Direct Services

Tudor Gardens

Inspection report

27-31 Tudor Gardens
Kingsbury
London
NW9 8RL

Tel: 02089084692

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30 March 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Our inspection of Tudor Gardens took place on 8 March 2016 and was unannounced. The manager was on leave when we visited and we were unable to access all the information we required, so we returned on 23 March and 30 March to complete our inspection.

Tudor Gardens is a care home registered for 15 people with learning disabilities situated in Kingsbury. Some of the people who live at the home have additional needs such as physical impairments, communication impairments and behaviours considered challenging. The home consists of three separate self-contained units, each with a separate door numbered (27, 29 and 31). At the time of our inspection there was one vacancy at the home. We last inspected Tudor Gardens on 18 August 2014 when we found that the home met the regulations that we assessed.

At the time of our inspection the home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (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 2008 and associated Regulations about how the service is run. The registered manager had recently taken over the management of another service managed by the provider. A new manager had been appointed to the home and at the time of our inspection they had commenced the process of applying for registration with CQC. Although the current registered manager was no longer based at the home, they visited regularly and covered for the new manager when they were on leave.

People who lived at the home told us that they felt safe, and this was confirmed by the family members and friends that we spoke with.

People were protected from the risk of abuse. Staff members had received safeguarding training and were able to demonstrate their understanding of what this meant for the people they were supporting. They were also knowledgeable about their role in ensuring that people were safe and that concerns were reported appropriately.

Medicines at the home were generally well managed. Staff members responsible for administering medicines had received appropriate training. However, the PRN (as required) medicine for one person was stored in a locked filing cabinet and information that it had been moved from the medicines cabinet had not

been shared with a staff member responsible for medicines in that unit. We were subsequently told that the medicines were no longer used, but the person's medicines administration record and care plan contained no record of this fact.

Our observations of staff at the home showed that people were generally supported in a caring and respectful way, and responded promptly to meet their needs and requests. However, we observed that a minority of staff members did not engage people in discussion and activities. We saw evidence that this was being addressed. However, we noted that people who lived at the home were required to move to another unit on two occasions during our inspection, due to staff supporting people on planned and unplanned activities outside the home. Therefore we could not be sure that the provider was able to ensure that sufficient staffing was available to support people at all times.

Staff who worked at the home received regular relevant training and were knowledgeable about their roles and responsibilities. However, the records that we viewed showed that a number of staff members had not always received regular supervision from a manager.

The home was meeting the requirements of The Mental Capacity Act 2005 (MCA). Information about people's capacity to make decisions was contained in people's care plans. Applications for Deprivation of Liberty Safeguards (DoLS) had been made to the relevant local authority. The majority of staff had received training in MCA and DoLS, and those we spoke with were able to describe their roles and responsibilities in relation to supporting people who lacked capacity to make decisions.

People's nutritional needs were well met. People told us that they enjoyed the food. We saw that alternatives were offered where required, and drinks and snacks were offered to people throughout the day. We saw good practice from staff members regarding offering choice and supporting a person with swallowing difficulties to eat and drink. However, during our first visit to the home, we observed that this was not always the case. This was raised with the manager, and we noted that improvements had been made when we returned to the home.

The physical environment of the home was suitable for the needs of the people who lived there.

Care plans and risk assessments were person centred and provided guidance for staff. We saw that these had been regularly updated and reflected any changes in people's needs.

The home supported people to participate in a range of in-house and group activities for people to participate in throughout the week. During our inspection we saw that two people had gone out to lunch supported by a staff member. We also noted that a local self-advocacy service had facilitated a well-attended meeting at the home.

People and their family members that we spoke with knew what to do if they had a complaint.

Care documentation showed that people's health needs were regularly reviewed. The home liaised with health professionals to ensure that people received the support that they needed.

There were some systems in place to review and monitor the quality of the service. However these were limited. We noted that there was a regular monitoring process for health and safety and medicines. However, there were no quality assurance measures and audits of, for example, care plans, staffing records and infection control.

The home looked after people's money and we saw that there was regular and effective monitoring. However, we had concerns about the fact that people had not been able to access significant sums of monies held in bank accounts, in some cases for a number of years. The provider showed evidence that recent actions had been taken to address this. ,
Policies and procedures reflected regulatory requirements and good practice.

People who used the service, their relatives and staff members spoke positively about the home.

We found four breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have taken enforcement action against the provider, and will report further on this when it is completed. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. Although medicines were generally managed well we had concerns about the storage and recording of an 'as required medicine' for one person.

We had concerns about the home's ability to ensure enough staff members were always available to cover planned activities and hospital appointments.

People had up to date risk assessments that provided guidance for staff on how to manage risk.

Staff members had received training in adult safeguarding and were aware of how to protect people from abuse.

Is the service effective?

Requires Improvement

The service was not always effective. Some staff members had not received regular on-going supervision from a manager.

Staff training met national standards for staff working in health and social care and was regularly refreshed to ensure that knowledge was up to date.

The home was meeting the requirements of The Mental Capacity Act and associated Deprivation of Liberty Safeguards.

Is the service caring?

Good

The service was caring. People were well supported by staff and we saw good examples of positive and caring interactions. We saw that concerns about the approaches of a minority of staff members were being addressed.

People's personal, religious and cultural needs were met.

People had access to advocacy services, and a regular monthly meeting facilitated by a local self-advocacy organisation took place at the home.

Is the service responsive?

Good

The service was responsive. People's care plans were up to date and provided guidance for staff on how best to meet their needs.

People were able to participate in a range of activities, both within the home and in the wider community.

There was an accessible complaints procedure and people and their families knew how to use it.

Is the service well-led?

Requires Improvement

The service was not always well led. Quality assurance processes were limited and we had concerns about the fact that the provider had not addressed a longstanding issue in relation to people's access to bank accounts in a timely manner.

The manager did not have access to all staff supervision records through the provider's on-line system.

Staff members were knowledgeable about their roles and were enabled to discuss these at regular team meetings.

There was effective partnership working with health and social care professionals.

Tudor Gardens

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 8 March 2016 and was unannounced. The manager was on leave when we visited and we were unable to access all the information that we required, so we returned on 23 March and 30 March to complete our inspection.

The inspection team consisted on one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service, in this case services for people with learning disabilities and autistic spectrum conditions.

Before the inspection the provider had completed a Provider Information Record (PIR). This is a form that asks the provider for key information about the service, what the service does well, and what improvements they plan to make. We also reviewed our records about the service, including previous inspection reports, statutory notifications and enquiries.

During our visit we spoke with six people who lived at the home. We also had telephone discussions with two family members and a friend. We spent time observing care and support being delivered in the communal areas, including interactions between staff members and people who lived at the home. In addition, we spoke with the registered manager, a new manager who was in the process of applying for registration and three members of the care team. We looked at records, which included the care records for five people who lived at the home, 10 staff recruitment records, eight staff supervision records, policies and procedures, medicines records, and other records relating to the management of the home. Subsequent to the inspection we spoke with the operations manager for the service on the telephone.

Requires Improvement

Our findings

A family member told us that they considered the service to be "very safe." A friend of a person told us, "People are well looked after at Tudor Gardens."

People's medicines were generally managed safely. The provider had an up to date medicines procedure. Staff members had received medicines administration training, which was confirmed by the staff members that we spoke with and the records that we viewed. Records of medicines were of a good standard, and included details of ordering, administration and disposal of medicines. People's care plans and risk assessments included guidance in relations to people's medicines.

However, we had concerns about the storage and record keeping in relation to PRN (as required) medicines. When we were shown the medicines storage arrangements for number 31 Tudor Gardens, the staff member that we spoke with was unable to understand why the prescribed PRN medicine recorded on the person's medicines administration record was not contained within the medicines cabinet. On our return to Tudor Gardens, we were told that the medicine had been stored within a locked filing cabinet because it was no longer required. However we noted that there was no record of this in the person's care plans nor in their medicines administration record, and the medicine had not been disposed of. There was no record of any communication with staff regarding the fact that the medicine was no longer required, and the staff member that we spoke with could not understand why it was not stored within the medicines cabinet. The medicines audits that we received subsequent to our inspection also made no reference to this.

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

We looked at the staffing rota and observed how support was provided. Staffing levels at the home appeared to be sufficient to support people's day to day needs. However, we had concerns about how the home managed situations where people required additional support to participate in activities, or to cover for staff absence. During our inspection on 8 March, one person required two staff members to support them during a planned hospital appointment. We saw that people were required to move from their homes at numbers 27 and 29 Tudor Gardens for a period of approximately two hours. When we asked about this, we were told that this was an unusual occurrence, and was due to other staff members needing to support other people on the day. The manager told us that, for planned appointments, additional staff members would be provided through, for example, an early start to their afternoon shift. However, the staffing rotas that we saw did not show where staff had been required to commence their shifts early, and we did not

observe that any additional staff were on site or deployed in taking people to activities. When we returned to the home on 23 March, we noted that people living at one unit were required to move to the unit next door for a period of approximately 30 minutes. We were told that this was due to a staff member who was late arriving for their shift and that there was a need to cover the handover period. Since this occurred on both days of our inspection we could not be sure that appropriate actions were in place to prevent the likelihood of this recurring in the future.

This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was an up-to-date safeguarding adults procedure. Staff members had received training in safeguarding and regular refresher sessions were arranged to ensure staff knowledge was up to date. Staff members we spoke with demonstrated a good understanding of safeguarding and were aware of their responsibilities in ensuring that people were safe. They knew how to report concerns or suspicions of abuse using the procedure. We reviewed the safeguarding records and history for the home and saw that there had been no safeguarding concerns raised since our previous inspection.

There were suitable arrangements in place to protect people from identified risks associated with day to day living and wellbeing. Risk assessments for people who used the service were personalised and had been completed for a range of areas including people's behaviours, anxieties, health and mobility needs. Situational risk assessments were in place for a wide range of activities both inside the home and within the local community. These included, for example, a range of personal care activities, food preparation and eating, community activities and use of public transport and taxis. We saw that these were up to date and had been reviewed on a regular basis. Risk management plans were detailed and included guidance for staff around how they should manage identified risks. Behavioural risk assessments included guidance for staff around providing positive approaches to supporting people and identifying and reducing 'triggers' that might create anxieties for people.

Small amounts of people's monies for day to day expenditure were looked after. We saw that records of these were well maintained, receipted, and that these matched people's cash balances. We observed that checks of monies took place on a weekly and monthly basis. We also saw evidence that the provider undertook an annual audit of monies maintained at the home.

We looked at eight staff files and these showed us that the provider had arrangements in place to ensure that they recruited staff who were suitable to work with the people whom they supported. Staff recruitment records included copies of identification documents, evidence of eligibility to work in the UK, two written references, application forms and criminal record checks. Detailed policies and procedures were in place in relation to staff recruitment and the staffing records showed that these had been followed.

The home environment was suitable for the needs of the people who lived there. The communal areas were spacious and that there was sufficient space for people to move around safely. Lifts and accessible bathrooms were in place for people who required these. People were able to personalise their rooms as they wished. The units at the home were well maintained, and we saw that during our inspection a maintenance worker was on site attending to small maintenance issues. Regular health and safety audits of the building had taken place. These included action plans, and we saw that identified actions had been addressed. Records showed that safety checks at the home, for example, in relation to gas, electricity, fire equipment and portable electrical appliances were up to date.

Accident and incident information was appropriately recorded. Staff members described emergency

procedures at the home, and we saw evidence that fire drills and fire safety checks took place regularly. An emergency out of hours call service was operated by the provider, and staff members knew who to call if required.

Requires Improvement

Our findings

A family member told that they were happy with the support from staff. They said that, "the staff have known [my relative] for many years and they are really good at meeting her needs."

The staff members that we spoke with had worked at the home for some time and many had worked with the people living there at a previous location. They were knowledgeable about people's needs and preferences.

We looked at staff supervision records for ten staff members. The provider's policy on staff supervision was that staff members should receive supervision from a manager on an approximately six week cycle. We noted that for eight people, the records showed that they received supervision less frequently. For two of these people there was evidence to show that they had had periods of illness where supervision could not take place. However, for others we could not be satisfied that the provider was meeting its own procedures and that staff members were receiving regular supervision. Although we noted that annual appraisals had taken place during the past year, the records for two members showed gaps of five months between supervisions, and for another staff member there were gaps of three months and eight months between recorded supervisions. Therefore we could not be sure that staff members at Tudor Gardens were always receiving appropriate on-going supervision in their role to make sure that their competency was maintained.

This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that all staff had received mandatory training such as safeguarding adults, infection control, manual handling, epilepsy awareness and medicines awareness. Additional training that related to people's specific needs was also provided, for example, in understanding learning disabilities, and positive behavioural approaches. Training was refreshed on a regular basis, and we saw that the provider maintained an on-line training matrix that alerted staff members and the manager if any training was due. One staff member told us that they thought that the training they received was good. Staff members also had opportunities to take up care specific qualifications and we saw that a number of staff members had achieved a care qualification. The manager told us that all new staff members received an induction when they started working at the service. We saw that the induction included information about people using the service, policies and procedures and service specific information such as the fire procedure and maintaining a safe environment. Induction training was provided that met the requirements of the Care Certificate for staff working in health and social care services.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes 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.

Staff at Tudor Gardens had received training in the MCA 2005 and demonstrated that they were aware of the key principles of the Act. We observed that staff members used a range of methods, including words, signs, pictures and objects to support people to make decisions. Information about supporting choice for people with limited verbal communication was contained in people's care plans, as was information about people's capacity to make decisions. People's care plans included information about restrictions that were in place, with evidence that these had been agreed with others, such as family members and key professionals, to be in people's best interests. Applications had been made to the local authority for Deprivation of Liberty Safeguards (DoLS) to be put in place for people who lived at the care home to ensure that they were not unduly restricted.

People said they liked the food at the home. One person told us, "The food is nice." However, our observations of mealtimes were mixed. At our first visit on 8 March, we observed a lunchtime meal where people were told by a staff member that they were having poached eggs and beans on toast. The menu for that particular meal showed that sausages were on the menu, but this was not offered, nor did we see people being offered any alternative. When we visited the home again on 23 March we observed another lunch session. This time people were offered hotdogs, fried onions and beans that were on the menu, and one person had chosen to have cheese on toast with ham. The staff member preparing the meal placed the bread rolls, sausage, onions and beans separately on the table so that people could be involved in putting their own lunch together. Records of meals maintained by the service showed that people ate a varied and healthy diet that reflected the religious and other dietary needs that were recorded in their care plans. One person at the home required a soft food diet, and we saw that menus were in place to support this. We observed a staff member preparing them a drink with a prescribed nutritional supplement. The involved the person in the process, talking with them about what they were doing. They stayed with them while they were drinking, chatting to them and reminding them to take their time where required.

We were able to see that people were generally offered drinks and snacks throughout the day. However during our inspection on 8 March when people were in the lounge at 31 Tudor Gardens, we observed that when a person asked for a cup of tea they had to wait approximately 30 minutes to receive this. At this point tea was made for everyone. We saw that one person threw their tea away in the kitchen sink. The staff members in the room took no notice of this. However, when another staff member returned from taking a person out, they asked the person if they would like some juice which they accepted and drank.

We spoke with the manager about the importance of providing and recording choice regarding food and drink. They told us that they would address this for each unit. When we returned to the home on 23 March we noted that the menus had been changed to include options.

There were effective working relationships with relevant health care professionals. We saw that regular

appointments were in place, for example, with challenging behaviour and hospital services, as well as the GP and dentist. Staff members accompanying people to appointments had completed a record of what had been discussed and agreed at these. Care plans included information about people's health needs which included details about the support that they required to maintain their health and wellbeing. The daily records maintained by the home showed that people's daily health needs were well managed. For example, we saw that health concerns were highlighted and passed on to incoming staff for action or monitoring as required.

People's families were involved in their care and their feedback was sought in regards to the care provided to their relative. A family member told us that "I know the staff well. They do keep in touch to tell me if they have any concerns about [my relative]."

Good

Our findings

A family member told us, "[my relative] is cared for very well." A friend of a person said, "I think that the staff do their best to support people who have quite complex needs."

We observed a number of positive examples of support to people who lived at the home. For example we saw staff members supporting people to participate in activities within the home such as games, and people were generally offered choices about what they wished to do. The majority of staff members interacted in a positive way with people, and communicated with them in ways that were appropriate to their needs. We observed one staff member supporting people to learn new Makaton signs. We also saw that a person who was anxious about a lost item was treated sensitively by the manager and staff members supporting them.

However, we also observed that some staff members did not always support people in ways that enabled choice and dignity. During the first day of our inspection on 8 March we heard a staff member shouting from the kitchen for people to come to lunch. We also observed the same staff member calling people 'boys' and had to ask what their names were, as the staff member did not refer to them by name. There was one occasion when people were not engaged with by staff members. During our first visit on 8 March, when people were required to move to the unit at 31 Tudor Gardens due to staff shortages, we observed that the two staff members who were providing support did not interact with people or engage them in any meaningful activity.

We spoke with the manager about our concerns regarding the fact that, although the majority of staff that we observed interacted positively and proactively, a minority of staff members did not appear to engage appropriately with people. They demonstrated that they knew who these staff members were discussed the actions that they that they were taking to address this. We noted that concerns had been discussed with a staff member during a recent supervision meeting. We also saw from the minutes of the most recent staff meetings that concerns about consistency and dignity of care and support had been discussed, and that guidance had been provided for staff about how they should support people.

The service was sensitive to people's cultural, religious and personal needs. We saw that information about people's religious and cultural and personal needs were recorded in their care plans. One person told us that they went to church regularly. Another person told us that they had a girlfriend.

People had strong links with their families who were involved in decisions about their care. The manager told us that people could access advocacy services if required, and we saw that information about local

advocacy services was available at the service. During our inspection representatives from a local self-advocacy service for people with learning disabilities came to the home, and held a well-attended meeting with people who lived there. We were told that this was a regular monthly meeting and that feedback relating to any concerns arising from this was provided to the manager.

Although the majority of people who lived at the home were unable to tell us about their care plans, family members said that they had been involved in recent assessments of people's needs.

Good

Our findings

People's needs were regularly assessed and reviewed and family members were involved in the assessment of their needs. A family member said, "They have involved us in assessments of people's needs."

Care plans were up to date and person centred, and contained guidance for staff in relation to meeting people's identified needs. The care plans were clearly laid out and written in plain English. There was a clear link to people's assessments and other information contained within their files. The majority of people who lived at the home did not understand what their care plan was. We noted that where people were unable to participate in reviews of their care plans this was not recorded. We discussed this with the manager who told us that this would be noted in people's plans in the future.

The care plans that we viewed detailed people's personal history, their spiritual and cultural needs, health needs, likes and dislikes, preferred activities, and information about the people who were important to them.

Care plans provided information for staff about the care and support that was required by the person and how this should be provided. These were provided in easy read formats. Plans included information about personal objectives, and provided detailed guidance for staff about how they should support people to achieve these. Each plan also included information about personal care routines that indicated where people were able to do things for themselves, and what support they required where they could not.

Plans in relation to behaviours clearly described behaviours that might indicate that a person was anxious or distressed, along with 'triggers' to be avoided where possible. These were supported with clear stage-by stage information to reduce levels of arousal and enable staff members to support the person to manage their behaviours in a positive way.

Information about people's communication needs was detailed and contained clear guidance for staff members on how to ensure that people were enabled to communicate their needs effectively. For example, there was information about how people communicated their needs, and how staff should respond to this communication using signs, pictures and objects of reference. During our inspection, we were able to observe staff communicating with people, and we saw that they used a range of methods described in their plans.

People participated in a range of activities within the local community that included shopping, walks and meals out. During our inspection we saw that two people went out to lunch accompanied by a staff member. One person attended a day service on two days each week. People's care documentation included individual activity plans and we saw that people participated in a range of activities. One person told us about the weekly Zumba class that they attended with another person who lived at the home. Another person told us that they went to regular Partnership Board meetings. People also told us about the models that they made, and the fact that they had baked cakes at the home.

However, another person told us that they did not go out to activities even though their activity plan showed that a number of community based activities had been arranged for them. When we discussed this with the manager, they told us that the person often refused to go out when it was time to leave for the relevant activity. We discussed the fact that this was not reflected in their daily care notes. The manager assured us that they would talk with staff about the need to record offered activities that were refused.

The home had a complaints procedure that was available in an easy read format. A friend of a person told us that they had raised a complaint and that this had been addressed. A person who lived at the home said that people had complained and that they now had fridges in their bedrooms.

Requires Improvement

Our findings

A family member told us, "we have always had a good relationship with the registered manager, but we don't know the new manager well yet."

The new manager was in the process of applying for registration with the Care Quality Commission. The previous manager who was still the registered manager for the service was currently managing another service, but visited the home on a regular basis.

We had concerns about access to staff records when we visited the home. The provider maintained an on-line system for staff records, and neither the registered manager nor new manager had access to all the relevant records for the home. Information about criminal records and reference checks were maintained by the provider's human resources department, and, when requested, we were promptly provided with these. However, when we asked to view the supervision records for staff, we were told that access to these was only provided to direct line managers. The manager was able to show us the records for staff members that she directly supervised, but had to ask a senior support worker to provide the supervision notes for the staff that they supervised. This meant that we could not be sure that the provider had processes in place to ensure that the quality and frequency of staff supervision was monitored by the manager.

Although the provider had a number of quality assurance processes in place, these were limited. During our inspection we were shown a copy of a recent service user satisfaction survey that showed positive feedback for the home. We also saw that a health and safety audit had taken place on 15 March 2016. This included an action plan. Subsequent to our inspection we were sent copies of medicines audits for the precious three months. However, we asked if other quality assurance processes took place and we noted, for example, that no audits of people's care plans and risk assessments, infection control procedures, or staff supervision had taken place. Medicines audits were in place but we noted that these did not include information about issues and changes in relation to people's medicines,

Although the day-to-day management of people's monies was audited on a regular basis, the home did not have access to other information about people's monies held in account by the local authority appointee service. Post office passbooks for 11 people were held in the home's safe. These showed that significant sums of personal money had not been able to be accessed by people because they were unable to sign for withdrawals. The provider told us that recent action had been taken to resolve this, and we were able to see a draft letter that was to be sent to family members regarding arrangements to enable these monies to be accessed. However, we were concerned that no previous action had been taken to resolve this since the

time of the most recent withdrawals from these accounts in May 2012.

The above concerns demonstrate a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff members had job descriptions which identified their role and who they were responsible to. The staff members that we spoke with were clear about their roles and responsibilities in ensuring that the people who used the service were well supported.

We saw that the manager interacted in a positive way with people who lived at the home, staff members and visitors.

Minutes of regular staff team meetings showed that there were regular opportunities for discussion about quality issues and people's support needs

We reviewed the policies and procedures.in place at the home. These reflected good practice guidance.

Records maintained by the home showed that the provider worked with partners such as health and social care professionals to ensure that people received the services that they required. Information regarding appointments, meetings and visits with such professionals was recorded in people's care files.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective quality systems in place to fully assess, monitor and improve the quality of services provided, or to mitigate risks relating to the safety and welfare of people. 17(1)(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff members had not always received appropriate periodic supervision in their role. 18(1)(2(a)

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was unable to demonstrate the proper and safe management, recording and storage of medicines 12(1)(2)(g)

The enforcement action we took:

We issued a warning notice on 25 April 2016. the provider is required to become compliant by 31 May 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider was unable to demonstrate that sufficient numbers of staff were deployed to meet people's care needs 18(1)

The enforcement action we took:

We issued a warning notice on 25 April 2016. the provider is required to become compliant by 31 May 2016.