Abbey Healthcare (Knebworth) Ltd

Knebworth Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was carried out on 14 June 2016 and was unannounced. We carried out this inspection due to concerns received about the service. At their last inspection on 2 June 2015 the provider was found to be meeting all the standards we inspected. At this inspection we found that they were not meeting all of the regulations. This was in relation to people's safety and welfare, staffing, medicines, consent and restraint, protecting people from abuse, person centred care and management systems. You can see what action we took at the back of our report.

Knebworth Care Home provides accommodation and personal care for up to 71 people. At the time of this inspection 56 people were living at the service.

The service had a manager in post who had recently applied to register with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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 and associated Regulations about how the service is run. However, the manager informed us that they were leaving the service and had withdrawn their application. We were informed by the provider that the manager left the service the week following the inspection.

People did not always receive care that met their needs and kept them safe. We found people's medicines were not managed safely and that staffing levels were not consistent or sufficient to meet people's needs. People's individual risks were not consistently assessed and managed and as a result incidents affecting people's welfare had occurred. People were not protected against the risk of abuse and some issues had not been reported appropriately. Recruitment processes were in place but needed reviewing to ensure they were effective.

People did not have their capacity to make decisions assessed and Deprivation of Liberty Safeguards were not applied for where restraint was being used. People were supported by staff who were trained and supported, however this was not consistent and required improvement.

People had a variety of foods but we found that appropriate support with eating and drinking, particularly in relation to dietary requirements, was not always received. Weight and nutritional monitoring was not effective. People had access to health and social care professionals, however, this was not recorded accurately and there were occasions when a person had required a service that had not been delivered.

People did not have end of life care plans in place even when they were nearing the end of their lives and this did not promote their dignity. People and their relatives were beginning to be more involved in the planning of their care. However, this was an area that required improvement.

Confidentiality was promoted in regards to records being retained securely but staff spoke loudly about people's needs where conversations may be overheard. People were positive about the kindness shown by

staff.

People's care needs were not consistently met and care plans did not include clear guidance for staff in regards to all aspects of their needs and communication was not effective.

Activities were available and work was ongoing to improve these. However, people who were nursed in bed did not receive activities. Complaints, in the most part, were responded to appropriately.

Quality assurance systems and audits completed had not identified the issues found on our inspection and as result people's safety and welfare were put at risk. Information presented to the manager by the staff team to enable them to monitor the service was inconsistent and inaccurate.

People, relatives and staff were positive about the manager and the improvements that had been made. However, the manager left the service the week following our inspection. Meetings were held and lessons learned shared however there was poor leadership on units to ensure safe practice was continued. The provider had set up managerial support in the form of a registered manager within the organisation and a clinical support lead and were recruiting for key lead roles in the service.
The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.
If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.
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The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People's medicines were not managed safely.

Staffing levels were not consistent or sufficient to meet people's needs.

People's individual risks were not consistently assessed and managed.

People were not protected against the risk of abuse.

Recruitment processes were in place.

Is the service effective?

Requires Improvement

The service was not always effective.

People did not have their capacity assessed and DoLS were not applied for where restraint was being used.

People had a variety of foods but we found that appropriate support with eating and drinking, particularly in relation to dietary requirements, was not always received. Weight and nutritional monitoring was not effective.

People were supported by staff who were trained and supported, however, this required improvements to ensure consistency.

People had access to health and social care professionals, but in some areas this had been delayed or missed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People did not have end of life care plans in place even when they were nearing the end of their lives.

People and their relatives were beginning to be more involved in the planning of their care. However, this was an area that

required improvement.

Confidentiality was promoted in regards to record retained securely but staff spoke loudly about people's needs where conversation may be overheard.

People were positive about the kindness shown by staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care needs were not consistently met.

People's care plans did not include clear guidance for staff in regards to all aspects of their needs and communication was not effective.

Activities were available and work was ongoing to improve these. However, people who were nursed in bed did not receive activities.

Complaints were responded to appropriately.

Is the service well-led?

Inadequate

The service was not consistently well led.

Quality assurance systems and audits completed had not identified the issues found on our inspection and therefore not protected people from harm and reduced further risks.

Information presented to the manager to enable them to monitor the service was inconsistent and inaccurate.

People, relatives and staff were positive about the manager and the improvements that had been made.

Meetings were held and lessons learned shared.

The provider had set up managerial support in the form of a registered manager within the organisation and a clinical support lead.

Knebworth Care 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2014 and to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Before the inspection reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we spoke with four people who used the services, nine staff members, two relatives, the manager, a supporting manager, a clinical support, the administrator and the regional manager. We also received feedback from professionals involved in supporting people who used the service and reviewed the recent reports from service commissioners. We viewed information relating to eight people's care and support. We also reviewed records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

People were not protected from risks and avoidable harm. We saw that one person had suffered an incident of choking after being given food by staff that they were unable to safely eat. Despite requiring emergency intervention, there had not been any assessment of the risk to this person and therefore there was no plan to reduce the risk of a reoccurrence. This person required a soft diet. After returning from hospital following their choking incident they had again been given solid foods by staff. This showed that staff were not aware of this person's dietary needs or their risk of choking. Following our inspection the provider sent us a risk assessment and care plan that had been devised for this person. However, these still contained inconsistencies in the advice for staff on the actions to take if the person choked.
We checked four pressure relieving mattresses, used to prevent and manage pressure ulcers, to see if they were set to the correct weight for the people that were using them. Two of the mattresses were set incorrectly. For example, one person weighed 69.85KG and their mattress was set to 120Kg. This may have increased the risk of a pressure ulcer developing. We also found that nutritional risk assessments were not completed consistently. For example, where a person had lost weight this was not referred to in the assessment or reflected in the care plan therefore preventing any necessary action to address the risk of malnutrition being taken. Other areas, such as moving and handling, pressure care and falls had been assessed but staff were not always able to deliver care that supported people's individual risks due to other demands on their time. .

The system in place to monitor accidents and incidents was ineffective as the information relating to these events did not consistently reach the manager. This meant that they were unable to accurately review these incidents and accidents for themes and trends or to make sure that appropriate action had been taken to mitigate any risks of reoccurrence.

People's medicines were not managed safely. We saw that people did not receive their medicines at the prescribed times and this may have had an impact on their health. For example, medicines prescribed to relieve the symptoms of Parkinson's disease were not always given at set regular intervals as prescribed; Medicines for anxiety and depression were not always given as the person was asleep. However, in these instances advice from the prescribing GP was not sought. We counted 12 boxed medicines and found that nine out of those 12 contained the incorrect number of tablets. This indicated that people may have missed doses of their medicines.

Therefore this was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People were not protected from the risk of abuse. We also saw that unexplained bruising and skin tears were not reported or investigated to ensure that they were not as a result of abuse or unsafe and inappropriate care. We also found that where a person had made an allegation of abuse against a member of staff this was not reported in accordance with the local authorities' procedures but investigated internally as a complaint. The supporting manager told us that they had called the out of hours safeguarding number and was advised to deal with it internally. However, they had no records to support this and the professional

they stated they called had no record of the conversation. Therefore appropriate action had not been taken to safeguard the person or to consider the risks to others from this staff member.

Therefore this was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People told us that they had to wait for support due to staff being too busy to assist them. One person told us, "It seems that every day the care gets a bit later and later by the time it gets round to us." Another person said, "The staff are overworked, when they come to you they rush and you get the sense they need to be somewhere else." Staff told us that they were frequently short staffed and busy. One staff member said, "This is how it is every day, it will take up until about 11:45 most days to get people washed and dressed."

On the morning of our visit staff were seen trying to organise themselves to be able to provide care for each person due to being short staffed. One night worker has been asked to stay longer to be able to offer the individual support some people needed. A nurse employed through an agency to cover vacancies was trying to balance the administrative work they were required to do, like request GP visits and record keeping against the need to give medicines to people.

Staff told us that there were insufficient numbers of them to meet people's needs in a timely manner. We saw one person was left in the hoisting sling for nine minutes. They had been prepared for transferring from their wheelchair to an armchair in the lounge. The staff member had placed the sling around the person, and slid the hoist into position in front of them, however there were no other staff available to assist the person. This meant the person had to stay in their wheelchair rather than be transferred to a comfortable armchair.

People were left in lounge unattended at breakfast and lunch. Medicines were received late and people were not repositioned as required to reduce the risk of them developing a pressure ulcer. Staff confirmed that care was task led and did not focus on the needs and preferences of the individual. One staff member explained "…it's time to toilet, then lunch, then toilet again, then we go again."

We spoke with the manager about how dependency was assessed and then monitored. They said they completed a dependency tool. This was reviewed every week through the manager's report. We discussed the specifics of the staffing for one of the floors within the home. The manager had estimated the length of time it took staff to support people to move positions, support people with continence needs and give people drinks. We explained that based on their calculation it would not be possible for staff to meet people's needs as set out in their care plans. When we explained, the manager agreed. "When you explain it like that then I can see what you mean." At 2.10pm, some staff members had not had a break or lunch since our arrival at 7.45am. This was pointed out to the manager who took action, however staff said they regularly worked long hours without a break.

The service had a recent bout of staff absence, sickness and staff leaving. They had tried to cover shifts with agency staff. However, this was not always possible. We also found that there were no arrangements in place to ensure that agency staff had the information they needed about people. We also found that an induction to the home did not always take place when new agency staff were sent to cover a shift.

Therefore we found the staffing situation at the service to in a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People were supported by staff who had their identity check and had undergone pre-employment checks. A criminal records check was completed and references were sought. However, we found that where employees had previously worked in a care environment, references were not always taken from that employer. We discussed this with the manager, interim manager and office manager and explained the value of obtaining a reference from a similar employment setting.

Requires Improvement

Is the service effective?

Our findings

People had not had their ability to make decisions independently assessed in accordance with the Mental Capacity Act (MCA) 2005. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met and found that service was not working in accordance with the MCA and DoLS guidance.

People were at times being unlawfully restrained due to the lack of understanding by staff and the MCA and DoLS process not being adhered to. For example, we noted that a person had their frame taken away from them with the specific intention to stop them getting up alone. One staff member said, "[Person] used to have a frame but they took it off [them] because [they] would grab the frame and totter off." However, there had been no capacity assessment, best interest's decision meeting and no DoLS application made to ensure they were acting in their best interests and in the least restrictive way possible. Another person who was recorded in their care plan as being able to get in and out of bed alone had bedrails in place which restricted their movement. There had been no assessment of the person's capacity to consent to this, no best interest decision and no DoLS application. The manager told us that they had only applied for DoLS in respect of people going out alone and for no other reason. The manager told us that there had been no MCA's assessments in place and this had been highlighted by a visiting professional who instructed them to address it. The manager told us they had only started work on this the day before our inspection, even though the visit from the professional was two weeks prior to this. We were unable to see any record of capacity assessments being completed. We also found that some staff were not clear about the process. One staff member told us, "It's what people can do with their minds."

This meant there was a risk of people not having their rights respected and therefore this was a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People received a nutritious and appetising breakfast and people told us they enjoyed their food. One person said, "The food is good." We saw people were served a choice of fresh fruit, cereals and a cooked breakfast. The chef told us that staff ask people what they want for their meals and send the menu sheet to the kitchen for preparation. However, we noted that the menu sheet was not prepopulated with people's dietary needs and staff, including agency staff, had to remember to enter requirements such as soft diet, allergies and diabetes, at the time of ticking the menu choice. We found that people had been put at risk from receiving food that was not suitable for them. We discussed the need to reduce the risk of a person receiving unsuitable food with the management team who told us they would address the issue.

People who were at risk of not eating or drinking enough had their intake recorded. However, we noted that a staff member completed these charts for a whole unit of people at the end of their tasks. This meant that records relating to people's intake may not have been accurate. This was a particular concern when we noted that one person had been admitted to hospital and been discharged with the discharge letter stating dehydration as an issue, but when we reviewed their fluid intake charts, they were recorded as having consumed a considerable amount of fluid. This indicated that their fluid intake record may not have been accurate.

People had their weight monitored and nutritional assessments which, in most cases, prompted the development of a nutritional care plan. However, we noted that where people had lost weight, this was not identified in the assessment and therefore no remedial action was triggered to further investigate the possible causes of the weight loss or to consult relevant health professionals.

Due to the inconsistency and risk of inappropriate foods being given and the inaccurate nutritional monitoring, this was a breach of Regulation 14 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff had received training but due to inconsistent leadership, there was limited supervision of practice to help ensure staff worked in accordance with their training. We saw that training including safeguarding people from abuse, moving and handling, first aid and medicines management had been delivered. However some training was due for an update and some staff were working based on training they had received prior to working at the service. One staff member said, "I had one training delivered here but I don't remember now which one. The rest of my training I had in my previous job." As the provider had not checked to ensure staff were knowledgeable they had no assurance that staff were competent to carry out their work to the required standard.

We were told that staff received an induction before starting work. One staff member said, "I started working here [period of time]. I had three days induction, one day orientation around the building and two shadowing. I started working on my own on the fourth day. I had worked in care before."

Staff supervision was irregular and this meant that their personal development was not being encouraged. One staff member said, "I have had no supervision yet." Another staff member said, "It is hard when we have these one to ones because we are just a few staff." There were opportunities for staff meetings which were used as group supervision and there was a manager on site who staff could go to if they needed to. Most staff told us that the manager was supportive. However, training and supervision was an area that required improvement.

People had access to health care professionals. However, at times, there had been a delay in some services, such as chiropody which meant that some people were left with overgrown toe nails. We saw that the GP had a weekly visit scheduled and staff told us that if anyone needed a visit from a health care professional in between these visits, then it would be arranged. We noted that required visits were recorded on the professionals list, however, it was not always clear what the professional was visiting for and it was not always recorded in people's medical notes. This meant that it was not clear if there had been appropriate referrals or if there were guidance from health professionals to be followed. Other services, such as a visiting hairdresser, were available. We also noted that an occupational therapist was visiting on the day of our inspection.

Requires Improvement

Is the service caring?

Our findings

Although we found that through most interactions people's dignity was promoted, in other areas it was not. On the middle floor we heard a person being upset and anxious in their bedroom with the door open. They were saying, "Look, I am not right, I can`t see. My hair is all over the place. Nurse, Nurse!" The staff in the bedroom were making the bed and had little or no interest to give reassurance and help the person settle. The staff member responded, "The nurse is gone. Go and have breakfast." and continued to make the bed. We observed the person was being anxious throughout the day and often calling out for the nurse to help. On occasion staff stopped and gave reassurance, however more often they ignored them and carried on with the tasks they were doing.

We also observed where people needed physical assistance dignity was not always promoted. For example, one person had been incontinent of faeces and this was left trailing, for more than five hours from when first recorded in the persons care notes,through the corridor up to and inside the person's door. This meant that everyone who visited the floor and people residing on that floor where aware of the person's situation.

We also found that people, who were near the end of their lives, did not have end of life care plans in place to ensure that they had a dignified death in accordance with their wishes and preferences. We observed staff be kind and caring but due to staffing restraints they were not able to provide the smaller details that made a difference to people at the end of their life. For example, consideration on the environment and spending one to one time with a person. This was an area that required improvement.

People told us that staff were kind and caring. One person said, "All staff, without exception, care for me and the other people." Relatives were also positive about the kindness shown to people. One relative said, "Very happy, very happy indeed, we visit daily and they care for [person] tenderly, with warmth and sincere affection." They went on to say, "The staff are so overworked, they work solid, no breaks, and it is they, the excellent, diligent and compassionate carers who give so much of themselves to hold it together." Everyone we spoke with told us that the staffing levels did not allow time for sitting and chatting.

People's personal information was held securely to promote their confidentiality. However, we noted that some staff spoke loudly and discussed people's care where they could be overheard by those who shouldn't have access to the information.

People's involvement was being encouraged and relatives were also involved in planning people's care. One relative said, "We are kept in touch with, and there seems to have been a real recent push to involve families more and more, so I can see they are trying to consult us." We noted that steps had been taken to involve people and although some people had not yet been involved, this was a work in progress.

Requires Improvement

Is the service responsive?

Our findings

People told us that they felt that their care needs were met, but at times this was delayed due to being short staffed. One person told us this meant they, at times, were unable to access the toilet soon enough. Another person told us that permanent staff were more effective than the agency staff. They said, "The trouble is with the temporary ones [staff] they come in and they don't know what they are doing half the time." We also noted that some areas of people's needs were not met, for example, foot care. We noted that details of people's care were not always recorded at the time of delivery and in one instance, staff recorded that they had supported someone to change position while we observed this not to be the case.

Our observations showed that care focused on completing tasks rather than respecting people's individual needs and preferences. An example of this was that people on had their care provided in turn in a counter clockwise direction, not based on what they needed or wanted. When the care staff were asked at 11:30am how many people still needed help with person care they told us two who were at the end of the corridor. They confirmed to us they had worked around the unit in rotation and not based on when people preferred to get up or when they needed assistance due to incontinence or other issues.

We observed one person who had one to one support from staff. They were sitting in their wheelchair without a pressure relieving cushion as recorded their care plan. This person had a pressure ulcer and their care plan stated that they needed support from staff to change their position at least every two hours; however staff failed to do this. The person was sitting bent forward in their chair in for at least five hours. Staff made little attempt to have a conversation with the person and did not assist them to transfer to a more comfortable chair.

People had individual care plans to instruct staff on how to support them. However, we found that not all needs were assessed and therefore planned for. For example, information in people's care plans relating to the risk of choking and moving and handling contained information that was inconsistent. We spoke with staff about the effectiveness of care plans. One staff member said, "No we don't get time to read the care plan, we hand over every day and like, me and [Staff member] work together all the time so know all of them and what they need. The agency would read the care plan maybe, I don't know, but we end up telling them what to do because it's quicker and to be honest the care plans are not great."

There was a range of activities displayed on a notice board and we saw group activities being taking place in the communal lounge of the first floor. In the morning activity staff were trying to engage people in ball games with little success. The regional manager told us that there had been an improvement to the activities programme and more outings were now taking place. People we spoke with told us that they enjoyed their own company and didn't join in with activities, they said they enjoyed their newspapers and TV programmes. We did note however, that people who were cared for in bed, and those on the nursing floor who were unable to tell us about activities, did not join in with anything throughout our inspection. Staff were busy providing care and support and were not able to provide anything in the way of activities. People's care plans included a section about life histories and past interests and some staff knew about these. However, they were unable to deliver activities that met those needs due to time not being available.

We were unable to ascertain if people's interests and hobbies were taken into consideration when planning the activity programme.

Therefore due to care not always being delivered in a person centred way and activities not being available to everyone, this was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People and their relatives knew how to make a complaint. However, there was a mixed response about how complaints were dealt with. One person reported in a survey that they felt the manager listened to their concerns and acted upon them appropriately. However they stated that when they needed to make another complaint in the manager's absence, it was not responded to even after they observed a member of the senior management team reading their letter. Most people and relatives told us that the manager, who has since left the service, listened to their views and took remedial action as needed.

Inadequate

Is the service well-led?

Our findings

There were systems in place to monitor the quality of the service. However, these were not effective as they had not identified the significant risks to people's safety and well-being that we found during our inspection. For example, unexplained bruising not being reported or investigated; people being restrained without appropriate safeguards and inappropriate responses to an allegation of abuse all of which put people at risk of harm. In regards to medicines management, we noted that a quality monitoring audit carried out three weeks before our inspection had not identified the issues we found in relation to people not receiving their medicines as prescribed and therefore remedial actions had not been implemented. Where audits had identified an issue, action was not always taken to address the concerns. This meant that significant risks to the health, safety and welfare of people were not identified and therefore they were not mitigated.
Where incidents occurred the risks to people were not always analysed and action was not taken to make sure lessons were learnt and people's safety and well-being promoted.

Systems previously in place to oversee the running of the home and help ensure the smooth running of the home had not been used. This had not been identified by the senior management team as not happening and information given to the provider was inaccurate. There were no checks in place ensuring that the senior management team were working in accordance with the provider's systems.

There was ineffective leadership on the units in the home. This meant that staff did not have consistent and effective supervision to ensure they were meeting people's assessed needs. The lack of permanent nursing staff and identified lead for each floor contributed to people's needs not being consistently met, incidents and events not being reported and inaccurate records. The management team had identified this as a concern and were in the process of recruiting a permanent clinical lead for each unit however they were not in post at the time of our inspection.

The manager had worked at the service for a number of months and had recently applied to register with the commission. However, shortly before the inspection they withdrew their application as they were leaving the service. The manager left the service the week following our inspection. It is a condition of the provider's registration that the service has a registered manager and we noted that the service has had a long history of absence of a registered manager. There had been several changes to the management of the service in the past three years which impacted on the consistency of the management of the service. We discussed this with the management team who told us they were currently working to recruit a new manager.

We asked for additional information to be sent to us on the day of the inspection about the management of the service but this was not received. Following the inspection, we met with a member of the management team and requested the information again. However, we still did not receive this information.

The ineffective quality monitoring and lack of action to mitigate risks to people using the service was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The ethos of the provider was to ensure a high quality of care and ensure people received an individualised

service. However, due to staffing issues and processes not being adhered to, this had not been consistent and there were areas where people received a poor standard of service that was task led and not focused on their individual needs.
The provider was reliant on temporary agency staff to cover for vacant posts and absence of regular staff but did not have sufficient arrangements in place to manage these staff and ensure they were knowledgeable, competent and able to meet the needs of people using the service.

A survey had recently been distributed to people living at the service and the manager was awaiting their responses. There had been some feedback that required addressing but no formal review had taken place and the manager told us they were waiting for all responses to be received. There was a suggestion box in the reception for people, relatives and staff to share their ideas and views. There had been no review of this as part of the quality assurance system. The manager was unable to tell us if any changes had been made in response to people's feedback.

There were regular meetings for people, their relatives and staff. A relative told us, "There are the meetings for this unit, which are good. They tell us what's going on, we tell them what we want, it's becoming like a partnership." The management team, including the regional manager, attended these meetings. The regional manager told us that they took a 'hands on' approach at supervising the service and people knew they could go to them if they needed to.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive person centred care.

The enforcement action we took:
NOD to restrict and positive conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent People did not have their human rights protected.

The enforcement action we took:
NOD to restrict and positive conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not have their safety and welfare protected.

The enforcement action we took:
NOD to restrict and positive conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not protected from the risk of abuse.

The enforcement action we took:

NOD to restrict and positive conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's nutritional and fluid intake was not sufficiently monitored.

The enforcement action we took:

NOD to restrict and positive conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place did not ensure the safety and welfare of people they were supporting.

The enforcement action we took:

NOD to restrict and positive conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient staff to meet people's needs and staff did not always have the information they needed to provide safe care and support.

The enforcement action we took:

NOD to restrict and positive conditions