minutes, one care staff member sat with two people involved in colouring in of pictures activity. We noted that throughout this whole period of observation the carer did not verbally communicate with people or provide appropriate eye contact. When spoken to they appeared to not understand what was being requested of them and were unable to hold any conversation with people. One person who used the service became visibly confused by this lack of interaction and then approached an inspector to seek out comfort and interaction. When we requested information from the member of staff they did not understand what we were asking for. We also observed staff on other units unable to respond to people's requests or understand what was being said to them when spoken to, demonstrate the ability to hold a conversation or respond to our requests for information from them.

Staff told us they had become concerned regarding the competency of some newly employed staff. They

gave examples of when staff had been instructed to support people with moving and handling and who despite having received training in safe moving and handling techniques, their understanding of what had been taught was not always evident and this had the potential to put people at risk. For example, in how to use a hoist sling safely and appropriately.

We discussed and questioned the process that had been used for the recruitment and selection of staff with both the manager and operations director. The manager told us that Skype interviews had taken place with overseas staff and that they had been satisfied these staff were competent and had an adequate grasp of the English language. However, the interview notes for these recently employed staff were brief. They did not provide evidence that all the questions asked had been answered as sections of the form to record responses to specific questions including action they would take to safeguard people from harm had been left blank. We were not assured that the staff selection processes in place was effective at determining the competency of staff for the roles for which they were employed. This had the potential to put people at risk of being cared for by staff who did not understand their needs and in particular those living with dementia.

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

Risks to people's safety had been assessed. Risk assessments had been personalised to each individual and covered areas such as moving and handling, management of people's medicines as well as the assessment of environmental risks to prevent falls.

At our previous inspection we identified shortfalls in action taken to provide a clean, well maintained environment for people to live in safely, free from the risk of cross infection.

We found during our inspection that there was personal protective equipment available for staff use, and cleaning schedules in place for staff to record when they had carried out specific cleaning tasks. The main kitchen was clean and systems were in place to evidence health and safety checks had been carried out to prevent the risk of cross infection and to help keep people free from harm. We noted work had been carried out to replace vinyl flooring in bathrooms. Carpets and soft furniture had been replaced and the previously leaking roof sky lights in bathrooms repaired. Some areas of the premises were found to have a strong odour whilst most of the premises were found to be clean. However, further work was needed to ensure a regular audit of mattresses was carried out which would evidence mattress cleaning schedules and a system for replacement of bedding when required. We found rooms without paper towels in wall dispensers which meant staff and visiting professionals did not always have easy access to effective hand washing facilities.

The provider's policy for managing risk included regularly reviewed risk assessments of the premises and equipment. Staff had received training in health and safety management, emergency first aid treatment and fire safety. This provided staff with the guidance they needed to know what actions to take in an emergency.

The provider had systems in place and staff trained in identifying acts of abuse and what steps to take to reduce the risk of people experiencing abuse. Staff had been provided with procedural guidance in reporting issues of concern such as whistleblowing and safeguarding policies and procedures to follow. The manager had been proactive in reporting safeguarding concerns to the local safeguarding authority for investigation. Staff meetings reviewed showed that safeguarding was a regularly discussed topic at staff meetings.

Medicines were managed and administered safely. People told us they received their medicines when they needed them. Medicines were stored safely and securely. Staff had received training in the safe administration of medicines. Alongside senior staff, we looked at systems and processes in place for the

management of people's medicines. We checked medicine administration records (MAR) and checked balances of stock against these records. We found that the provider operated an effective system which monitored the management of people's medicines on a daily, weekly and monthly basis which included an audit of medication stocks and records of people's medicines. This meant that there was a system in place to identify any medication administration errors in a timely manner.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in February 2016 we identified shortfalls in the monitoring of people at risk of inadequate food and fluid intake. At this inspection we found some improvements had been made.

People's comments in relation to the quality of the food provided were positive. Comments included, "The food is quite good and I like to have my meals in my room." And, "Yes the food is cooked well and appetising. I have no complaints."

People who had risks associated with poor fluid and food intake had 'food and fluid' charts completed to aid monitoring of their daily food and fluid intake. For all people cared for in bed, food and fluid charts were in place and regularly completed. Fluid consumption had been totalled up at the end of the day to check that people were receiving adequate fluid intake to maintain good health. We noted people had easy access to regularly replenished drinks throughout the day.

We observed the midday meal. The menus placed on tables reflected what was actually served. Staff showed people two plates of food to enable them to choose what they wanted to eat. However, there was little evidence of adaptive plate guards and adaptive utensils in use where people would benefit from these if provided.

We noted people's weight was regularly monitored and action taken to refer to people to specialists for advice and support. Malnutrition screening assessments had been completed on a monthly basis and where people had been identified as at risk of losing weight more regular weight monitoring such as weekly weights had been actioned. Referrals had been made to access specialist advice and support where continued weight loss remained a concern.

We observed staff did not always accurately record the food people consumed. This meant that monitoring of people's nutritional intake was ineffective. Where we observed people in the dining room during the midday meal, we found staff had recorded incorrectly for some people the amounts people had actually consumed of their meal. For example, one person staff had recorded they had eaten a full meal when we had observed them to refuse their savoury meal and only eat a little of their pudding.

One person identified as at risk of poor intake of nutrition and had been regularly refusing meals, refused their midday meal. Staff had taken the meal away they told us to be offered again later. However, when we questioned staff who had come on to the afternoon shift, this information had not been handed over to them and so they remained unaware of the need to offer this meal. The lack of effective handover of information put people at risk of not receiving adequate nutrition.

Health professionals told us they had advised staff about people diagnosed with diabetes, requiring regular snacks and a low sugar diet. They said staff had not always followed their advice given and this had the potential to put people at risk of developing further complications with regards to the management of their diabetes.

This demonstrated a continued breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had been supported with regular supervision and staff meetings and this was evidenced from a review of records. They said that they had good access to e-learning training and we saw that the manager used a spreadsheet to monitor overall attendance on the training in key areas. Face to face training was provided to enable staff to meet the needs of people living with dementia. However, staff told us this was brief and did not provide them with the knowledge they needed to respond appropriately to people who may present with distressed behaviour.

We requested to look at the induction training records for three newly appointed staff. Two induction check lists had been partially completed and one the manager told us was not available to view as this could not be located. We attempted to talk to two of the staff whose induction training records we reviewed to gain their views on the quality of the induction they had received. However, they had limited command of the English language and were unable to understand and respond to what we were asking.

The manager had a good understanding of their roles and responsibilities with regards to the Mental Capacity Act 2005 (MCA) and demonstrated an awareness of the requirement to assess people's capacity to consent to their care and treatment and to consider people's best interests when supporting them to make decisions. Staff told us they had received updated training via e-learning.

At our last inspection in February 2016 we identified a high number of people with bed rails in situ and gates across their doors which had the potential to restrict their freedom of movement. We found there had been a lack of needs assessment which would have identified a decision making process, which considered the best interests of the person and a care plan with guidance for staff in how to uphold people's human rights. At this inspection we noted some improvement had been made. People had their care needs reviewed and updated along with people such as relatives for those who lacked capacity to consent to their care and treatment. Following a review some of the gates had been removed and where others remained there was an audit to evidence the best interest of the person had been considered whilst considering their needs to remain safe.

People and their relatives told us they had access to healthcare professionals when required. Records showed that GP's and community nursing staff were contacted when people required support or advice. Staff told us that the GP visited the service on a weekly basis and community nursing staff visited the service daily to monitor people's health and wellbeing. People's records reviewed showed us they had access to opticians and chiropodists.

Requires Improvement

Is the service caring?

Our findings

The majority of people we spoke with were complementary about staff and said they were satisfied with the service they received. One person told us, "The staff are nice and come and chat. I like it here." Another said, "its lovely here, they leave you alone. They ask you what you want and ask you what you don't want." A relative told us, "Most are kind and respond to you when you need help. It is adequate for my needs." Relative's told us, "Staff are all very kind and nice to [relative]. [Relative] is not getting any stimulation but chooses to be left alone, [relative's] choice."

Throughout our inspection we observed interactions between staff and people. We saw examples of caring interactions where staff laughed and sang with people, incidents where staff reassured people who presented as anxious and distressed. Staff offered people choice of food, drinks and asked whether or not they would like to be involved in group activities. We also saw staff checking on people in their rooms asking them, "Are you warm enough?" and "Can I get you anything?" However, we also saw incidents where staff were less sensitive to people's needs. For example, we saw one person living with dementia calling out to a member of staff when the member of staff was leaving their room asking them, "Are you going to let me come with you?" The member of staff just carried on walking without acknowledging the person who continued to remain distressed.

We observed during the midday meal the majority of interactions to be positive. People were supported by some staff to eat their meal in a sensitive unrushed manner. Staff sat at eye level and chatted to people throughout the meal in a sensitive and supportive manner. However, we also saw other staff on one unit constantly telling people to sit down as people noted to be living with dementia tried to get up as they were unable to sit for long periods of time without becoming restless. We were not assured that these staff had the required knowledge and skills to respond to the needs of people living with dementia in a sensitive, appropriate and enabling manner.

People told us their privacy and dignity was maintained when staff supported them with their personal care. One person said, "They close the door and have always treated me with respect." Another person told us, "I don't feel uncomfortable with most staff. Of course there are some staff you prefer over others but you don't always have the choice of who helps you with having a wash or a bath do you."

Relatives told us there were no restrictions on visiting times and they were kept informed of any changes in their relative's care. People told us that they were supported to maintain contact with their relatives and friends. We observed a steady stream of visitors throughout the day. All of the relatives we spoke with were positive about the care and support their relative received.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in February 2016 we found care plans had not been regularly reviewed and contained limited information. Staff did not previously have easy access to care plans including risk assessments in order to deliver people's care and treatment in a way that met their needs and kept them safe as care plans had been locked away. Staff and people who used the service had also not been involved in the review of people's care.

At this inspection whilst we found some improvements had been made we found continued shortfalls in the planning and provision of care for people in relation to their personal care. For example, care plans for some people in relation to supporting them with their continence care including those with indwelling catheters and people's access to baths and showers did not provide up to date and relevant guidance. For example, one person's care plan stated they should be offered a bath every day and if this person declined to be supported with a full body wash. However, we found a lack of recorded evidence to show that in the last two months this person had been either offered or supported with a bath or shower. Where people had indwelling catheters there was a lack of up to date guidance as to the assessed regularity of bag changes, the fitting of leg bags and steps staff should take in response to continence equipment failure. Feedback from healthcare professionals showed us that one person had been without night catheter bags for a week before staff had taken action to rectify this.

People and their relative's told us that they had been involved in the initial assessment of their care and support needs before they came to stay at the service. We found improvements in the assessment and planning for people's end of life wishes and preferences. Care plans were informative in providing for staff a life history of the person which staff told us was useful when supporting people living with dementia. There was improved information regarding people's interests including supporting their spiritual needs.

We noted for one person who was sight impaired staff had been provided with guidance notes in the person's room as to what they should do to support this them. For example, when eating their meal by explaining what was on the plate and when entering their room to, 'knock and introduce yourself'. This was helpful for new or agency staff.

We noted a weekly programme of activities was published and displayed on notice boards throughout the service. People told us they enjoyed the group activities provided by designated staff responsible for planning and providing group and one to one activities. We observed a group of people enjoying a musical bingo game. People's care plans included a snapshot of their previous occupation, hobbies and interests.

People said that they were supported to voice any concerns they might have. We reviewed the provider's process for responding to complaints. Records showed that complaints had been logged and an audit trail of steps taken to resolve complaints promptly to the complainant's satisfaction. There was evidence of the manager's investigations and of action taken in response to their findings. For example, a complaint regarding the unsafe use of moving and handling equipment and laundry issues such as items missing and relatives finding their loved ones in other people's clothing. However, where one person had complained

about not having access to a bath there was no written outcome. We discussed this with the manager who told us the action they had taken in response to this complaint and they would update their records to reflect the action taken.

We reviewed relatives and residents meeting minutes. We saw that people had been asked their views regarding the food provided, the standard of laundry care and people's views to aid planning of group activities and menus. Attached to these meeting minutes was an action plan where the manager demonstrated their planning in response to issues raised by people with target dates for completion. For example, in response to concerns regarding the standard of laundry and dinner plates not kept warm.

Requires Improvement

Is the service well-led?

Our findings

Since our last inspection in February 2016 a new manager had been appointed and had been in post for four months. The current manager had applied to be registered with the Care Quality Commission (CQC) and their application was currently being processed.

People were positive about the new manager describing them as, "Calm", "Approachable and understanding", "There when you need her." and "Always around and not afraid to get involved and care for people herself." Relatives told us, "Been not too bad a transition. I would recommend the home to others." and "The new manager seems OK you can approach her if you have any worries."

Staff were also complimentary regarding the overall leadership of the service. They told us, "It is better now, this manager responds to us when we need something for example when you need equipment such as pressure mats", "This manager asks you to do something and she lets you get on with it. This manager is the reason we are going in the right direction", and "Things are steadily improving. I feel supported by the manager. No one told me how to do my job but she has told me how to plan ahead and she has given me lots of ideas and I meet with her regularly. The door is always open and I am always running things past her. We have regular staff meetings. Staff morale is quite chilled and relaxed compared to how it was in the last year."

Staff told us they were provided with regular supervision and annual appraisals. We noted supervision planning documents demonstrated that supervision and appraisals had been planned in advance to enable staff time to prepare and meetings recorded. Regular staff meetings were held where a variety of subjects were discussed. A review of staff meeting minutes showed us that staff were able to question practice and discuss other issues such as the handling complaints, safeguarding people from the risk of abuse and work performance issues.

Feedback we received from health care professionals told us they had observed some improvement in the service since the appointment of the new manager. They had observed a high turnover of staff but also said this was settling down with the employment of new staff. However, they also told us they remained concerned at the high influx of newly appointed staff who lacked understanding of and the apparent ability to respond to changes in people's health care conditions such as, the care of people diagnosed with diabetes, with indwelling catheters and those at the end of life.

We observed the manager to demonstrate clear vision and caring values in their conduct and discussions with staff, relatives and people who used the service.

Since our last inspection we noted that there were improved governance systems in place to regularly assess, monitor and mitigate risks relating to the health, welfare and safety of the people who used the service. Records showed that the manager and provider carried out a range of audits and where shortfalls had been identified. In response action plans had been produced with timescales in place and dates of completion. Checks were carried out on the cleanliness of the environment, health and safety, a review of

care plans and checks to ensure medicines were stored and administered safely. A monthly audit had been completed on monitoring the number of falls and audits which monitored people at risk of losing weight including a log of the actions taken in response. This meant that there systems in place to assess, monitor and mitigate the risks to the health, safety and welfare of people and systems to evidence planning for continuous improvement of the service.

However, the provider told us they had recognised areas where there was identified need to sustain further improvement in the monitoring of the service. For example, to improve the effectiveness in the recruitment and retention of staff and to ensure sufficient staffing levels were maintained at all times.

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 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The nutritional needs of people were not always met. There was inadequate monitoring of people at risk of inadequate nutrition and records maintained of the food consumed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to deploy sufficient numbers of suitably qualified, competent skilled and experienced staff to make sure that they can meet people's care and treatment needs.