

St. Cecilia's Care Services Limited

St. Cecilia's Nursing Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Good 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 15 and 16 February 2018. It was unannounced on day one.

St. Cecilia's Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service accommodates up to 44 people in one adapted building. The building has five floors with office space and ancillary facilities on the basement floor, communal spaces and four bedrooms on the ground floor and bedrooms on the first, second and third floors. At the time of our inspection there were 39 people who used the service.

The provider is required to have a registered manager at the service. The last registered manager left the service in December 2017 and the vacant position had been recruited to. 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 an acting manager in place who had been seconded from a sister service until the new manager was in post. We have referred to them as 'the manager' in this report.

This is the first inspection of the service since it registered with the Care Quality Commission (CQC) in January 2017. We found breaches of Regulation 17 (good governance) and Regulation 18 (Staffing) of the Health and Social care Act 2008 (Regulated Activities) 2014.

You can see what action we told the provider to take at the back of the full version of the report.

Management systems were not always effective in identifying shortfalls in the quality of the service. Some records were not complete or well maintained. The completion of pressure relief charts was inconsistent and the risks to people around weight loss were not always fully identified and reviewed by the care staff.

Staff induction was not robust and agency staff induction was not taking place. Staff supervision had also not been carried out, which meant their work practice was not discussed with them in an effort to improve their performance.

Staff were recruited safely. Whilst there were enough staff on duty to care for people safely, the deployment of staff sometimes impacted people's care. The quality of care provided was inconsistent due to staff struggling with the environment and the increased needs of people who used the service. This was identified as an area that needed to improve.

Medicine management practices were being reviewed by the manager and action was taken to ensure medicines were given safely and as prescribed by people's GPs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were able to talk to health care professionals about their care and treatment. People could see a GP when they needed to and they received care and treatment when necessary from external health care professionals such as the district nursing team and speech and language therapists (SALT).

People had access to community facilities and the range of activities provided in the service ensured people could engage in stimulating and interesting social activities.

People and relatives knew how to make a complaint and those who spoke with us were happy with the way any issues they had raised had been dealt with.

This is the first time the service has been rated as Requires Improvement.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

Medicine management practices were reviewed by the manager and action was taken to ensure medicines were managed safely.

The provider had effective recruitment procedures in place. Although there were enough staff to meet people's needs safely staff deployment was not always consistent.

People were protected from the risk of abuse and staff were aware of safeguarding vulnerable adults procedures.

Is the service effective?

Requires Improvement ●

The service was not consistently effective.

Staff received training but they did not receive an effective induction or supervision.

People's capacity and consent was documented. Deprivation of Liberty Safeguards applications were made appropriately.

People received support to access health care services.

Is the service caring?

Requires Improvement ●

The service was not consistently caring.

Some people were at risk of isolation and left waiting for care and support to be delivered appropriately.

People's privacy and dignity was maintained by staff and people were included in making decisions about their care whenever this was possible.

Is the service responsive?

Good ●

The service was responsive.

Care plans were person-centred and staff were patient and kind when delivering care.

Staff supported people to plan for care at the end of their life.

There was an effective complaints policy and procedure in place and people felt their concerns were listened to.

Is the service well-led?

The service was not consistently well-led.

Some management systems and processes were not effective in identifying shortfalls and omissions in the quality of the service.

There was a clear leadership structure with identified management roles.

Staff understood their roles and responsibilities. The manager had submitted notifications to CQC in a timely way.

People who used the service, relatives and staff members were asked to comment on the quality of care and support.

Requires Improvement ●

St. Cecilia's Nursing Home

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 15 and 16 February 2018 and was unannounced on day one.

The inspection team consisted of two inspectors, a nurse specialist and an expert-by-experience on day one. Two inspectors completed the inspection on day two. 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 knowledge of caring for older people and people living with dementia.

Prior to our inspection we looked at the information we held about the service, which included notifications sent to us since the last inspection. Notifications are when providers send us information about certain changes, events or incidents that occur within the service. We also contacted North Yorkshire County Council (NYCC) safeguarding and commissioning teams. We used information the provider sent us in the provider information return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

At this inspection we spoke with the provider, the manager, assistant manager and the training manager; we also spoke with three nurses, three care staff and two ancillary staff. We spoke with 10 people who used the service and one visitor over the two days of inspection. 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 looked at four people's care records, including their initial assessments, care plans and risk assessments. We also looked at two other care records in relation to weight and food/fluid management. We looked at medication administration records (MARs) where staff were responsible for administering medicines. We also looked at a selection of documentation relating to the management and running of the service. This

included quality assurance information, audits, recruitment information for three members of staff, staff training records, policies and procedures, complaints and staff rotas.

Is the service safe?

Our findings

The atmosphere at the service was relaxed and people were at ease in the company of staff. People living at the service told us they felt safe living there. Comments included, "I feel very safe here, always plenty of staff and the food is lovely", "I like it here, staff are very nice, very helpful" and, "It's very safe here, I can see a doctor straight away. Can't fault it here." A visiting relative told us, "My relative is very safe here. We have no worries at all about the standard of care."

People and relatives felt there were enough staff on duty most of the time and said, "Never have to wait long if you ring the bell" and "Always plenty of staff when I've been here. Can't fault it here – give them a gold star!"

Robust recruitment practices were followed to make sure new staff were suitable to work in a care service. The provider used a dependency tool to determine the levels of staff required to meet people's needs, and we saw that the levels of staff on duty matched those calculated by the tool. However, the layout of the building had an impact on the efficiency of the service. We saw people were late getting up, the lunch time meal was served late and some care was task based in order to get through the daily routines. Staff told us they did not have enough time to stop and chat to people and this was borne out with people in their rooms who said they sometimes felt isolated. Staff told us, "The difficulty is with having four floors to cover and it is time consuming going through several keypad doors with trays of food, and to and from bathrooms." The manager was aware of these issues and we spoke about their plans for improving time management of the daily routines.

The manager told us they were recruiting to increase the staffing levels and this included both care staff and housekeeping staff. Staff told us, "It can be tiring, we work hard and work as a team. We are usually fully staffed and the manager uses agency when we cannot cover the shifts." Our checks of the agency records showed that not all the agency staff had a personal profile in place and there was no induction records for them. Without these records the provider would find it difficult to demonstrate agency staff identification was checked prior to them starting work in the service and that agency staff were shown and understood the emergency systems and equipment. This was a potential risk to the health and safety of people who used the service and was discussed with the manager. They said they would ensure all the profiles and induction sheets for agency staff were completed straight away.

We looked at ten Medicines Administration Records (MARs) and spoke with the nurse responsible for medicines and the manager. We saw that although there were some minor actions needed to improve practice, people received their medicines safely and as prescribed.

Medicines were stored securely in a locked treatment room and access was restricted to authorised staff. There were appropriate arrangements in place for the management of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse); they were stored in a controlled drugs cupboard, access to them was restricted and the keys held securely. Staff regularly carried out balance checks of controlled drugs in accordance with the provider's policy.

Room and fridge temperatures where medicines were stored were recorded daily, and these were within recommended limits. MARs contained photographs of service users to reduce the risk of medicines being given to the wrong person, and all the records we checked clearly stated if the person had any allergies. This reduced the chance of someone receiving a medicine they were allergic to.

Some people were prescribed topical medicines to be applied to the skin, for example creams and ointments. Topical MARs were completed on daily sheets by care staff to record the application of these medicines. We checked the records for one person and found staff had not applied their creams as they had been prescribed.

Administration records had been completed fully to show the treatment people had received. However, we found there was no guidance to enable staff to safely administer medicines prescribed to be given only as and when people required them, known as 'when required' or 'PRN'. Having this guidance in place is 'best practice' to ensure people receive PRN medicines appropriately.

We gave feedback to the manager at the end of our inspection. They told us they would take action to review the topical MARs and implement 'PRN' protocols for each person who used the service.

Staff received training on making a safeguarding alert so that they would know how to follow local safeguarding protocols. Staff told us they would have no problem discussing any concerns with the managers and were confident any issues they raised would be dealt with immediately.

There were care notes and risk assessments in place that recorded how identified risks should be managed by staff. These had been updated on a regular basis to ensure that the information available to staff was correct. The manager monitored and assessed accidents within the service to ensure people were kept safe and any health and safety risks were identified and actioned as needed.

There were contingency arrangements in place so that staff knew what to do and who to contact in the event of an emergency. The fire risk assessment for the service was up to date and had been reviewed in March 2017. Fire safety training and fire drills/evacuation scenarios had taken place in the last year. Personal emergency evacuation plans (PEEPs) for people who used the service were completed and a summary of these was kept in the emergency grab bag in the entrance hall of the service. A PEEP records what equipment and assistance a person would require when leaving the premises in the event of an emergency.

The provider had a business continuity plan in place for emergency situations and major incidents such as flooding, fire or outbreak of an infectious disease. The plan identified the arrangements made to access other health or social care services or support in a time of crisis, which would ensure people were kept safe, warm and have their care, treatment and support needs met.

Records showed us that service contract agreements were in place which meant equipment was regularly checked, serviced at appropriate intervals and repaired when required.

An infection prevention and control audit had been completed and had an action plan in place. We looked at the communal areas and a sample of bedrooms (with people's permission). Premises were clean and there were no malodours. People told us, "They give my room a clean every day" and "My room is clean and they change the bed linen regularly."

Is the service effective?

Our findings

We found the records of induction were brief and needed to be more robust. Discussion with the training manager indicated that they would be introducing the Care Certificate induction. This would ensure that staff who were new to working in care received a consistent induction in line with national standards. They also said they would develop an induction programme for the agency staff used by the service.

Supervision is a process, usually a meeting, by which an organisation provides guidance and support to its staff. Although the staff we spoke with said they felt valued and listened to by the management team, we found that staff were not receiving regular supervision and new staff did not have documented supervision until they completed their three month probationary period. The training manager was aware of this and said when the new manager came into post they would be addressing this.

The lack of a robust induction and supervision for new staff and agency staff meant that people could be cared for by staff who lacked the skills and knowledge to meet their needs.

The evidence above indicates this is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A training programme was in place for new staff and there was continuing training and development for established staff. People we spoke with thought staff were well trained to be able to meet their needs. One person told us, "See them (indicating a member of staff). They are very good, will do anything for you." We observed staff using equipment correctly to lift and transport people. Staff always used people's preferred names when talking to them.

There was evidence of good communication between the staff on each shift. The three registered nurses demonstrated a good understanding and knowledge about all the people who used the service. The afternoon shift (nurse) did a walk round of the bedrooms to check where everyone was and that they were comfortable, before starting their normal routine. The handover sheet completed at the end of each shift contained up to date information of each person's health and wellbeing.

We observed interaction between staff and people was kind and courteous. Interaction between staff members was polite and appropriate. Although one member of staff felt they didn't give enough time to each person as morning rounds took a long time (finishing about 12.30), the people whose care we looked at had received care and attention as per their care plans.

One person with hearing difficulties communicated with us using a whiteboard. Staff had to raise their voices to enable effective verbal communication, but the person was comfortable with them doing this.

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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. Where people lack mental capacity

to make 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 are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We found that people had been assessed for capacity, and DoLS referrals were being made to the supervisory body. An overview sheet showed that the manager was monitoring and updating these as needed.

Our observations of staff and people interactions showed that people were given daily choices and their wishes and decisions were respected by the staff. For example, we observed one person sat where they could see outside of the service. Their care plan clearly stated that this was their preference and asked staff to facilitate this for them.

People had access to a Doctor and other health care professionals. They told us, "Very easy to see a GP, just tell staff or reception, they get one out" and "I saw a GP yesterday, first time in two weeks. You just tell a nurse when you want to see a doctor." Evidence of visits and appointments by and to health care professionals were clearly recorded in people's care notes.

For the majority of people their weights were recorded where the staff had been able to weigh them and changes were also made to the frequency of weighing if their weight had gone down. This showed that staff were usually responsive to change. However, we saw that for one person their weight record showed they had lost 8.2kg in three months. Their care plan had not been reviewed since December 2017 and although a GP had been out to see the person in February 2018, staff had not spoken to the GP about the weight loss. Checks of their care files showed nothing was documented about their weight loss either. We asked the manager to address this, which they did immediately.

Specialist (profiling) beds were provided for people who used the service. These could have bed rails fitted if needed and accommodated pressure relieving mattresses where people were assessed as at risk of pressure damage. Pressure relief documentation was in place, but this did not always record when a person had received pressure care. We noted some records had gaps in excess of four hours between turning/moving a person, which meant this care would be ineffective. Discussion with people indicated the care was being given, which meant the problem was one of recording and not a lack of care. The manager told us they would address this with the staff.

We observed a selection of hot and cold drinks and snacks were taken to people on the ground floor from 10.30 onwards. This trolley reached floor 3 at 12.45, which was just before lunch time and people said their drinks were not always hot. Staff encouraged people to drink, frequently replacing empty beakers with fresh squash and juice. We observed lunch being served in two lounges at 13:00, which people told us was much later than normal. There were microwaves on each floor and staff said this was to reheat food as and when needed, as occasionally meals were not as hot as people liked. People declined to eat in the dining room. Meals were brought into the lounge areas on trays. We observed two people were assisted to eat their lunch by family members. Staff assisted other people who needed help. Portion sizes were generous and the food looked and smelt appetizing. Everyone ate at their own pace and the atmosphere throughout was relaxed.

The layout of the building was far from user friendly, particularly for people who may be disorientated due to cognitive impairment, or have poor vision. Accommodation was spread out over four floors, with narrow corridors and some 'blind end' corners. This type of layout can lead to people being socially isolated and potentially 'overlooked', and was also challenging for staff to work in and respond quickly if required. The presentation of the environment within the service was a 'work in progress'. Some of the areas we saw were

stark and impersonal, but these were being upgraded and those completed were more homely and inviting. The provider had a refurbishment plan, which showed the improvements made over the last year. The manager was aware of the limitations of the environment. They said their plans to increase staffing and ensure they were deployed effectively on allocated floors would help reduce isolation and ensure needs were met for people who chose to stay in bed, their room or who were receiving end of life care.

Is the service caring?

Our findings

We received differing views regarding staff approach and how people using the service were involved and encouraged to express their views. Staff spoke about the people they supported respectfully. Staff said it was a good service with a homely atmosphere but that staff were short of time to spend with people because of increased dependency levels and the layout of the environment.

During our inspection we found staff were still getting people up and out of bed at 12:30 and they said they struggled to get everything done before lunch time. One person had no fluids in their room at 11:25 and another person was in bed, with their drink on a nearby cupboard but out of reach. We saw people sat in their rooms without their glasses on or hearing aids in. This meant they could not see or hear things properly, this affected their walking, communicating and orientation needs. We saw no evidence of oral care taking place and observed one person in bed with a dry and crusted mouth. There was nothing documented in the care files about oral care.

People told us they felt isolated in their rooms at times and we observed this in practice. Whilst visiting rooms on the second and third floors we observed staff were very busy assisting people to get up but apart from the member of staff serving mid-morning drinks, we observed only one incident of interaction between a person staying in their room and member of staff. This was when a member of staff 'popped their head around the door' and asked the person if they were okay and left.

While we identified areas for improvement we also observed areas of good care practice and staff were kind and gentle when they attended to people's personal care. People told us they thought staff cared about them. When we asked if staff treated them with kindness and respect they told us, "Staff here are very nice, very helpful", "All the staff know my name" and "I can't see but they do try to make me happy."

People said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. A visitor told us, "All staff are absolutely marvellous. From cleaning staff to nurses. They never 'talk over' my relative, always speak to them as an individual" and "Care here is very personalised."

Everyone we spoke with at the service told us staff made visitors very welcome, always offered them tea and cake and pets were also made welcome. People told us about the Valentines' day lunch, to which family members had been invited. They said, "We had a lovely party. A lovely time, lovely food, games – it was a lovely day."

Relatives told us that some staff knew people very well and had a good understanding of their needs. People's wishes with regard to their preferences were recorded and taken into account when care was provided. For example, one person was a practising Christian and their care file included a detailed 'me and my life' section which had been completed by the person and their family. We saw evidence of care being given which indicated their wishes were complied with. Their care plans mentioned to make sure they wore their gold cross and they received pastoral visits.

We were told by staff that people could have a bath or shower whenever they wished and information in the care files showed that these usually took place on a regular basis. We observed three people, each having had a shower that morning, were sat in a small lounge waiting to have their hair put into rollers by the hairdresser. People were dressed individually with clothes of their choosing and their rooms contained their personal belongings and items that were important to them.

Some people had communication difficulties which meant that they could not always express themselves verbally. However, one person showed us their communication book developed by the SALT. This helped them express their wishes and choices to others and staff ensured the person took this with them when they moved to another communal area. Where possible, information was presented to people in a way that made it easier to understand using signs, pictures, symbols or photographs. For example, people were able to choose their daily meals using the picture menus made available to them.

Is the service responsive?

Our findings

Assessments were undertaken to identify people's support needs and care plans were developed outlining how these needs were to be met. Each person living at the service had their own care file, which contained a number of care plans. The care plans contained information which detailed the person's support needs and how they preferred to receive that support. There were risk assessments in place which summarised how to keep people safe whilst enabling them to maintain their independent abilities and maintain self-direction. One person told us, "I can't speak too highly about the kindness of the staff and the general care; I'm very happy and content."

Where people had the capacity to contribute towards their assessments, care plans, and care reviews, they were encouraged to do so. The majority of care plans were reviewed and updated monthly with their involvement, or with their next of kin's involvement, where appropriate. One visitor told us, "The staff talk to me a lot about my relative's care, I still feel very involved in their life." People were invited to attend reviews of their care and treatment each year with the funding authority and other people involved in their care. Families and advocates were also invited.

The nurses carried out a variety of clinical interventions as part of their role of caring for people who used the service. They used nationally recognised risk assessment tools to assess people's level of need and reduce the risk of harm. We saw they had completed nutritional risk assessments using the Malnutrition Universal Screening Tool (MUST) and assessed people for risk of developing pressure ulcers by using a Waterlow screening tool. The Waterlow scores were kept up to date, checks of a selection of scores showed they were recorded and care changed as necessary in the care plans.

People with complex needs had appropriate care and support to manage their medical conditions including specialist equipment such as syringe drivers for pain relief and air mattresses/cushions for comfort and pressure relief. Families were made welcome in the service and were able to assist their loved ones with their care and support as wished. There was no-one requiring end of life care at the time of our inspection. However, we saw evidence that work had gone into discussing end of life wishes and choices for people who used the service.

Activities were on offer daily and these were facilitated by an activities coordinator. People had the choice of joining in the planned activities, although some people preferred not to join in and chose to spend time in their room or in the other communal areas within the home. The activities coordinator had plans in place to spend time with people who chose to stay in their rooms if they wished.

We observed throughout the day that people were involved with activities. For example, we saw people having their hands washed and massaged and their finger nails being painted. Others played dominos in one sitting room with a member of staff and in the afternoon were entertained by a singer who performed to a good audience. A relative showed us photographs of various activities at the service, these included visits from the Owl Sanctuary, Halloween and Christmas celebrations. People told us they were able to access religious activities as wished.

One person who used the service told us they were the self-appointed 'Residents Advocate'. They said, "I'm very happy living here, I get pleasure out of helping the other residents. I go around the ground floor in my wheelchair talking to everyone. Every month we have a residents meeting, I go around and ask people what they would like to do. We have days out in the summer, go on the esplanade. Go out for fish and chips."

People and relatives told us they would speak to the manager or staff if they wished to make a complaint. We saw that the service was responsive to concerns and complaints. The service had a policy in place for dealing with complaints. The service had received four complaints in the last 12 months and we saw that complaints were acknowledged, taken seriously, actions taken and apologies and explanations given where required.

Is the service well-led?

Our findings

The service had been without a registered manager since December 2017. The provider had made arrangements for interim managers to oversee the service and had recruited a suitable applicant to the post. The new manager was due to start employment the week after our inspection. The provider, interim manager and assistant manager were available during our inspection and assisted us throughout the process.

This is a breach of section 33 of the Health and Social Care Act 2008.

We will take action outside of this report with regard to the above breach.

Management systems and processes were in place for the governance of the service. Audits were used to monitor quality and included senior management oversight to ensure that complaints, incidents and accidents were analysed. These systems were devised to help drive improvements.

However, we identified that not all management systems were understood and used effectively. For example, staff induction was not robust and agency staff induction was not carried out. Staff supervisions had not taken place and although staff felt well supported by the managers, clear goals were not being set for staff to identify priorities and provide feedback on progress to consolidate and improve their performance. Despite medicine audits being carried out they did not pick up on the issues with topical medicine charts and PRN protocols that we found during the inspection. The audits of records and care files also had not picked up on the poor recording of pressure care or the lack of action when one person had sustained a large weight loss.

The management systems to monitor staff were not adequate to provide us with sufficient assurance that people received appropriate care and support at all times. For example, the manager was aware of the problems that the environment and deployment of staff had on the ability of staff to meet people's needs and the risk of isolation. These concerns had been raised by people and relatives at a meeting in December 2017. However, although the manager said they had a plan to improve things, at the time of our inspection the care people received sometimes fell short of that which they required. People were late getting up, meals were served late and were sometimes cold, staff did not ensure people were wearing spectacles or hearing aids as needed and oral care was not always given.

The lack of effective systems to monitor and improve the safety and quality of services was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and visiting relatives said they had noticed positive changes in the service over the last year. They told us, "The new owner listens to us and is very approachable. There are big improvements taking place in the service at the moment."

Staff all spoke highly of the new management and felt they were very much involved – one said the owner

was passionate about the service. Policies had been updated. Staff reported that the documentation kept changing in an effort to get a good system in place, but were understanding of the need for this.

People, relatives and staff were sent satisfaction surveys in May 2017, the responses to these were mainly positive. There was no action plan or analysis completed for the surveys and the assistant manager said they were not aware that this had been done, but would make sure it was carried out for the 2018 surveys. Meetings had been held for staff and relatives / residents and minutes were sent out to families where requested. The minutes were also on display in the reception area of the service. We saw that action had been taken following the last meeting in December 2017 in that a new activities person had been recruited, minutes had been sent out to families and displayed in the service and a menu planning meeting had been held with people in January 2018.

We asked for a variety of records and documents during our inspection. We found these were well kept, easily accessible and stored securely. Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The manager had informed CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

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 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems and processes were not always effective in monitoring and improving the safety and quality of services to ensure compliance with the regulations. A complete and contemporaneous record was not always maintained in relation to each service user's care. Regulation 17 (1) (2) (a) (b) (c).
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	The provider failed to have an induction programme that prepared staff for their role. Staff did not receive appropriate supervision and support to ensure they had the skills and competence required for their role. Regulation 18 (2) (a)