Tudor Bank Limited

Douglas Bank Nursing Home

Inspection report

Lees Lane
Appley Bridge
Wigan
Greater Manchester
WN8 0SZ

Tel: 01257255823
Website: www.tudorcarehomes.co.uk

Date of inspection visit:
20 November 2018

Date of publication:
22 January 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 20 November 2018 and was unannounced.

At our last inspection the service was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because medicines were not managed safely. At this inspection we found that the management of medicines still required improvement and the home continued to be in breach of regulation 12. Improvements were needed for the reporting of medicine errors and the subsequent actions, the recording of topical medicine application and the storage of medicines.

We found that people who lived at the service were not always risk assessed in relation to their specific needs. We found an example were a person who required one to one support did not have a risk assessment in place to show why they needed this level of increased supervision. People who lived at the service were not always assessed for the risk of choking where it was required. This was also a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that people were assessed against the risk of malnutrition and de-hydration however, people did not always have access to quality food and the dining experience for people living with dementia was poor. Therefore, we found the provider to be in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that people were not always engaged with in a dignified and person-centred way. We observed care and support on both units and found very little stimulating activity. People's representatives told us that social activities and stimulation at the service was poor. We found that the service had collated person-centred information about people they supported. However, information was not always included in care plans or risk assessments. We found that care plans and observations of care were task focused. This meant that people did not always receive care and support in a person-centred way. The provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at audits undertaken by the registered manager and compliance team and found quality monitoring systems were in place however were not always effective. The provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

Following the last inspection we asked the provider to complete an action plan to show what they would do and by when to improve the key questions safe, responsive and well led to at least good. We found that improvements had been made in relation to environment safety, however medicines management still required improvement.

Douglas Bank Nursing Home (Douglas Bank) is a 'care home'. People in care homes receive accommodation

and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Douglas Bank is situated on the outskirts of Wigan. The service accommodates up to 40 adults, who need support with personal or nursing care, including people living with dementia. The majority of bedrooms have en-suite facilities and are of single occupancy, although a few double rooms are available for those wishing to share facilities.

Since our last inspection the legal directors for Douglas Bank had changed. However, the registered provider 'Tudor Bank Limited' had not changed. A legal director is a head of an organisation generally with certain powers and duties relating to management and administration. A registered provider is an individual person, partnership or organisation registered with CQC to carry on one or more regulated activities.

The service had a registered manager in post at the time of our inspection. 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 was run.

The service had a safeguarding policy and procedure. We found that staff understood what constituted to abuse, however people were not always safeguarded in relation to the management of their medicines. People who lived at the service were protected by safe recruitment practices.

Most accidents and incidents had been documented. There was a follow up procedure to check on injuries. However, we found failings around reporting medicine error incidents.

People who lived at the service, their representatives and staff told us that staffing levels were not always sufficient. The registered manager told us that staffing levels were being reviewed and times of the day and night that had been identified to require extra staffing would be fully considered in line with the provider's dependency risk assessment.

We saw that the provider had undertaken many areas of refurbishment, these included redecoration, resurfaced car park and new windows. The provider and registered manager showed us future refurbishment plans and we noted improved standards of cleanliness and environment safety throughout the service.

We found that staff did not always follow safe procedures when dealing with contaminated waste. Staff had access to protective clothing however, did not always use it.

People were assessed before they were admitted to ensure that the service could meet their needs.

The provider supported staff and provided training to make sure they had the skills and knowledge to care for the people who lived at Douglas Bank.

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.

We found that the service had policies and procedures for supporting people at the end of life. However, people's end of life care plans did not always reflect DNACPR decisions.

We received positive feedback about the registered manager and senior staff. The senior management team were co-operative throughout the inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Medicines were not always managed in a safe way.

There was a safeguarding policy however, this was not always followed.

We found gaps in the recording of individual risk management for people that lived at the service.

People who lived at the service, their relatives and staff told us that there was not always enough staff to support people in a safe and person-centred way.

Infection control standards were not always followed by staff when providing personal care.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always supported to maintain a balanced diet.

People's needs were assessed in line with current legislation and professional advice was sought.

Staff received support and training to make sure they had the skills and knowledge to deliver effective care.

People who lived at the service were assessed prior to admission to ensure that their needs could be met.

The service had started to make adaptations throughout the environment to enable people living with dementia and visual impairment.

Consent to care and treatment was sought in line with legislation and guidance.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People who lived at the service were not always supported in a dignified way.

Staff did not always understand the needs of people they cared for to make sure that people who could not effectively communicate were respected and provided with the emotional support they needed.

We received mixed feedback from people that lived at the service and their representatives when we asked them if they were treated with kindness, compassion, dignity and respect.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans focused on people's needs and did not always include person-centred information.

Life story information had been collated however, was not always included in care plans.

People knew how to complain and the registered manager maintained clear records of complaint management.

People were asked about their end of life preferences and care plans were written in conjunction with people's wishes however, end of life care plans did not always include information about people's DNACPR decisions.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was a clear strategy to improve however, we found that this required more time to be implemented and sustained.

The registered manager had quality assurance methods for measuring risk and to identify improvements at the service. There was oversight from the provider.

The service worked in partnership with other agencies.

The service had recently had a high turnover of staff, this meant that the culture at Douglas Bank had started to improve, however there was still a high use of agency staff.

Douglas Bank 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 20 November 2018 and was unannounced. The inspection team consisted of three adult social care inspectors, one pharmacist inspector, one pharmacist inspection manager and an Expert by Experience who had personal experience of caring for a family member. An Expert by Experience is someone who has experience of using services.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed previous reports and notifications that are held on the CQC database. Notifications are important events that the service must let the CQC know about by law. We also reviewed safeguarding alerts and information received from a local authority.

During the inspection we used observation to gain feedback on people's experience at the service. We sat with people in communal areas and observed the care and support people received.

During our inspection, we spoke with four people who lived at the service, seven relatives, the provider, the registered manager, the head of compliance, a compliance manager, the deputy manager, a registered nurse, a senior care worker, three care assistants and two senior care assistants.

We carried out a pathway tracking exercise. This involved us examining the care records of people who lived at the service closely to assess how well their needs and any risks to their safety and wellbeing were addressed. We carried out this exercise for six people who lived at the service.

We looked at a sample of records including three staff files, staff rotas, training and supervision records, incident records, minutes from meetings, complaints and compliments records, medication records, maintenance records and certificates, policies and procedures and quality assurance audits.

Requires Improvement

Is the service safe?

Our findings

At our last inspection the service was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because medicines were not managed safely. At this inspection we found that the management of medicines still required improvement and the service continued to be in breach of regulation 12.

We noted that the service had a policy on handling of medicines and this was available for staff to read, however we found this was not always being followed. We saw evidence that the providers policy for reporting medicine errors was not always followed to escalate the incidents and share information. For example, one person had been given a medication for treatment of severe arthritis after it had been discontinued. The person's GP had not been informed and escalation procedures had not been followed. A second person had been given an antibiotic treatment at increased frequency, their GP had not been informed and escalation procedures had not been followed. This meant that there was a risk people would not be reviewed appropriately and learning from events would not take place.

We looked at ten people's medication administration records (MARs). One person had not been given a medicine for 29 days although it was in stock and there was no explanation for this written on the MAR or provided to us when we asked about this. One person was receiving a medicine in the form of a patch, there were records in place to document the application and removal of the patch although this had not been completed for four days, this meant that we could not be assured that staff were safely rotating the site of application in line with manufactures guidelines.

We looked at how the service managed people's prescribed pain relief. We found when pain relief was administered the times were not always recorded so it was not possible to be assured that the medicines were being administered at safe intervals.

Some people were prescribed thickening powders (used to thicken fluids for people with swallowing difficulties); these were stored in a lockable trolley. The service had implemented a system to ensure that the thickener was accessible to trained staff, however the records used to record the administration did not always contain the correct information and there was a risk that people could receive the wrong consistency.

Medicines were not stored safely, the fridge temperature was recorded daily, however the temperature deviation had not been reported to management or the thermometer reset for seven months. Medicines can be ineffective or unsafe if they are stored outside of the manufacturer's instructions.

Topical medication administration records (TMARs) were used to record application of peoples prescribed, moisturising and barrier creams and ointments. There were body maps in place for people with instructions for staff to use when applying. The TMARs were not always signed when they were applied. One person was prescribed a cream to be used after each incontinence pad change and this had not been applied for ten days, another person was prescribed a cream to treat a skin condition and this had been applied only 40

times out of 56. This meant that we could not be assured that people were having their topical medicines applied safely.

The administration of Controlled Drugs (medicines subject to stricter legal controls because they are liable to misuse) were recorded correctly and they were stored in a secure place.

Instructions for people receiving medicines as and when required were in place and these supported staff to identify when a person might need medicines and non-drug interventions that could be used to support the person. We saw pain scores being checked for people to support the decision to offer pain relief.

We found that people were not always protected against abuse and avoidable harm. We observed the support people received in communal areas. We found that people were generally supervised, however one person who was meant to be supervised on a one to one basis was not always in eye sight. This placed the person and others around them at risk of harm.

We looked at people's care records and found that individual risk was not always assessed. A person who was meant to be continually supervised because of the risk to themselves and others had not been risk assessed and a care plan had not been formulated. We found other examples of people being at risk of choking and risk assessments did not always clearly identify their needs. This showed that people's safety was not consistently managed.

We found that the provider had a policy and procedure in place for the prevention and control of infection. However, through our observations we found that staff did not always follow safe procedures when providing personal care. For example, we saw a care worker assist a person who lived at the service to the bathroom, the care worker did not use protective clothing and this placed them and others at risk of cross infection.

We looked at incident records in relation to falls and found clear record keeping which showed how lessons would be learnt and improvements made. However, incident reporting was not always consistent as we have highlighted in the above medicines evidence. This meant that the provider did not always ensure robust systems were in place to identify and prevent risk for people who lived at the service.

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

When we asked people who lived at the service and their representatives if they were protected from abuse, improper treatment and avoidable harm we received consistent feedback, "Yes" and "Definitely."

Staff told us that they were not able to provide a consistent good standard of personal care for people at Douglas Bank because they were "Rushed" and "Understaffed."

We asked people who lived at the service and their representatives if they were supported by sufficient numbers of suitable staff to stay safe and meet their needs. People told us, "There isn't enough staff, often [Name] clothes are wet because there isn't enough staff to help." "Weekends and evening are short staffed." "[Name] requires a high level of support and if they had not been assisted to bed before shift change at 8pm, it tended to be after 10pm before they got to bed, as night staff had suppers to attend to." And "Sometimes [Name] has to wait five to ten minutes for staff to help."

We discussed staffing levels with the registered manager and they assured us that staffing would be

reviewed and assessed in line with the providers dependency tool.

Environmental improvements had been made. The registered manager showed us areas around the service that had been refurbished. The car park had been resurfaced and there was a structured refurbishment plan that showed areas that had been redecorated and work to be undertaken. The service was clean and free from clutter. We noted relevant servicing of equipment had been undertaken and environment safety checks had been completed which included a fire risk assessment and emergency contingency plan.

Requires Improvement

Is the service effective?

Our findings

We received mixed feedback from people who lived at the service and their representatives about the quality of food provided. People told us, "Food is diabolical, disgraceful.", "Porridge is like rubber." "It was a bad dinner today." "You get a good Jack-bit (snacks) here and plenty of it." "The food is luke-warm or cold and is served on cold plates." And "The food is fine at the weekend."

We found people were not always adequately supported by staff to eat and drink and this placed them at risk of malnutrition and dehydration. For example, we observed breakfast being served on the dementia care unit, staff did not follow food safety standards, we saw them serve two people cold porridge and cold tea that had been left on the side for some time, the porridge looked congealed. We also saw staff use a microwave to heat others people's breakfast and they did not check the temperature of food before it was served. This placed people at risk of being scalded. We found that people were not always given choice and control at meal times, we observed people leave their meals and staff did not offer an alternative or encourage them to eat.

We reviewed how people's needs and choices were assessed and their care and support delivered to achieve effective outcomes. We found a poor standard of record keeping in relation to daily charts. For example, we checked daily diet and fluid intake records for five people who lived at the service, we found gaps in record completion, discrepancies in people's diet types and we also observed a support worker make a false entry during the inspection for a person who had not eaten their breakfast and the record was completed to show that the person ate a full breakfast. In accurate record keeping placed people at risk of not receiving support as they require.

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

We looked at a pre-admission assessment for a person recently admitted to Douglas Bank, we found that their needs had been assessed prior to admission, risk assessments were completed on admission and identified risk was care planned.

We found a good standard of information in people's care records about access to health care professionals. For example, one person's care records showed they had been assessed by a range of external health professionals: the speech and language team (SALT), podiatry and tissue viability.

People's representatives told us that staff were good at keeping them informed about any changes to their relatives' health, "Yes, they keep us informed of changes." "Yes, they let us know when they call the GP and then they give us feedback afterwards." And "They are good at letting us know, they keep us informed about arranging for the SALT team and the physio."

We looked at staff training records and found that the provider ensured staff had access to a range of training courses and records showed that staff had completed courses allocated to them. These included

basic first aid, MCA and DoLS, dementia awareness, infection control, safeguarding adults and health and safety. We also looked at staff supervision records and found that all staff had received supervision from their line manager and a schedule was available which showed further planned one to one sessions with the registered manager.

We asked staff if they felt supported by the registered manager and provider. Staff told us, "Yes I am supported, the training is good here". And "I had a good induction which included training."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment with appropriate legal authority when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met. We found that people were assessed in line with principles of the MCA and detailed mental capacity assessments were undertaken. The providers had systems in place for supporting people who were deprived of their liberty. Records were kept and staff we spoke with demonstrated understanding of the MCA and associated DoLS.

We reviewed how are people's individual needs were met by the adaptation, design and decoration of premises. We found that some consideration had been made in relation to creating a dementia friendly environment. We saw the dementia care unit had been redecorated and people had access to directional signage to help them find their way around. We found that communal bathrooms and toilets were locked and restricted people's access to such areas and could infringe on their independence. The provider told us this area of the service was not used by people who were able to access the bathroom independently however, a risk assessment had not been undertaken and people who lived at the service had not been consulted in relation to bathrooms being inaccessible without staff support.

Requires Improvement

Is the service caring?

Our findings

We reviewed how the service ensured that people were treated with kindness, respect and compassion and that they were given emotional support when needed. We observed in both communal areas of the service and found people who lived at Douglas Bank did not always receive care and support in a kind and respectful way. For example, we observed the ground floor lounge area between 09.30hrs and 14.40hrs, during this time we saw a support worker stand over a person when assisting them with their meal, they did not explain to the person what they intended to do and did not talk to the person throughout the intervention. Another example was when a person who lived on the dementia care unit told a support worker that they needed the bathroom and they were ignored on two occasions until the inspector asked for the person to be supported.

We observed care and support to be task focused and people's needs were not always responded to. One person was laid asleep on the lounge sofa throughout our morning observations on the dementia care unit, they appeared uncomfortable and very lethargic however, staff did not engage with the person to stimulate them or offer them food or fluids. We discussed this with the deputy manager who then advised staff to wake the person to orientate them to the time of day.

We found staff did not always protect people's dignity. We observed a support worker carrying a person's incontinence aid into a communal area and then assisted them to the bathroom, this identified that the person was incontinent and therefore was not dignified. We also saw another member of staff showing an external contractor around the service. They did not always knock on doors before entering and we observed them enter a bathroom without knocking and a person was being assisted in this area.

We did however, also see some positive interactions between support workers and people that lived at the service. We saw one support worker put their arm around a person and comforted them. We saw another senior support worker engage with people in a kind and respectful way and they clearly understood the needs of people in their care.

We checked how the service supported people to express their views and be actively involved in making decisions about their care, support and treatment as far as possible. We looked at resident survey results from September and October 2018, we saw that six people who lived at the service had completed the survey and actions to their comments were recorded. For example, one person requested more entertainment and the activity worker had responded to the individual. We also looked at relative survey results from October 2018, we saw that five surveys had been returned and these contained mixed responses including, 'we were not involved with our relative's care plan', 'there is a lack of activities', 'there is not enough staff' and 'We are happy with the improvements that have been made and are continuing to be made'.

We saw minutes for the last resident and relative meeting which was held in July 2018. The registered manager told us that meetings were scheduled twice per year.

Staff showed understanding of protecting and respecting people's human rights. We discussed equality and diversity with staff and they described the importance of promoting equality and diversity in the work place. We looked at how people's individual needs were met in relation equality and diversity, a person who lived at the service told us about how their choice to reside was respected and "staff do not interfere with my choices even though to others they may seem eccentric." We discussed the Equality Act 2010 with the registered manager and they told us about the work they had done to protect staff from unfair treatment at work. The Equality Act 2010 legally protects people from discrimination in the work place and in wider society. For example, all staff received training in equality and diversity and maintaining dignity during their induction.

Requires Improvement

Is the service responsive?

Our findings

We reviewed how people's needs and choices were assessed and their care and support delivered to achieve effective outcomes. We found people who lived at Douglas Bank were not always supported in a person-centred way. We observed care and support to be task focused and people were not always empowered to maintain their person-hood and independence. For example, we saw that a person who lived on the dementia care unit was able to move around freely and staff were deployed to support them on a one to one basis, however staff did not engage with the individual to encourage them to maintain their interests or facilitate social stimulation. We asked a care worker supporting the person if they could tell us about the person's background or interests, we found that staff lacked knowledge of the person's identity and what was important to them.

We looked at people's care plans and found that they were task focused. Care plans did not incorporate person-centred information about people that lived at the service and what was important to them.

We found that staff did not always identify when people who lived with advanced dementia were trying to request support. For example, we observed a person who lived on the dementia care unit standing up and sitting down repeatedly, they pulled at their clothes and clearly showed signs of needing to use the bathroom. Two support workers told the individual on separate occasions to sit down and did not identify the person's need for support from their restless body language. We asked support staff to assist the individual which they did in a kind and respectful manner. We also found that some people who lived at the service were disengaged. Throughout our observation for 40 minutes, two people sat in the dementia care unit lounge stared consecutively at the wall across from them. Staff did not interact with them to provide stimulation or emotional support. This meant that the people did not always experience positive outcomes.

We asked people who lived at the service and their representatives if they were satisfied with the level of social activity and stimulation they received. We received mixed feedback, "My [name] is frustrated and has nowhere to go." And "Social activity is rare but when it is available [name] really enjoys it". Relatives told us that regular entertainment was provided downstairs but this was limited for people who stayed the dementia care unit. During this inspection we did not observe any social activity other than church communion which was held in the ground floor lounge.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We evaluated how people were supported at the end of their life to have a comfortable, dignified and pain-free death. We found that the service had systems in place to support people at the end of their life. We saw examples of end of life care planning that included people's wishes and preferences. However, we found that DNACPR decisions were not always included in people's end of life care plans.

We checked how the service used technology to respond to people's needs and choices. We saw that the provider had installed a new nurse call system. The system enabled the management team to analyse staff

response times and reports enabled the registered manager to review staffing levels in relation to dependency of people that lived at the service.

We checked if the provider was following the Accessible Information Standard. The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need. We found there was information in people's care plans about their communication skills to ensure staff were aware of any specific needs and resident survey documents had been formulated in an easy read style.

Requires Improvement

Is the service well-led?

Our findings

We reviewed how the service promoted a clear vison and approach, to deliver high-quality care and achieve positive outcomes for people. We found that the registered manager and provider understood areas that had declined and areas that continued to require improvement at Douglas Bank. The registered manager demonstrated a clear vision towards improving staff culture and to embed improved and sustainable systems. We received positive feedback about the registered manager. People's representatives told us, "Yes she is approachable." And "Yes the manager is nice and always approachable." Two relatives told us that the provider had attended the last relative meeting and that their contribution was well received.

The service changed ownership in July 2017. The registered manager commenced in post in February 2018 and throughout 2018 there had been a high turnover of nursing and care staff and this had a positive impact on the culture at Douglas Bank. During the inspection the provider was on site and we saw them engaged with people who lived at the service, visitors and staff. We provided feedback for the provider and we were reassured by the provider's response in relation to how the service intended to improve.

We checked if the monitoring systems ensured that responsibilities were clear, and quality performance, risks and regulatory requirements were understood and managed. We found some shortfalls in the oversight of medicines. Failings were also found at the last inspection. We discussed this with the registered manager and felt reassured that they would address our concerns immediately. However, the provider continued to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and this showed ineffective quality assurance systems therefore we will take proportionate enforcement action against the provider to ensure that improvements are made and sustained.

We looked at quality assurance audits for all areas of service provision and these included, health and safety, care files, daily management audits and quality dining audits. We found that failings found at this inspection around person-centred care, dignity and respect standards and nutrition had not been identified by the registered manager. This meant that the provider did not always ensure that lessons could be learnt and improvements made. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how people who used the service, staff and others were consulted on their experiences and shaping future developments. People's representatives told us that regular meetings were arranged and we saw evidence of meeting minutes and planned meetings. Staff meetings were held on a regular basis and we found that the registered manager maintained a good standard of communication with staff, residents and visitors.

We evaluated how the service worked in partnership with other agencies. We received feedback from a visiting professional who told us that the registered manager and senior staff at the service worked in partnership with them and were transparent when sharing information about people in their care. However, we found examples where the provider did not always escalate medicine errors to the involved medical professional, this placed the person at risk of harm.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure that people were supported in a person-centred way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure that people received their medicines in a safe way. The provider did not always ensure that people were risk assessed in relation to individual risk.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider failed to ensure that people were supported to maintain a healthy diet to prevent malnutrition and de-hydration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to effectively assess, monitor and quality assure the service.