R S Oakden

Penkett Lodge

Inspection report

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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection was carried out on 10 and 21 August 2018. The first day of the inspection was unannounced.

Penkett Lodge 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
Penkett Lodge is registered to provide support for up to 27 people. At the time of our inspection 23 people were living there. The registered manager explained that the home has some double rooms, these are only used by people who ask to share a room.

The home has a registered manager. 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.

At our last inspection of the home in March 2017 published in May 2017 the service was rated requires improvement overall. We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of Regulations 11, 12 and 17.

This was because day to day care practices did not always enable people's consent and freedom of choice to be respected. The moving and handling techniques used by staff in support of people's mobility was not always safe and did not always mitigate risks to their health, safety and welfare, and medicines were not always managed or administered in safe way. We had also found that some of the provider's quality monitoring systems were ineffective in identifying and addressing inappropriate care and unsafe medication practices.

After that inspection the provider wrote to us to say what they would do to meet their legal requirements. At this inspection we identified that improvements had been made with regards to regulation 12, safe care and treatment and regulation 11, need for consent. During this inspection we found breaches in relation to Regulations 10, and a remaining breach to 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.

Staff did not always treat people with dignity and respect. Some of the language staff used in front of people, such as "feed her", was not respectful. We also found that the way in which the building was maintained and looked after was not always safe or dignified. For example, we found that towels and face clothes were faded and fraying, people's bedrooms and communal areas were not always well looked after. This included curtains that were missing hooks, chipped and peeling wallpaper and paint and stained table mats and dirty condiments.

On the first day of our inspection we found that the call bell system was not consistently working correctly and that an outside door had not had a keypad fitted although this had been identified as required by the registered manager.

Systems were in place for checking the quality of the service provided. However, these were not effective at identifying and addressing improvements needed within the service. This included improvements to the environment, repairs and ensuring people were always treated with dignity.

Systems were in place for safeguarding people from the risk of abuse and reporting any concerns that arose. People said they felt safe living there and staff knew what action to take if they felt people were at risk of abuse. A system was in place for raising concerns or complaints and people living at the home and their relatives told us they would feel confident to raise a concern.

People's medication was safely managed and they received their medicines as prescribed. Staff provided people with the support they needed to manage their physical and mental health care needs.

A series of assessments of people's care needs had been carried out and regularly reviewed. Where people required support, this was addressed in their care plans which provided guidance for staff on how to meet people's needs. Plans were regularly reviewed although we discussed with the registered manager how these reviews could be more meaningful.

Equipment and the building were monitored regularly to check they were safe, however this system was not always effective.
The building had adaptations and equipment to support people with their mobility and personal care. This included grab rails, adapted bathing facilities and a passenger lift.

There were enough staff working at the home to meet people's care needs, although people told us that at busy times they sometimes had to wait for support. Systems were in place and followed to recruit staff and check they were suitable to work with people at risk of abuse or neglect.
Staff had received training to help them understand and meet the care needs of people living at the home. Staff told us that they felt supported and we saw that they had regular staff meetings and supervisions with senior staff.

A series of activities were arranged at the home each afternoon and people living there told us that they enjoyed taking part in these.

People had a choice of meals and were offered plenty of drinks and snacks throughout the day. People told us that they liked the meals provided and always had a choice. Mealtimes were not always relaxed sociable occasions with staff available to provide support when people needed it.

The provider met the requirements of the Mental Capacity Act 2005. People were supported to make choices and decisions for themselves. Where people lacked the capacity to make important decisions for themselves then the provider took steps to protect them. This included applying to the local authority for a Deprivation of Liberty Safeguard (DoLS) for the person.

Records in the home were stored confidentially in locked offices.

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.

Equipment in the home did not always work safely and effectively and identified environmental risks were not always quickly addressed.

Enough staff were available to support people and systems were in place check new staff were suitable to work with people who may be vulnerable.

People's medication was safely managed.

Is the service effective?

Requires Improvement

The service was not always effective.

The environment was shabby and in need of decoration and repair.

Staff received training and support to understand and meet people's needs.

People had a choice of meals which they enjoyed. Mealtimes were not always sociable occasions and support was not always readily available.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always support people to maintain their dignity at mealtimes.

Staff did not always speak about people in a respectful manner or listen to people's choices.

Information about the home and how it operated was made available to people and their visitors. People's visitors were welcome at any reasonable time.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff did not always listen to and act on people's decisions.

Care plans were in place which provided information on the support people needed.

Activities were available for people to take part in. People told us that they enjoyed these.

People knew how to raise a concern or complaint and said they were confident to do so.

Is the service well-led?

Requires Improvement

The service was not always well led.

Systems for quality assuring the service provided were not effective at identifying and therefore improving areas of concern.

The home had an experienced manager who people knew, liked and trusted.

Penkett Lodge

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 carried out on 10 and 21 August 2018. Two Adult Social Care inspectors carried out the inspection which was unannounced.

Prior to our visit we looked at any information we had received about the home including any contact from people using the service or their relatives and any information sent to us by the provider. This included the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also spoke to the local authority to ask them to share any relevant information they held about the home. This helped us to plan our inspection.

During the inspection we looked around the premises and met many of the people living at the home, eight of whom we spoke individually with. We also spoke with nine members of staff who held different roles within the home, including the registered manager and provider.

We spent time observing the day to day care and support provided to people, looked at a range of records including medication records, care records for six of the people living there, recruitment records for two members of staff and training records for all staff. We also looked at records relating to health and safety and quality assurance.

Requires Improvement

Is the service safe?

Our findings

At our last inspection of the home in March 2017 we found the service was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the moving and handling support provided to people was not safe and did not mitigate the risk of potential harm. During this inspection we observed staff moving people safely therefore the provider was no longer in breach of this part of regulation 12.

At our last inspection of the home in March 2018 we found the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.This was because medication was not ordered and accounted for safely. At this inspection we found improvements had been made and the provider was no longer in breach of this part of the regulation.

We looked at how people's medication was ordered, stored, recorded and administered and found that this was well managed. Locked storage was used, with a fridge available if needed and temperatures of the room and fridge had been monitored regularly.

We looked at a sample of medication including medication prescribed for 'as required' use, in variable doses, medication subject to misuse and prescribed to be taken at different times of the week. Records were clear as to the dose, time and route of application and stocks tallied with records indicating people had received their medications as prescribed.

People did not have a risk assessment or care plan for the use of paraffin based creams. We discussed this with a senior member of staff and following the inspection, the registered manager wrote to us to inform us that this had been implemented.

On the first day of the inspection we spoke to one of the people living at Penkett Lodge who told us they wanted to look after their own medication. On the second day of the inspection we spoke to the person who told us the registered manager had discussed this with them, ordered a safe place to store their medication and had firm plans in place to implement this once the storage arrived.

Staff were aware of how to identify any safeguarding concerns that arose and how to report these, and telephone numbers for reporting safeguarding concerns were displayed in the home. Records of safeguarding concerns that had occurred were maintained and these showed that concerns were noted and appropriately reported.

Risks to people's safety had been identified in their care plans and appropriate action recorded to minimise the risks occurring or causing harm. This included risks associated with people's mobility, skin integrity, risk of falls and nutrition.

Records relating to people living at the home were stored securely in locked offices and were accessible to staff who needed to read or add to people's records. Records we looked at were generally up to date. we

observed that some records were in disarray , Although the registered manager and staff could locate records we requested,. For example, a file containing DoLS information was not in order and it was difficult to locate the information we were looking for.

One person told us that their call bell did not show on the staff board as the correct room number. On the first day of the inspection we checked a call bell and found that it did not work, a second call bell showed a different room to the one the person was calling from. We asked the registered manager to arrange for all call bells to be checked and on the second day of the inspection this had been undertaken. Handsets had been sent for repair, all rooms had a working call bell and a list of which call bells related to which room was available for staff, we checked this with staff and found they were aware of the interim arrangements.

An external door near to the kitchen was alarmed, we opened the door and the alarm sounded but nobody came to look what was happening. When we shut the door, the alarm stopped. This meant that someone could leave the building without any check being made. Prior to our inspection one of the people living at the home had left the building without being noticed. They were unharmed but had been previously assessed as not understanding the risk associated with leaving the home. The registered manager told us that they had purchased a keypad for this door but were waiting for the provider to fit it. This had not been completed on the second day of our inspection and, we discussed this with the registered provider who offered reassurances that it would be fitted as soon as possible. The registered manager later wrote to us to advise a contractor would be fitting the keypad week commencing 27th August 2018.

The home had a series of internal and external checks in place for the safety of the premises and equipment. This included checks of water temperatures, lighting, fire system, small electrical appliances and gas.

Information on how to support people in an emergency was available in the home. This included a fire evacuation plan and individual personal emergency evacuation plans (PEEPs). We discussed with the registered manager adding further information to the PEEPS so that it was clear what support people required with evacuation. We asked Merseyside Fire Service to visit the home as we were unsure of how safe the records and closures on some doors were. The fire officer was generally satisfied with the arrangements in place and made several recommendations the registered manager agreed to oversee.

The home was clean during our inspection with soap, hand gel and paper towels available for staff to use.

Accidents that had occurred were logged onto accident forms. These were reviewed regularly by the registered manager. People who had had more than one accident were routinely referred for advice and support. For example, we saw that a referral to the falls team had resulted in one person receiving a wrist band which activated to alert staff if the person fell.

One of the people living at Penkett Lodge told us, "Staff are quite good. A little short staffed at times." Another person reiterated this saying, "Sometimes you have to wait." A third person said, "Plenty of them if they did it. All they do is talk." During the two days of our inspection we saw that there were sufficient staff available to provide people with the support they needed.

We looked at recruitment records for two members of staff who had commenced working at the home recently. These showed us that staff had undergone an interview process and checks including obtaining a Disclosure and Barring Service check and references had been carried out. These recruitment processes helped to ensure staff were suitable to work with people who may be vulnerable.

Requires Improvement

Is the service effective?

Our findings

During our last inspection of the home in March 2017 we found the provider was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. This was because day to day care practices did not always enable people's consent and freedom of choice to be respected. At this inspection we found that improvements had been made and people told us they were able to make everyday choices for themselves.

Although the home was clean, it appeared shabby and in need of care. Examples of this on the first day of the inspection included grubby, stained table mats and condiments, curtains not properly attached to their rail, mismatched chairs, marked wallpaper and peeling paint. Some of the towels and face cloths people were using had lost their colour and were frayed. On the second day of the inspection we saw that table mats had been replaced and condiments cleaned.

During the inspection, the provider told us that within the past year they had made some improvements to the environment including replacing carpets and decorating. He explained they intended to implement the second phase of the plan to improve the environment. Following the inspection, the registered manager wrote to tell us that the provider was in the process of putting this plan together. She also told us that action had been taken by staff to improve the existing environment. For example, chairs in the two lounge areas had been moved around where possible so that they were not as mis-matched and the rooms would appear more inviting.

Penkett Lodge provided bedroom accommodation over four floors with all shared communal areas on the ground floor. A lift was available to take people to all floors. There were some bedrooms that could be shared by two people, however the registered manager explained that these were only used for two people if requested by both people.

The home had an enclosed back garden which had been assessed as unsafe for people to use. The provider told us that work was being planned for this area so that people could use it safely.

Adaptations were available throughout the home to support people with their mobility and personal care. These included hand rails, grab rails in bathrooms and toilets and a passenger lift.

Prior to people moving into the home a member of staff had met with the person and with people relevant to them and carried out an assessment of their needs. This was then used to establish whether the home could meet the person's needs and commence a care plan to guide staff on how to support the person.

The majority of care staff had achieved a nationally recognised qualification in care and records showed that staff had received training in a variety of subjects suitable to their role. This included training in understanding dementia, fire awareness, infection control, moving and handling people and end of life care. Staff told us that they received the training they needed to understand people's needs and carry out their role safely and effectively.

Staff meetings were well attended and used as an additional learning tool by the registered manager. Recent items had included supporting people to stay hydrated, reporting safeguarding and use of hand gel. Staff were able to add items to the agenda and said they felt comfortable speaking out.

Staff had had one to one supervision from a senior member of staff. This provided staff and their manager with the opportunity to discuss their role, any concerns they may have and their training needs.

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 be 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 or authorisations to deprive a person of their liberty were being met and found that they were.

The registered manager was able to tell us who had an authorised DoLS in place, and for whom a DoLS had been applied for. Care plans contained information about people's ability to understand and make decisions and demonstrated that staff had consulted with them. For example, we saw that one person had given their consent to a treatment in the event a medical condition temporarily affected their ability to do so. People's capacity to make an important decision had been assessed on three different occasions to determine whether their capacity fluctuated. Their capacity to make decisions was reviewed regularly and consideration was given to what decision was in the person's best interests.

One person told us that they had regular health appointments and explained staff helped them to prepare for their appointment and accompanied them. Records showed that people had been supported to monitor and maintain their health. For example, one person had lost weight and care records showed that staff had helped them to get weighed weekly and to gain weight. Records also showed that staff worked alongside people's GP, district nurses and other health professionals to support people.
One person told us, "The food is great. They ask you in a morning, give you a choice of what's available." Another person said, "We have different meals every day."

People had access to jugs of cold drinks through the day and a bowl of fruit was available in the dining room. Staff also provided people with regular hot drinks and snacks. Hot meals were provided twice daily and people had a choice of food. Breakfast was served as and when people were ready with no set times.

The cook was aware of the different diets people needed and had received appropriate training. The kitchen had been awarded a five-star rating from the Foods Standards Agency in August 2017, this is the highest rating that can be awarded.

People's nutritional needs had been assessed and where they required extra support to maintain their weight a care plan was in place along with monitoring records. We looked at records for one person who had lost weight and saw that staff had completed monitoring forms and weighed the person weekly until their weight stabilised.

Requires Improvement

Is the service caring?

Our findings

We observed that the environment people lived in or used was shabby and did not always appear cared for. One person was in bed during the first day of our inspection. Their room appeared uninviting with clothes strewn on a chair and curtains hanging down at the windows. The person was not at the home at the time of our second inspection and we saw an uncovered jug of water had been left in their room for several days, the bed was unmade and clothes strewn over a chair.

We saw another person who had injured their hand sitting in the dining room asleep with their breakfast in front of them. They later woke up and struggled to put the jam on their toast due to their injury. Staff were not available to offer help or support although some passed through the dining room during this time.

Systems in the home did not always support people to remain as independent as possible. We spoke with one person who had managed their own medication previously and intended to do so once they moved out of the home. They said they would like the flexibility of managing parts of their medication themselves. We discussed this with the registered manager. On the second day of the inspection, following our intervention, systems were being put into place for the person to store and manage their medication independently, however this had not been offered to the person before we mentioned it.

On the first day of the inspection we sat in the dining room and lounge over the lunch time meal. One person was served fish pie and peas the member of staff supporting her mixed the meal together without asking. This meant the person would not have the opportunity to taste the different components of the meal. The member of staff then announced, "I am going to feed her now." This is not a dignified way to talk about supporting a person with their meal.

In the lounge two people sat with their meal in front of them. Neither attempted to eat it and the food was clearly getting cold. A member of staff brought one person their pudding whilst their main course was untouched and said, "Eat some for me." the person didn't and the member of staff left. A pudding was then put in front of the second person, again with no reference to their uneaten meal. Shortly after, two members of staff asked the two people if they were going to eat their meals. No member of staff sat with them. We then observed one person put their fingers into their food and attempt to eat it that way. The second person then attempted to eat their meal but was struggling as they were slipping down in their chair. Eventually we asked staff to help her sit upright. Ten minutes later a member of staff entered the room and speaking about a third person in the room said, "I am going to feed her in a moment."

One person asked for a pudding at 1.35pm. At 2pm they were still awaiting their meal and said, "All I want is my pudding, it's all I wanted before." At that point a member of staff offered her a savoury meal and she replied, "All I want is my pudding." The member of staff replied, "Can you eat some of your meal, then I will feed you pudding." The lady responded, "No", however after being asked again she said, "All right." Shortly after staff asked, "Is that nice," the person replied, "No! I am looking forward to my pudding." A few minutes later after eating very little of the main course the person said, "If pudding is ready now I will have it." After the staff member asked twice if the person was sure we intervened and asked why the person had to eat a

main course when they had clearly refused it three times and made it clear their choice was to have a pudding.

Throughout the meal we did not see people being given the support they needed to maintain their dignity. Nor did staff speak about people in a way that respected their dignity.

This is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because people were not treated with dignity and respect at all times and their personal preferences were not always meaningfully listened to.

One of the people living at the home told us, "It's great. I am very happy with the staff. Nothing is too much trouble for them". Other people told us they liked the staff team.

We saw some caring interactions between staff and people living at the home. This was usually when staff were not focused on carrying out a 'task' such as supporting people with meals. Staff regardless of their role interacted with people and responded to requests they made. For example we saw the maintenance person responding to one person's request for a drink. When we talked with staff we found they had a good knowledge of people as individuals. Staff displayed an empathy for people in understanding how their health and living at the home may have affected the person. They were able to discuss the person's likes, dislike and life before moving to the home as well as describing the person's care and support needs.

People could have visitors at any reasonable time of the day and throughout the inspection we observed visitors arriving.

One of the people living at the home told us that they signed a form to agree to their care plan. They explained staff, "Say I can read it if I want to." Care records showed that people had been given the opportunity to discuss their care plan with staff and comment if they wished to.

Requires Improvement

Is the service responsive?

Our findings

People told us that they could make their own decisions and choices about how they spent their time. One person explained they liked to stay up late. They said "Night staff are great. They help me." However, as discussed elsewhere in this report staff did not always listen to people and spent time trying to persuade the person to make a 'wise' decision' rather than understanding that if the person had the ability to make a decision then constantly trying to persuade them otherwise was not listening to the person and respecting their choices.

A copy of the complaints procedure was available in the hallway at Penkett Lodge. On the first day of the inspection this was not visible as a plant and other pieces of paper had been placed in front of it. The procedure did not give the name or contact details for the registered manager or provider. The people we spoke with knew how to raise a complaint, however these details should be provided in the complaints procedure as not all visitors would know. No complaints had been recorded at the home in the past twelve months.

We spoke with two people who were sitting in their bedrooms. They had their call bell nearby and told us that when they used it staff responded quickly. Other people told us that depending on the time of day and how many staff were available sometimes they had to wait a little while for support.

Individual care plans were in place for the people living at Penkett Lodge. These contained sufficient information to assess the person's needs and provide guidance to staff on how to support the person. This included assessing risks to the person's safety, their skin integrity and their ability to understand information and make choices. Where an assessment identified the person required support, for example with their health, personal care or safety then a care plan was in place to guide staff. Care plans had been reviewed regularly to check the information was up to date and accurate. A number of the monthly reviews were worded identically and did not identify any changes that may have occurred. We discussed this with the registered manager, who later wrote to us to confirm that plans are reviewed weekly by senior staff and monthly by herself. She also informed us that any changes would in future be recorded on the review sheets.

One of the people living at the home explained the home had regular activities and they enjoyed taking part in these. The home employed a part time activities coordinator and we saw people engaged in activities throughout the inspection. One person said they got a daily newspaper and told us they were quite happy with the activities arranged. Group activities took place in the lounge most afternoons and we saw staff encouraging people to join in and making the activity as inclusive as possible for the people in the lounge.

Information was made accessible to people in different ways, for example a menu board displayed the day's menu and people we spoke with knew what was for lunch that day.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection of the home in March 2017 we found the provider was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because some of the provider's quality monitoring systems were ineffective in identifying and addressing inappropriate care and unsafe medication practices. At this inspection whilst we found that improvements had been made in some areas including medication management and staff moving and handling practice. However, we found that the provider remained in breach of this regulation. This was because systems failed to identify and address some of the areas of concern we noted during the inspection.

The registered manager undertook a walk around of the building and a health and safety check each week. Any areas requiring repair or attention were listed in the maintenance book. There was not always an audit trail to show whether work requiring the provider's attention had been passed to him. For example, we received conflicting messages about why a keypad had been purchased but not fitted to an external door. Following the inspection, the registered manager advised us that they had put a system into place to ensure the provider was informed weekly of any outstanding works and provide a clear audit trail.

Areas of concern that we found included the lack of a keypad fitted to an outside door, call bells not working or working incorrectly and areas of the environment that were shabby or in need of decoration. We also observed that staff did not always listen to people meaningfully or talk about people in a respectful and dignified manner. A thorough quality assurance system should note and address these matters.

This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because systems did not operate effectivity to assess, monitor and improve the quality of the service.

The home had a registered manager who had been in post since 2010. One of the people living at the home said the registered manager was, "Very busy, but very helpful to us." Another person told us they regularly spoke with the registered manager and said they wereeasy to talk to. Staff reiterated these views telling us they found the registered manager approachable and helpful.

We met with the provider and saw records that he visited weekly and met with the registered manager. He explained he intended to put a plan in place to improve the environment of the home.

The last record we saw of a meeting held with people living at the home and their relatives was in June 2017. We did see a large selection of thank you cards sent to the home. The majority of these were not dated so it was difficult to know how recently they had been received.

We looked at the results of a satisfaction survey carried out in 2017. This showed that all of the people living at the home had answered all of the questions. There was no record of any comments made, no areas for improvement identified and no action plan. This means that the satisfaction survey had not produced any meaningful results that could be used to further improve the service provided by the home.

At the end of the first day of the inspection we asked the registered manager to carry out investigations into concerns that had been raised with us. We also asked her to check that all call bells were in working order and take action if they were not. On the second day of the inspection we found that the registered manager had responded positively to these requests and undertaken as much of the work required as she was able to.

The provider had notified the Care Quality Commission (CQC) of incidents that had occurred in the home in accordance with our statutory requirements. This meant that CQC were able to accurately monitor information and risks regarding Penkett Lodge.

Ratings from the last inspection were displayed in the home as required. From April 2015 it is a legal requirement for providers to display their CQC rating. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People who used the service were not always treated with dignity and respect and their personal preferences were not always listened to.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's quality monitoring systems did not always operate effectivity to assess, monitor and improve the quality of the service.