Shaw Healthcare (Group) Limited

Maitland Park Care Home

Inspection report

Maitland Park Road
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Tel: 02074246700

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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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Maitland Park Care Home is a care home providing personal and nursing care for up to 60 older people some of whom live with dementia. At the time of the inspection, there were 46 people using the service. The accommodation was provided across three floors, with communal areas located on each floor.

People's experience of using this service and what we found
We identified several shortfalls during this inspection. More improvements were needed to ensure the home met requirements of previously identified breaches in person-centred care and the governance of the home. However, we saw that the managers were working towards making positive changes at the home. A range of improvement and contingency plans were in place to ensure effective progress. This progress had been slowed down by the COVID-19 pandemic and focus on improving staff dynamics at the home. Additionally, the managerial oversight was reduced with the management team only including the registered manager and periodic support from the senior management team. This had been now addressed as the new deputy manager had been employed. The registered manager informed us that improvement in all identified areas of concern would recommence in January 2021.

At this inspection we identified the staff culture at the home was not always open and transparent. Staff needed to improve how they dealt with matters of concern related to people's safety, care and treatment. We identified staff had not always taken prompt action to ensure people received safe care and they had not always felt comfortable raising concerns when they saw poor practice from their colleagues. The managers were aware of these issues and were acting to support all staff to move towards a shared vision of a person-centred, opened culture at the home. Most staff responded positively and they told us morale was improving.

Family members gave mixed feedback about staff working at the home saying that while some staff were nice and caring, others were less friendly. People and external professionals spoke positively about staff who supported people.

We found medicines at the home were not always managed safely. Improvements were needed to the management of PRN (as required) medicines, creams and ointments, sharing information on medicines administered by external professionals and acting when medicines overly affected people. The provider also needed to assess the risks related to people receiving medicines.

People's care plans needed to improve to provide staff with person-centred information on how to meet the specific needs of individual people. At the time of our inspection, the provider was in the process of introducing electronic documentation for planning and delivering care. The aim was to reduce the amount of difficult to navigate paperwork and to ensure care plans fully reflected people's individual needs.

The provider needed to improve systems and procedures related to effective gathering, recording and

sharing information about people's care, task allocation during shifts and effective communication with family members.

Staffing arrangements needed a further review to ensure enough staff were deployed during each shift. Although staffing levels were reviewed regularly to match people's needs staff told us they had not always had enough time to complete the required care tasks and have time for needed breaks when working. This could affect the quality of care provided.

The managerial oversight had improved since our last visit. Shortfalls had been mostly identified through a range of the quality assurance systems and reflected in improvement plans. Further work was needed to develop additional processes and procedures to ensure the best quality of care and customer support across all areas of service delivery.

The registered manager received positive feedback from all stakeholders including people, most family members, staff and external professionals. We saw they had a good understanding of the governance at the home as well as shortfalls and how to address them.

New staff were recruited safely. Risks to people's health and wellbeing (with exception to risk around medicines administration) were regularly assessed. Staff had good knowledge of identified risks and allowed people to make risky decisions about their care where appropriate.
The home environment was well maintained. It was clean and in good order. The provider had a process for reporting, recording and effective analysis of accidents and incidents. There were appropriate systems in place to prevent and control the spread of infection. This included additional measures related to reducing the risk of COVID-19 infection and spread.

At the time of our visit, the atmosphere in the home felt calm and peaceful. Staff and residents seemed to be cheerful, however many people longed to see their relatives who they could not see due to Covid-19 pandemic. The home was in the process of arranging rapid COVID-19 testing for family members to enable people to see their loved ones while the pandemic continued.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement (published 03 September 2019) and there were two breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection, enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We received concerns about the culture at the home that increased the risk of harm to people. As a result, we undertook a focused inspection to review the key questions of the safe and well-led domains. We also reviewed the previous breach in effective domain.

The overall rating for the service has remained the same. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Maitland Park Care Home on our website at www.cqc.org.uk.

Enforcement
We have identified a new breach with the management of medicines and two continuous breaches in relation to person-centred care and the governance of the service. We made two recommendations about safeguarding, staffing levels.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection approach. If we receive any concerning information we may inspect sooner.

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 always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question to check if the provider had made improvements following shortfalls identified during our last inspection.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Maitland Park Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team consisted of one inspector, one pharmacy inspector, a specialist nurse advisor and two experts 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.

Service and service type
Maitland Park Care 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed the information we had received about the service since the last inspection. We sought

feedback from the representatives of the local authority.

During the inspection
We spoke with four people who used the service. We spoke with 14 members of staff including the operations manager, the registered manager, three team leaders, two nurses, five care staff, one member of the domestic team and the maintenance worker.

We reviewed a range of records. This included two people's care records and multiple medication records. We looked at four staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate the evidence found. We looked at training data and quality assurance records. We received feedback from two professionals who regularly visit the service. We also spoke with further six staff members in including the new deputy manager. Our Expert by Experience spoke with 16 family members and friends.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

● We were not assured that people had received their PRN (as required) medicines as intended by the prescriber. In the case of two people, who were prescribed PRN painkillers, medicine administration records (MARs), for the past 6 months, did not have any record of their PRN painkiller being administered to them. There was no evidence to show that staff carried out a pain assessment to check if these people were in pain and that staff offered and administered the medicines as prescribe.

● At the time of our visit, there were not always PRN protocols available to guide staff on how and when to administer PRN medicines. A sample of the missing PRN protocols were submitted to the CQC after our visit. Because the protocols were not present during our visit and their absence was highlighted by the inspection team, the provider could not assure us that staff were given appropriate information on how to administer PRN medicines to people.

● We were not assured that staff had administered creams and ointments to people as prescribed. Many people using the service were prescribed barrier creams to protect and heal their skin from damage. We were told that these were administered by care staff who recorded the administration on the topical medicine administration records (T- MARs). We asked for these records and none were available for November 2020. Some T- MARs were available for October 2020, however, these were not fully completed to show that creams and ointments were administered.

● We were not assured that staff took prompt action when medicines overly affected people's behaviour. One person had an increased dose of medicines in September 2020 to help manage their distress. We observed this person to be extremely sleepy in the afternoon and another dose was due to be administered in the evening. Staff confirmed that this sleepiness appeared after the dosage of medicine was changed. We saw no records showing how the decision about the change of medicine was reached or that this behaviour change has been reported and reviewed.

● Staff did not have systems and a robust process for monitoring when people had medicines administered by visiting healthcare professionals. External professionals held these records. This meant that if a dose was late or missed, there was a risk staff would not know to act. Additionally, if a person was transferred to another care setting (i.e. hospital), records would not be easily accessible.

● Care staff had not been provided with information and guidance on risks related to people receiving medicines. This is especially necessary for people on high-risk medicines. For example, people taking anticoagulants (blood-thinning tablets) are at high risk of bleeding. However, staff were not given information on possible side effects of such medicine, what to look out for and what action to take if risk occurred.

● Monthly medicines audit had been completed. However, they did not highlight shortfalls identified by us during our visit.

Systems were either not in place or robust enough to demonstrate medicines were always safely and effectively managed. This had put people at risk of harm. This was a further breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had a medicines policy and procedure in place.
● Staff who administered medicines were trained and their competencies had been assessed.
● Staff recorded administration of regular medicines on MARS and they signed each administration to confirm they gave medicines to people.

Systems and processes to safeguard people from the risk of abuse
● We judged that staff needed to improve how they dealt with matters of concern related to people's safety, care and treatment. This was because staff had not always taken prompt action to ensure people received safe care.
● Staff had training in safeguarding and they told us they knew what action to take if people were at risk of harm. However, staff had not always acted quickly to report issues of concern around people's safety. In one case, a serious incident was not reported for five days, although at least four staff knew about it. Records showed that the matter was not reported as the managers were not present at the time of the incident. However, staff took no action to ensure the senior management team at the provider's level or an external safeguarding body was notified so immediate action could be taken to protect the person. We noted that the management team took appropriate action as soon as they were made aware of the concern.
● We were not assured that when people were unwell, staff always acted to ensure this was looked into. We have been made aware of at least two occasions where people's medicines overly affected them, but staff raised no concerns or asked for a review. Family members said, "I seem to be doing all the pushing. My relative had a cough. I asked for him to be seen by a doctor. The nurse said it was the first time she knew he wasn't well. COVID-19 test was negative, but he sounded 'chesty'. They did nothing else about it" and "I've asked if my relative lost weight, but they said it was nothing major. The video calls suggest to me my relative looks drawn and may have lost weight."
● We were not assured that people always received personal care as needed. At least two family members thought that appropriate personal care was not always given to their relatives. They said, "I saw my relative, they were dressed in the worst combination of garments, their hair wasn't brushed. They looked dishevelled." People's daily notes included forms to record that personal care was completed. One person did not have it completed for more than 2 weeks then it was completed for a week with some days blank. A team leader explained the form was only completed if the person was resisting care if they were "compliant" it was not filled in. Failure to complete documentation when care was given meant that we could not assess whether the necessary care to keep the person safe and well was being provided.

We saw that the managers acted when they were made aware people were at risk of harm. This included additional training and supervision for staff. However, to ensure staff fully understand their individual responsibility around raising concerns when people are at risk, we recommend that the provider provides further training and ongoing supervision for staff on safeguarding.

● We also received positive feedback about staff at the home. One person said, "Staff are angels they clean me and feed me well." Some family members thought their relatives were safe. They said, "As far as I can work out my relative seems all right" and "Before the lockdown, I always felt the residents were safe here."

Staffing and recruitment
● Although staffing levels were reviewed regularly to match the needs of people receiving care, staff gave mixed feedback on the number of staff deployed. Most staff said that they could get very busy which

affected their ability to complete people's care notes or have sufficient breaks during their shift. One staff member said, "Sometimes I was so exhausted my hands were shaking. It was sometimes a struggle to help people. Some days I couldn't take a break." Most staff said they would get support from staff from other home's units when needed. However, there was a risk that people's care would be affected because staff would be too busy or too tired to support them.
● People told us staff supported them promptly. Family members said that overall, they thought there were enough staff to speak to when they visited. Some family members said more staff would be beneficial.

We recommend the provider further assesses and reviews the level of staff deployed to support people at the home.

● New staff were safely recruited. We looked at recruitment records for four staff members employed since our last visit in July 2019. Recruitment checks, such as references from the previous employer and proof of identity, Disclosure and Barring checks (DBS) had been completed for these staff. The DBS helps employers make safer recruitment decisions and prevent the appointment of unsuitable people. We saw that all staff had been checked through the DBS process.

Assessing risk, safety monitoring and management
● We identified there were no risk assessments related to the safe use of medicines. We addressed this matter in "Using medicines safely" section in this domain (above).
● Other risk assessments were in place, these were related to the use of bed rails, moving and handling, falls, manual handling, emotional well-being. These were carried out at appropriate intervals.
● Appropriate risk assessment was carried out when people made decisions about their care which were not always safe. For example, one person refused certain elements of care. We saw there were risk assessments in place around this refusal. Staff understood the risks and appropriately allowed the person to make their own decisions about their care.
● Health and safety and fire risks were managed appropriately. Required checks of gas, electrical and fire safety systems and other safety checks were carried out to keep people safe. People had a personal emergency evacuation plan (PEEPs) which included details of the support they needed from staff to leave the premises in case of fire.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Learning lessons when things go wrong
● The provider had a process for reporting and recording of accidents and incidents. We saw that the management team reminded staff about the process to ensure all accidents and incident were promptly and appropriately reported so supportive action could be taken.
● The managers investigated and analysed reported accidents and incidents for any trends and patterns so

that improvement action could be taken.

● The managers used staff meetings, daily short team meetings and supervisions to gather information about reported accidents incidents and events that could cause harm to people. These meetings were also used to discuss any lessons learnt and introduce actions on improvements.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question to check if the provider had made improvements following shortfalls identified during our last inspection.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
At our last inspection, the provider had failed to robustly assess needs relating to the health, safety and welfare of people. There were also issues related to effective recording information about people's care. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

- People's care plans needed to improve to provide staff with individualised information on how to meet the specific needs of people who used the service. One person's mental well-being and a behaviour support plan stated that the person could become aggressive when anxious and they should be offered reassurance. It did not specify what would make them anxious, how would this manifest and how staff could help to prevent this. There was a similar lack of information on how to effectively support people related to care plans around managing diabetes, pain monitoring, specific care at night, promoting independence when providing personal care.
- Recording of people's care needed to improve to show what care was and was not provided, when it was provided and how. There were forms in people's daily notes to record that the various elements of personal care were completed (wash, mouth care, hair, nails, skincare etc…). These forms were not always completed. Failure to complete this type of documentation meant the provider could not assure us that staff provided the necessary care to keep people safe and that their needs had been met.
- It was not always easy to find information about people's care which might have been needed to provide safe and effective care. People's files were thick with documentation and it was difficult to negotiate through them. During our visit, we did not see any protocols for PRN medicines (as required) as staff could not locate them. Another person did not have a catheter plan in their file to guide staff on how to maintain it. We were provided with this document shortly after our visit. In another example, a person was receiving wound care which was being appropriately managed. However, the required photos of one wound were not in the file. Staff told us that photos had been taken but not printed as the printer had not been working. This was not followed up to ensure the information was appropriately updated.
- Systems and processes to safeguard people from the risk of abuse or improper treatment were not always effective. There was no system around pain monitoring. In one case Abbey pain scale (which is for use to assess pain with people with dementia) was used for a person who was able to verbalise pain and had capacity in this area of their care. In another case, a person had dementia and was previously prescribed daily pain relief medicine. This medicine was later changed to be given when required, but there was no evidence to show that staff had assessed if the person was in pain and needed their medicine.

● There was no shared procedure followed by staff on when they should complete care records. Staff told us this was a matter of prioritisation and depending on what was happening on the shift. Some staff said they preferred to complete records immediately after the task, some a bit later and other before the end of their shift. The lack of clear and common agreed procedure around recording care meant some records were done a long time after care was provided or not completed at all. This also meant the record could have been recorded incorrectly.
● Systems on how the information on people's care was gathered, shared and recorded needed to be reviewed. This was to ensure all parties involved in people's care had most current information about them. This was especially important when communicating with external professionals, during shift changes and when people moved between units at the home.
● There was no formal process to check if a referral to an external professional was acted on and that required appointment was given. This meant that if an appointment did not take place staff would not necessarily know about it. There was a risk that important assessment or treatment could be missed leading to unsafe care.
● The handover form completed by staff during shift changes gave very limited information about each person, often just saying that there was no change or no concerns. If an agency staff who does not know people was allocated to do the shift, they would have to rely on verbal information provided by the staff or a nurse on the shift. There was a risk important information about people's care would not be passed on.
● The process around transferring people from a residential to the nursing unit within the home appeared informal and not robust. Staff told us that a handover would be given by the team leader to the nurse and that care documentation would go with the person. There was no step by step procedure for staff to follow to ensure that the transfer was safe and effective. The provider could not assure us that all information about care for a person would be fully communicated and consulted with relevant parties including staff, external professionals and relatives. We were made aware of at least one instance when a transfer was not managed effectively, not all parties were notified about it and the outcome for the person was different than the initially arranged move to the nursing unit.

The failure to robustly assess needs relating to the health, safety and welfare of people and thorough recording of what care was provided was a continuous breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We discussed process around care planning and records keeping extensively with members of the management team both during our visit and during our post-visit communication with the home. We were advised that at the time of our inspection, the provider was in the process of changing to electronic documentation for planning and delivering care. The nursing staff and the managers both thought this would help to solve the problems around the confusing array of paper which made finding information difficult. Staff were also undergoing additional inhouse training and upskilling around the need to complete documentation on care provided to people.
● Nurses and the team leaders were very knowledgeable about the people they cared for and were able to discuss their needs and how these were met. They talked about the people holistically and in a person-centred way.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

At our last inspection, the provider's quality assurance systems were not robust. They had not identified and addressed the deficiencies we found. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014. At this inspection, we found that some improvements were made and further improvements were needed to fully meet the regulation 17.

- The provider's quality assurance systems had not identified shortfalls related to the management of medicines.
- The provider still needed to introduce and further develop systems and processes to effectively gather, record and share information about people, their care and their changing needs. This was related to keeping comprehensive records of people's care and effective communication about care shared with other professionals, between staff at the home and when people were transferred between the units.

Above is the evidence of a continuous breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

- Provider's quality assurance systems had identified general shortfalls related to person-centred care planning. The provider was taking action to address it.
- Care staff received training and induction to help them to understand their role. However, some staff who were new to the service felt they were not always given a clear explanation of their specific care duties during each shift. This related to the clarity of task allocation during daily handovers and performing care tasks that were new to staff. We fed this back to the managers and they told us they were working on improvements.
- The managers were clear about their role concerning managing the home, supporting staff and meeting regulatory requirements. Notifications about significant events at the service had been submitted to the CQC and the rating from the last CQC inspection was displayed as required by the law.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people, Continuous learning and improving care

- Staff had not always promoted person-centred culture as they did not always act promptly to ensure

people received the best possible care. We were told this was more likely to happen when the managers were not present. This was related to not notifying managers and external professionals about safeguarding concerns and delivering aspects of care as agreed in care plans. We described this in detail in the safe section of this report.

● The staff culture at the home was not always positive, open and inclusive. Several staff members told us that the atmosphere amongst staff was not always pleasant and supportive. This was especially noticeable amongst staff who worked at the home for a long time including care staff and team leaders. One staff member said, "Some staff are more welcoming other less. There is some hostility between some staff, they talk negatively about each other." Another said, "Some staff are hard to get on with. Not a very good experience."

● Staff had not always felt confident with raising concerns about the care provided. We noted this had been raised by a staff member in one of the team meetings when a whistleblowing policy was being discussed. One staff member told us, "I wanted to complain about the other workers for being unpleasant to work with. This staff had been working there a long time and I felt my complaint would not change anything."

● People we spoke with said they like the staff working at the home. One person said, "There was a staff member who did not care about the correct support. But she then improved before she left." Family members gave us mixed feedback on their experience of the staff at the home. They said it largely depended on which staff they communicated with during their visit or telephone contact. They said, "Some staff are kind and caring. Others are almost matron like" and "Nurses (two names given) do reassure me, but I'm not sure about other carers. I can't put my finger on it really."

● The management team was aware of staff related issues and was taking action to support all staff. We discussed the above with members of the senior management team at the home and the providers level. We saw that they were acting to drive positive changes within the team to move towards a shared vision of person-centred culture at the home. This included team meeting discussions on effective communication and respect towards each other, workshops for team leaders around effective team building, staff supervisions and raising concerns when seeing poor care practice. Performance management and disciplinary processes were used when required.

● The managers had formulated safeguarding protection and the team improvement plan to ensure improvements were taking place. Further workshop for staff on person-centred culture was scheduled for January 2021. The managers were also planning a team building day to promote effective and respectful team working.

● The management team at the home was fairly new. The registered manager was appointed in June 2019, and the deputy manager in September 2020. People and most relatives spoke positively about the managers. One person said, "I cannot emphasise how this place is improving." A relative said, "The manager is really great, he listens yes. He was great in April when there were several Covid-19 positive cases. He was run off his feet, I was super impressed with the manager."

● We also saw positive examples of a person-centre approach. Family members told us that they and their relatives were involved in care planning and reviewing. In another example, a family member told us that their relative's room was not up to expected by them standard and this was quickly and well addressed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics, Working in partnership with others

● Involving people and communication with relatives needed to improve. Due to matters around the COVID-19 pandemic, there were no service users' surveys and relatives' meetings during the last year. The registered manager said they were doing their best to keep families informed about the pandemic and people's wellbeing. We were told that the registered manager communicated with relatives on a regular basis either by weekly phone calls or letters. There was also a corporate communication with relatives from the provider. This communication was not always consistent. Some relatives said they had not received

updates on the management of the COVID-19 at the home, some about their relative's wellbeing. The registered manager was aware of this and they were working on improvements. This included issuing a newsletter for relatives and updates for the families about the residents of the day events for their relatives.

● Staff spoke positively about the registered manager. They said the registered manager was ambitious for staff promoting their professional development encouraging positive teamwork and listening to staff concerns and suggestion. Staff said, "The registered manager lifts staff morale. He wants staff to professionally develop and progress" and "the registered manager started training us (care support staff) in medicines administration. Previously only team leaders were doing it. this helps with the work and makes us feel better about our work here."

● Staff participated in team meetings where they could discuss matters related to the service delivery and best care practice.

● External health and care professionals gave positive feedback about the staff at the home. One professional said, "Staff work collaboratively with us in a very positive way."

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 9 HSCA RA Regulations 2014 Person-centred care The registered person had not ensured that care and treatment to service users met their needs and reflected their preferences. Regulation 9 (1) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not ensured care was provided in a safe way for service users because: They had not ensured the safe and proper management of medicines. Regulation 12 (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not operated effective systems to: Assess, monitor and improve the quality of the service. Regulation 17 (2) (a) Assess, monitor and mitigate the risks relating to health, safety and welfare of service users. Regulation 17 (2) (b) Maintain accurate, complete and

contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.
Regulation 17 (2) (c)