Nugent Care

James Nugent Court

Inspection report

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26 April 2018

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced inspection of James Nugent Court on 23 and 26 April 2018.

James Nugent Court 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. James Nugent Court is a modern-purpose built home. It has 56 bedrooms with en-suite accommodation situated over two floors. At the time of inspection James Nugent Court was providing care for 49 people.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager in post was going through the process of registration with the Commission.

During our inspection, we identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulated Activities 2014 in respect of Regulations 11 consent; 12 safe care and treatment; 17 good governance and 18 staffing. We also identified a breach of Regulation18 the Care Quality Commission Registration Regulations regarding notifying of significant events. You can see what action we told the provider to take at the back of the full version of the report.

We found that the Mental Capacity Act 2005 and the Deprivation of Liberty (DoLS) 2009 legislation had not been adhered to in the home. We saw that mental capacity had not always been assessed appropriately, consent had not always been sought, covert medication processes had not been followed and DoLS conditions that were to be applied by the home had not been carried out.

The medication procedures were not managed effectively as there were medications not administered correctly as prescribed. Equipment was not monitored to ensure it was working appropriately.

Accidents, incidents and complaints had not been managed appropriately. Audits of the service were ineffective and in some cases not carried out.

People received support with their health care. However care plans and risk assessments had not been updated accurately and in some cases contained contradictory guidance that if followed would pose a risk to people's health and safety. People's personal emergency evacuation plans did not match their risk assessments.

Monitoring information for peoples care such as fluids and nutrition intakes had not always been completed and in some cases had been duplicated with differing information. Information from other professionals such as dieticians had not been transferred into care plans.

We saw no evidence of a robust induction process into James Nugent Court and we questioned the effectiveness and validity of the training staff had received as we identified serious concerns with the service. Supervisions and appraisals had not regularly taken place.

The manager had reduced the number of agency staff being used however feedback we received from people using the service, relatives and staff all indicated there were still issues regarding staffing levels.

People we spoke with told us they felt safe at the home and they had no worries or concerns. People's relatives and friends also told us they felt people were safe. We observed staff to be kind and respectful towards people. The home provided a range of activities to occupy and interest people

Infection control standards at the home were good and these standards were commented on by both people living in the home and their relatives.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location from the providers registration.

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

Medicines were not managed safely.

People's needs had changed and risk assessments had not been updated. People's personal emergency evacuation plans did not match their risk assessments.

Accidents and incidents were not managed safely.

People living in the home, relatives and staff reported low staffing levels.

Is the service effective?

Inadequate

The service was not always effective

People's mental capacity had not been assessed in accordance with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards conditions had not been adhered to.

Appropriate consent processes had not been followed.

It was not always clear if staff had received an induction and training was not effective.

Is the service caring?

Requires Improvement

The service was not always caring

Staff did not always have the appropriate guidance to support people.

We observed staff to be caring, respectful and approachable.

People appeared at ease with staff.

Is the service responsive?

Requires Improvement

The service was not always responsive

Some people who lived in the home did not have a plan of care that was appropriate and met their needs.

End of life information in care plans was not always correct.

A range of social activities was provided and the activities co-ordinator took time to build positive relationships with people.

Is the service well-led?

Inadequate

The service was not Well-led

Statutory notifications were not submitted to the Commission when required.

Quality assurance systems for identifying risks to people's health and safety and to inform the service about improvements needed were not effective.

Processes such as accidents and incidents were not effectively managed by either the manager or the provider.

James Nugent Court

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.

The inspection was prompted in part by notification of incidents that had occurred within the home. However, the information shared with CQC about the incidents indicated potential concerns about the lack of oversight in regard to the risk of unsafe medicines management, unsafe pressure area care and the mismanagement of the mental capacity procedures. This inspection examined those risks.

At the time of inspection CQC were aware that the incidents had been brought to the attention of the Local Authority. As part of the inspection we assessed on-going regulatory risk to people in the service.

This inspection took place on 23 and 26 April 2018 and was unannounced. The inspection was carried out by two adult social care inspectors, one medicines 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.

Before the inspection we asked for information from the local authority and we checked the website of Healthwatch Liverpool for any additional information about the home. We reviewed the information we already held about the service and any feedback we had received.

During our visit we spoke with six people who used the service, two people's relatives and nine members of staff. We also spoke with a community matron. We looked at care notes for six people who used the service, medication storage and records, six staff records, accident and incident report forms, health and safety records, complaints records, and other records for the management of the home.

Inadequate

Is the service safe?

Our findings

People and their relatives we spoke to told us they felt safe in the home, however during the inspection we found concerns about the safety of the care being delivered.

We checked the medicines and records for nine people. We found that all nine residents had photographs, which reduced the risk of a medicine being given to the wrong person. However, allergies were not always recorded on residents' Medicine Administration Records (MARs) increasing the risk of a medicine being given to a person with an allergy to it. We checked the two medication rooms on the ground floor and second floor and found them to be too hot for the storage of medicines. The ground floor's room temperature had been recorded at 30°C for the previous seven days and on one day had been recorded as 32°C. The fridge temperatures on both floors had been recorded as being above the recommended range (The recommended temperature for storing medicines is 25°C). Two members of staff told us they did not know what the numbers meant. Not storing medicines at their recommended temperature may reduce their effectiveness.

We found a number of issues that related to medicines being administered unsafely. Some examples were; two people were prescribed a painkiller, which required a four-hour interval between each dose. Although the home had a system in place to record, the time a dose had been administered; it was not completed each time. This may have increased the risk of a person being given a dose too early and increasing the risk of harm.
A third person who had recently been discharged from hospital had a handwritten MAR chart with several errors on, which had been completed and checked by two separate senior carers. A medicine used to relax muscle spasms had been written to be given twice a day, rather than three times a day, which would reduce the effectiveness of the medicine in relaxing the person's muscles. A recent discharge letter had recorded that this person was experiencing pain from the muscle spasms, which may have increased with the incorrect dose being given. A calcium supplement for low calcium levels was given once a day rather than twice a day, reducing the effectiveness of the medicine and a medicine being used to increase this person's mood was being administered at a third of the dose that had been prescribed by their doctor. The sudden reduction in this medicine increased the risk of the person experiencing withdrawal side effects and a reduction in its effect.

We saw how another person who had Parkinson's Disease (PD) that affected their swallowing reflexes was not administered their time specific medicines as prescribed, which may have reduced the effectiveness of the medicine to control the person's PD symptoms. The same person had their fluids thickened with fluid thickening powder to reduce the risk of the person choking; however, there was no record of when the person had had their fluids thickened to determine if they had been thickened to the correct consistency. Another person who was prescribed a liquid medicine for their bladder was given an expired bottle of medicine for 11 days. The senior carer was unaware that the medicine had expired, as they had not checked the expiry date before administering it.

We asked for topical (cream) medications charts during inspection but we did not receive them as they

could not be found, these medications were not being managed appropriately.

This meant that the proper and safe management of medication was not in place for the people living at the home.

These were breaches of Regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the care plans and risk assessments for six people and found a number of concerns. People's files had an 'About me' document in them that had conflicting information contained. Examples included one gentleman whose care plan said he had epilepsy in one part and in another it stated they didn't. Another example was where it was identified a person had a number of health needs including blood pressure and hydrocephalus. Guidance said this 'needed monitoring'. There was no information on how these health needs required monitoring. Another example was where a person needed support of '2-3 staff' when receiving personal care, however there was no guidance saying why or how to support the person. One person had challenging behaviour but we saw no information as to how staff could prevent the challenging behaviour, or how they protect the person or themselves when they hit out.

We saw that risk assessments had not been carried out when there was a need, an example of this was where one person who fell and had a significant injury did not have a falls risk assessment in place or a review following the incident.

Monitoring information such as charts for pressure area care/nutrition/fluids were not always completed fully by staff and in some cases were not provided to the inspection team. One person had had their blood pressure taken and it was significantly high. We asked about this and we were told by the deputy manager "It might have been [persons] normal blood pressure. There was no evidence this had been investigated. This meant that there was no management oversight in the assessing of risks to the health and safety of the people living at the home.

These were additional breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Personal Emergency Evacuation Plans (PEEPS) had been completed however these were not adequate. The PEEPs had information in them that conflicted with peoples mobility risk assessments. The manager told us that there had been nothing in place prior to his coming to the service.

We looked at how accidents and incidents were managed within the home and found that this procedure was not adequate. The documents had incident/accident/near miss recorded on them however these were not always completed by staff so it was unclear how the service categorised any occurrence. These incidents had not been followed through with changes implemented to care plans for example, if a person's record informed [person] was falling it would state 'staff to monitor'. However information on strategies for staff did not have the appropriate information to keep people safe.

This meant that there was no management oversight in monitoring, assessing and ensuring the safety of the people living at the home.

These were additional breaches of Regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that all staff in the home had a Disclosure and Barring service (DBS) check completed. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults.

We saw the premises were safe. We looked at a variety of safety certificates that demonstrated that utilities and services, such as gas, electric and small portable electrical appliances had been tested and maintained and we saw that the fire alarm system had been checked regularly. We observed that home was clean with no offensive odours we saw that gloves and aprons were freely available and that antibacterial hand gel was available throughout the home. One relative told us "[Persons] bedroom is very clean and always smells nice. There are fresh towels in the bedroom. The dirty washing bin is always empty. The laundry system is effective."

We asked people and their relatives about staffing in the home with a mixed response. One person said that they had a call bell but had to wait for it to be answered at times and has waited up to 20 minutes. Also that there was not enough staff on nights. A relative told us "No relative would feel there was enough staff. Some residents require two staff, such as to take them to the toilet, so if one person is on a break that leaves one person on the floor." However we were told that the manager was "Trying to stop the use of agency staff. Bank staff would be ideal." The manager told us that they were working on staffing levels and had successfully reduced the amount of agency staff used, this had improved the continuity of the care being provided.

Inadequate

Is the service effective?

Our findings

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. The service was not working within these principles.

We saw the manager had a tracker in place that identified 13 DoLS authorisations were in place and that all those that had expired, had been reapplied for prior to them expiring. However we did not see any care plans in the care files we viewed relating to DoLS. One person had a condition on their DoLS that stated the home was to include in the care plan an action plan for the event if the person were to vacate the building unaccompanied. We checked the care file and there was no action plan regarding this in place, the manager and deputy were not aware of the condition. We asked for all other DoLS authorisations to be checked.

We saw that one person had bed rails in place but there was no reference to this within their care plan. There was no consent to their use or a risk assessment to ensure they were safe.

We saw that two people who lacked capacity were being given their medicine in a covert manner (hiding the medicine in food or drink), however they had no record of a best interest meeting between health care professionals and relatives. Their care plans lacked the detail on how their medicines should be administered and no guidance had been taken from a pharmacist to see if their medicines could be crushed.

We identified that there were inadequate mental capacity assessments. Two instances showed a decision about a person's capacity had been made prior to carrying out any assessment.
This meant that there was no management oversight in monitoring, assessing and ensuring the health and safety of the people living at the home.

These were breaches of 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were told that all staff had received an induction when first employed by the service, however this was not always apparent. We saw that some staff had attended a corporate induction however there was no evidence of the induction into the home.

We looked at the training provision for staff. The manager had a training tracker in place that showed the

training that had been attended by staff. We identified that some staff had attended up to 10 refresher courses on one day. We asked the manager how they ensured the training was effective and that staff knowledge was checked. We were told that the provider had competency and knowledge checks in place, however following the concerns we identified during the inspection we questioned the value and effectiveness of the training received, an example of this was medication. We saw that medication competency checks had been carried out, however following on from the above evidence the quality of the checks were questioned.

We saw that no regular supervision or appraisals had been carried out. Supervision provides staff and their manager with a formal opportunity to discuss their performance, any concerns the staff member may have and to plan future training needs.

This meant that staff were not provided with the relevant training and support to enable them to carry out their duties at the home.

These were breaches of 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at diet charts during the inspection. These charts are meant to be completed by staff to monitor the food and drink intake a person has throughout the day. One person had three separate charts all dated 22 April 2018, each with different information recorded regarding fluids. One recorded 500mls, the second 1230mls and the third recorded 1390mls. There was no record for 23 April. The person's nutrition care plan advised to aim for 1500-2000mls of fluid each day. We questioned how the staff were able to effectively monitor a person's intake to reduce the risk of malnutrition or dehydration with conflicting information.

We observed lunchtime and observed a family member helping a person with their meal. The relative had to ask the carer to replace the person's meal and reminded the carer that the person only ate soft food. The carer returned with more sandwiches but these contained sliced tomato which the relative had to remove. This indicated that the staff did not know about the person's dietary requirements or the risk to the person if they ate food with the wrong consistency.

This meant that there was no management oversight in the monitoring of nutritional records where there were identified risks to the health of the people living at the home.

These were additional breaches of Regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people about the meals the feedback was positive. Comments included "Everything is nice and fresh. The food is fresh" and "[Person] seems quite happy with the food. She came in with not a good appetite but now she eats everything. They are good at adapting her food."

We looked around the home and saw that bedrooms were well furnished, decorated and had an en-suite. We saw people had a fitted fridge if they wanted, a television and a telephone point. We saw memory boxes outside most of the bedrooms on the ground floor, and the hallways and lounges were well carpeted and decorated. The communal areas had seating areas and looked inviting and relaxing. The gardens were fairly extensive and well tendered. The home had a 'Coffee Shop' on the top floor that was very popular with people and their relatives, appropriate music playing in the background and home-made cakes made by the cook. We saw there was a sweet shop for people and there were plans to introduce a 'Post Office' where people could buy cards and post letters.

Requires Improvement

Is the service caring?

Our findings

One visitor told us that their relative was treated with dignity and respect, they told us "The staff speak to [person] all the time. They adhere to his wishes. They take notice." Another relative told us "The staff are friendly and approachable. No matter what's going on, I always get greeted by staff when I walk in." One person told us "I'm as happy as I could be. The staff are very nice and helpful and very kind. My husband is getting his care needs met." We observed staff interactions with people who lived in the home and people were approached and communicated with dignity and kindness. One relative told us "The best thing is the relationship the staff have with the residents. The staff treat people as individuals and I can see that in how they talk to the residents."

We asked people if they had choices in the way they lived and if they were respected. We saw that staff throughout the day where respectful and discreet when supporting people with personal care. During our visit people moved about freely and communicated with us and staff.

During our tour of the building we saw that there was a notice board in the reception area that had information displayed for the benefit of people living in the home as well as visitors. This included activities, complaints and safeguarding information.

The manager stated he had not held a resident and relative meeting since being in post and we saw that the last meeting had been held in September 2017 where Christmas activities, introductions of new staff and electronic care planning had been discussed. One relative told us "There aren't any relatives' meetings under the current manager but he does encourage relatives to talk to him. There is also a suggestion box."

We were not able to see a 'Service user Guide' for James Nugent Court during the inspection, this was sent following the inspection. This is a document that should hold information for people and their relatives if they were wanting to move into the home. However, the home had a Statement of Purpose in place that held incorrect information. A Statement of Purpose is where a business describes what they do, where they do it and who they do it for. It stated that the current manager was registered manager for the regulated activities however he was not yet registered. It also stated there are 56 beds; 46 residential and 14 nursing, even though the home was not providing nursing care at the time of inspection. This did not add up to 56. This was partially rectified during inspection but this meant that we were not able to know how for how long this document had been incorrect.

We observed that confidential information was kept in locked cupboards in the main office. This meant that people's right to confidentiality was being respected.

However during the course of the inspection we were aware of a number of incidences that were not recorded or potentially responded to safely and appropriately. This meant that staff working at the home did not always recognise people's diversity. There were occasions where staff had omitted to respond to people's needs or provided information or support and this potentially impacted on the wellbeing of people living in the home.

Requires Improvement

Is the service responsive?

Our findings

We looked at care files for six people and found these did not always reflect people's needs. One person's 'maintaining independence plan' stated it should be reviewed four weekly as a minimum but the last recorded review was February 2018. One care plan had a blank risk assessment with no mobility care plan and this person had previously fallen and injured themselves. When we raised this with the deputy they found a mobility plan on the electronic system which reflected use of zimmer and unsteady gait. This was in March 2018 however there was no reference to a fall and an injury. A care plan regarding an injury to the neck was in the file dated in March 2018. There was no date of the injury and no information about whether the mobility plan had been updated since the injury. This meant that a person's mobility had not been effectively assessed and so staff did not have the information on how to support the person appropriately.

Other examples included a care plan regarding anxiety stated that the person could not report pain, fear or discomfort. Staff were to assist when anxious and use diversional therapy. There was no information as to what diversional therapy may be successful for the person. We saw in a 'Health passport' under the heading of 'Hearing' it stated "Goodish- maybe needs checking." This was not sufficient. A moving and handling care plan stated two staff to assist and 'utilise equipment provided for safe transfers' however there were no details regarding what equipment was safe to use. Also there was a continence plan that stated the person was doubly incontinent, wears pads and will ask for help. However there was no detail as to what continence equipment was to be used.

We saw that another person had been seen by a dietician and their care plan contained information regarding the recommendations, however this had not been transferred to a nutrition plan, this meant that staff did not have appropriate guidance such as how to fortify meals.

We saw that 'About me' documents held conflicting information. An example of this was where it stated the person had paid for their own funeral however in another part of the file it stated the person had no end of life plans.

We were told during the inspection that the care plans were in the process of being transferred to an electronic filing system. However during the course of the inspection we became aware that they were being transferred without being reviewed. This meant that incorrect or conflicting information would continue to be used by staff when supporting people with their needs.

The home had a complaints policy that was on display for people to access, this was up to date and had been reviewed. This was displayed at the entrance to the building making it easily accessible for everyone. We asked people if they felt they could raise concerns and everyone said they could. However the manager in post told us that no complaints had been made since they had been in post. We saw that a complaints file was available and included the complaints policy and procedure. A log was available at the front of the file that listed two complaints in November 2017, but there were no notes or outcomes available for these. We saw two from October 2017 had been dealt with and concluded. We also saw that one complaint from August 2017 had no evidence of investigation or outcome. We could not be certain that complaints were

being recognised or dealt with appropriately.

This meant that there was no management oversight in monitoring, assessing and ensuring quality of service being delivered to the people living at the home.

These were additional breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home employed an activities co-ordinator and we were able to see that activities were in place for the people living in the home. These included cake making, communion, afternoon tea, bingo, ukulele group and chair exercises. One person told us "The best thing is the Ukulele Group on Wednesdays. They sing in the café. They are very good. The café is on the 2nd floor. It is very good. It is open Monday, Wednesday, Thursday and Friday after 2pm. There is quite a lot of entertainment. There are trips out from time to time."

Inadequate

Is the service well-led?

Our findings

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider had recently appointed a new manager and they submitted an application for registration with CQC.

From April 2015, providers must clearly display their CQC ratings. This is to make sure the public see the ratings, and they are accessible to all of the people who use their services. The provider was displaying their ratings appropriately in a clear and accessible format at the entrance to the home.

The provider had not made timely notifications to the Commission when required in relation to significant events. Including serious injury of a spine, head injury and no DoLs notifications sent when they have been approved

This is a breach of Regulation 18 of the Care Quality Commission Registration Regulations 2009

The manager had not carried out any audits within the home and we looked at the audits the provider had carried out. These were not comprehensive. It was not clear who had responsibility for any actions and what timescales were in place and there was duplicated information. The last provider audit that was given to us during inspection was dated January 2018. This included medication audits and care plan audits. However due to the findings of our inspection the quality and validity of these were questioned by inspectors.

We saw that there were no audits in place surrounding incidents and accidents or falls. We discussed with the manager the high number of falls and we were told that the provider had arranged a visit to complete a root cause analysis in March 2018 but this had been cancelled. A concern had been raised to them about the high number of falls in January 2018. However during inspection we found the high levels continued through from February 2018 through to April 2018. This meant no actions had been taken to identify trends to reduce the number of incidents. We asked the manager who said "These are the ones I know about." This indicated that the communication between staff and management was not sufficient.

We spoke with the providers health and safety manager who stated head office are made aware of all significant injuries through their on line system. We were told that each week the health and safety manager and two quality assurance officers go through all incidents and look for trends and put actions in. All of this was logged at head office and that they then would alert the manager if there were any trends identified. However, none had been sent to the manager at the time of the inspection. We asked why the manager was not auditing this information as they were working with the people living in the home, we were not given an answer. This is not person centred practice.

This is an additional breach 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw a summary of results for last service user survey, however we were unable to see any dates on the survey so we could not be certain when it had been carried out. 100% of people said staff treat them with privacy and respect. It stated the service needed to improve the range of activities available and relatives would like agency staff to be reduced. 95% of people feel they can say how they want things done. 89% of people would recommend the home.

During and following this inspection we shared our findings with the local authority commissioning and safeguarding teams.

The service had policies and procedures in place, these covered subjects such as complaints, health and safety, medication, safeguarding and recruitment however these policies were not always followed.

We asked staff if they felt supported by the manager and they all said that they did, one staff member said, "Manager keeps staff up to date. Very proactive, only manager says they have an open door policy and actually means it" another staff member said, "I feel supported, staff work well together. Not supported by the provider, never see them, never spoken to them." People we spoke with were able to identify the manager and told us they felt comfortable approaching them if they had any concerns.

Prior to the inspection we had received concerns from the local authority and medical professionals that included medication and mental capacity processes, however we spoke to a community matron who told us the they had a good working relationship with the home and that they were supporting a person in the home well with the support of the community health professionals.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had not made timely notifications to the Commission when required in relation to significant events.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff induction, training, and supervision was insufficient.