Sanctuary Care Limited

Furzehatt Residential and Nursing Home

Inspection report

59 Furzehatt Road
Plymstock
Plymouth
Devon
PL9 8QX

Tel: 01752484008
Website: www.sanctuary-care.co.uk/care-homes-south-and-south-west/furzehatt-residential-and-nursing-home

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26 March 2018

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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 took place on 20 March 2018, 21 March 2018, and 26 March 2018 and was unannounced.

Furzehatt 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.

Furzehatt Residential and Nursing Home is divided into two units. The residential and nursing unit are situated within the same building and divided by a reception area at the main entrance. The nursing unit provides nursing care for a maximum of 32 people and the residential unit supports a maximum of 29 people. At the time of the inspection 28 people were being supported on the nursing unit and 18 people within the residential part of the service.

There was a management structure in place. The service had a registered manager. 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 the last inspection on the 14 and 15 April 2016, we rated the service as Good overall. At this inspection we rated the service as Requires Improvement. This is because systems were not always in place to keep people safe, this included, medicines, risk management, and incident reporting. Staff were not always provided with sufficient information to meet people's needs consistently and safely. Quality Audits had not been effective in identifying concerns we found at this inspection. The quality of care across the service was not always consistent.

Prior to the inspection we had received concerns from the local authority safeguarding team, regarding people's care at the service. A safeguarding meeting had taken place with the local authority prior to the inspection and we were told a number of safeguarding investigations in relation to these areas of concern were on-going and therefore not concluded at the time of the inspection. We did not look at these specific investigations as part of the inspection, however, we did use this information to inform us about how we needed to conduct the inspection and areas of care we needed to consider and review.

The local authority had also informed us prior to the inspection, that due to the high number of concerns received, they had met with the provider and requested an improvement plan and assurances about people's safety. Due to the concerns the local authority had agreed a suspension on all residential and nursing placements, whilst investigations were ongoing and improvements made. At the inspection the registered manager confirmed these suspension arrangements, and that they also would not admit any privately funded people during this time.

The Care Quality Commission had also spoken to the registered manager and written to the registered provider on two occasions since the last inspection about concerns raised by relatives about people's care

and medicine issues in the home. The registered manager and registered provider had responded to requests for information about these concerns at the time and had provided us with assurances about people's safety. However, despite these assurances issues relating to people's safety were found during this inspection.

During this inspection we found inconsistencies in systems and the quality of care provided across the service. When concerns we found related to a particular part of the service, we have reported on this by referring to either the nursing or residential unit. This information can be found within the full version of the report.

At this inspection we found people were not always safe. People did not always receive medicines in a way they were prescribed and staff did not always have guidance to follow to help them decide when certain medicines needed to be given. Systems were in place to report medicines incidents, however, staff were not in all cases clear about the type of medicines incident they should report. Some incidents relating to medicines such as a missed dose, or refusal by a person to take medicines had not been documented as an incident. This meant the service did not in all cases have an oversight of medicines incidents to enable them to review if appropriate action had been taken and to consider patterns and lessons learned. The medicines related concerns found during the inspection had not in all cases been picked up as part of the homes medicines audits and other quality assurance

We saw a number of good examples of risks to people being identified, reported and well managed. However, the quality of information relating to risks associated with people's care was not consistent across the service. For example, when risks had been identified staff did not always have the information they needed to help ensure the risk was managed consistently and in a way the person needed and preferred.

Systems were in place for staff to report and escalate incidents. However, these had not in all cases been followed by staff to ensure people's health and well-being was protected. For example, during the inspection one person's health had deteriorated and medicines prescribed to the person had failed to be delivered by the pharmacist. The person's health deteriorated significantly over a twenty four hour period resulting in the need for an emergency hospital admission. Staff had failed to effectively escalate this incident and to ensure the person's health needs were met in a timely manner. This incident was reported to the registered manager at the time of the inspection.

People did have access to a range of healthcare services. However, care plans did not in all cases provide staff with sufficient information about how people's specific healthcare needs should be met. This meant there was a risk of people's healthcare needs not being met consistently by the service. Systems were in place to monitor people's health, such as food and fluid charts, skin monitoring and repositioning charts and weight monitoring forms.

A programme of audits was in place. These checks were undertaken by the registered manager, staff and the registered provider, and included audits of medicines, records and the environment. However, these checks had not identified concerns found during our inspection, particularly in relation to medicines, risk management, incidents and care planning. For example, checks and audits were in place to review medicines and although the registered manager and provider had assured us improvements had been made to the medicine management systems, medicines errors and inconsistencies were still found.

Following the inspection we took immediate action to ensure people were safe. We told the provider to provide assurances that people were safe in relation to medicines, management of risk and the escalation of incidents. The provider sent us assurances within the timescale requested, this included a plan to review

care plans and risk assessments, to provide updated medicines training for staff on the residential unit and to provide training on incidents and the escalation of concerns. This action satisfied us that immediate concerns relating to people's safety had been addressed.

People's care plans were not in all cases personalised, and did not always provide staff with sufficient information about people's routines and how they chose and preferred to be supported. Although people's plans of care were reviewed at regular intervals or if needs changed, information was not in all cases updated to reflect these reviews and changes. This meant staff did not always have access to clear and accurate information about people's needs.

Staff undertook a range of training and said they felt supported by their colleagues and management. However, some staff on the residential unit said some training was not in-depth enough to reflect the complexity of people's needs, such as supporting people living with dementia. Following the inspection the provider sent an action plan to address immediate concerns we had found relating to people's safety and management of risk. The plan included an action to provide staff with additional training in relation to caring for people with dementia and associated behaviours.

People, relatives and staff spoke positively about the registered manager. Comments included; "The manager is approachable, they always stop and say hello", and "If I have any concerns I speak to the manager and they would usually sort it". However, some staff and visiting healthcare professionals said the management and quality of care was at times inconsistent across the service. Comments included, "Roles and responsibilities are not always clear at weekends and evenings", and "Systems and processes between the residential and nursing unit are so different, which isn't helpful if you have to work between the two". Two visiting health care professionals said staff worked hard and wanted to meet people's needs effectively. However, they said care was sometimes inconsistent, "Some people received good care, and other aspects of care could be neglectful, I think this is about the management of the home".

We received mixed views from people and staff about staffing levels and how staff were organised. Some said staff were available in sufficient numbers to meet people's needs and to keep them safe, comments included, " There are always staff around and they are always quick to help me if needed" whilst others said they did not always feel there were enough staff particularly when people wandered and needed close supervision. One person said, "I don't want to stay in the lounge sometimes as I feel vulnerable and I get worried about others when staff are not around".

People were supported by staff who cared and respected their privacy and dignity. We saw staff responding promptly and with compassion when people were distressed or felt unwell. Staff were open and honest throughout the inspection and visiting healthcare professionals commented positively about the staff's response to any suggestions about people's needs or improving practice.

People were provided with a varied and nutritious diet. People and relatives were very positive about the food provided at the service, comments included, "The food is tasty and there is plenty of it" and another said "the food is marvellous, enough to eat and a good choice". People's specific dietary needs were known and understood by staff. People were able to enjoy their meals in an attractive and calm environment. When people required support to eat, this was done discreetly and in a way that preserved people's dignity and independence.

People were supported to partake in a range of activities and to occupy their time in a meaningful way. People were supported to maintain important relationships and friends and family were made to feel welcome in the home.

People lived in a service which had been designed and adapted to meet their needs. Systems were in place to regularly check the environment and equipment was safe. People were protected by the provider's infection control procedures, which helped to maintain a clean and hygienic environment.

People's legal rights were upheld and consent to treatment was sought. When people lacked the capacity to make decisions, best interest meetings were held and advocacy services were provided if required.

People were protected by the provider's safe recruitment practices. Staff did not start working in the home until all required checks had been completed. This helped ensure all staff working in the home were safe and appropriate to work with vulnerable people.

As part of this inspection we have made recommendations to the provider regarding personalised care planning and the availability of accessible information.

We found breaches of the regulations. The action we have taken can be found 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.

Medicines were not always managed safely. People did not always receive medicines in the way they had been prescribed to them.

People's risk assessments did not always reflect all the risks relating to their care or guide staff how to mitigate them.

People did not always feel safe. Staffing levels in some parts of the service were not always sufficient in numbers or organised in a way to ensure people's needs were met and to ensure people felt safe and protected.

People were not always protected by clear systems for escalating and reporting concerns and safety incidents.

People were protected by safe recruitment practices.

People lived in a home that was clean, warm, and well-maintained.

Is the service effective?

Requires Improvement

The service was not always effective.

People did not always have access to support in a timely way when their health deteriorated.

People's care plans did not always provide sufficient detail to staff about their specific healthcare needs and how they should be met.

People with nursing needs received support from staff who undertook relevant training.

People received care from staff who felt supported in their role.

People did have access to a balanced and nutritional diet.

People's human rights were protected.

Is the service caring?

Requires Improvement

People were being supported by staff who cared about them, demonstrated compassion and who were respectful and kind. However, some systems, processes and overall governance of the service did not ensure the quality of care was consistent across the service.

People's privacy and dignity was promoted and maintained.

People family and friends were welcomed into their home.

Is the service responsive?

Requires Improvement

People's care plans were not in all cases personalised, and did not always provide staff with clear, detailed and up to date information about their needs.

People were supported to follow their interests and occupy their time in a meaningful and therapeutic way.

People were supported to maintain relationships with people who mattered to them and to access the community and local events.

People were able to raise concerns and complaints and these were investigated following a complaints procedure.

People were cared for by staff who undertook training in end of life care. Information about people's wishes in relation to end of life care was documented and understood.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Systems were in place to assess and monitor the safety and quality of care provided but these had failed to identify concerns raised in this inspection.

People's experiences had sometimes been used to learn and improve the quality of the service. However, the lack of clear reporting procedures meant some incidents were not reported appropriately or used to drive improvement across the service.

People were supported by staff who cared about them and

wanted to provide a good quality service. However, systems, processes and leadership were not in all cases sufficient in ensuring consistent, safe, effective and responsive care was provided.

People and relatives said the registered manager was approachable and spent time talking to them and listening to concerns. People were provided with information about the service and were able to give feedback.

Furzehatt Residential and Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 20 March 2018, 21 March 2018, and 26 March 2018 and was unannounced. The inspection was carried out by one adult social care inspectors, a member of the medicines team, a specialist nurse advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses similar services.

The inspection was prompted in part by safeguarding concerns we had received via the local authority safeguarding team. These included concerns about, poor and neglectful personal care, poor care in relation to management of people's skin and risk of falls, failure to recognise and respond effectively in response to changes in people's health needs and poor end of life care. Concerns also related to high levels of admission and re-admission to hospital. At the time of the inspection nine individual safeguarding investigations were on-going. We did not look at these specific investigations as part of the inspection, however, we did use this information to inform us about how we needed to conduct this inspection and areas of care we needed to review as part of the inspection process.

Prior to the inspection we reviewed the records held on the service. This included the Provider Information Return (PIR) which is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed previous inspection reports and notifications. Notifications are specific events registered people have to tell us about by law.

During the inspection we spoke with 27 people and nine relatives. We reviewed 14 people's care records. We also spoke with eighteen members of staff, which included the registered manager, regional manager,

activities coordinator and chef. We reviewed 5 personnel records, staff induction plans and the training matrix. Other records we reviewed included the records held within the service to show how the registered manager reviewed the quality of the service. These included audits, minutes of meetings and policies and procedures. We spoke with three visiting nurses, a doctor, and a paramedic. Following the inspection we also spoke with the regional director for the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us. We undertook this observation within the residential unit as it was easier to observe people sitting in the communal lounge. We observed how people spent their day and the interactions they had.

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After our inspection, because of identified concerns, we told the provider to send us an action plan and assurances about people's safety. We also informed the commissioners and local authority safeguarding team about our immediate concerns.

Requires Improvement

Is the service safe?

Our findings

The service was not always safe.

At the last inspection on the 14 and 15 April 2016 we rated this key question as Good. At this inspection it has been rated as Requires Improvement, because people were not always protected by the systems for the management of medicines, which placed some people at risk of ill health and poor care. People's risk assessments did not always reflect all the risks relating to their care or guide staff how to mitigate them. Systems were in place for staff to report and escalate incidents. However, in one case the systems had not been followed by staff to ensure a person's health and well-being was protected.

We checked the arrangements for managing medicines and saw that people were not always receiving medicines in the way that they were prescribed and that staff did not always have guidance to follow to decide when to give certain medicines.

We checked 24 medicine administration records (MARs). Seven of the records we checked were for people receiving nursing care. Nurses completed MARs for this group and it was possible to tell that medicines were given as prescribed. Seventeen of the records we checked were for people living in the residential part of the service. Medicines were given to people by care staff, who had received online medicine training and were assessed as competent. However, we saw that medicine administration did not always follow best practice and staff did not always give medicines as prescribed.

The MARs for four people receiving residential care showed they had been prescribed antibiotics. The MAR showed that people had not in all cases been administered their antibiotics at the prescribed dose. This could mean that they were not effective and could lead to deterioration in a person's health.
We raised this concern with the registered manager at the time of the inspection. Immediately following the inspection we asked the provider to look into these concerns and told them to send us a report of their findings and assurances that people were receiving their medicines safely. The provider wrote to us and reported their findings in relation to each of the four people concerned. They told us they had found staff had taken appropriate action in relation to one person who had refused on a number of occasions to take their antibiotics. Staff had escalated their concerns to the person's GP and this was being monitored. However, the other three people had not received their medicines in the way they had been prescribed. When staff had been aware of missed or refused medicines they had not always escalated this appropriately to ensure action was taken.

Guidance was not always available to help care staff decide when a medicine prescribed to be taken 'when required' (PRN) should be given. For example, one person was prescribed medicines to help with anxiety or agitation and were given these medicines regularly, but with no evaluation of need or effectiveness. Three other people were prescribed PRN medicines for pain relief and health conditions associated with allergies and digestion. Protocols were not in place to guide staff about, why, when and how these medicines should be administered. This could mean people would not receive medicines safely and in a way they needed.

Systems were in place to report medicines incident's, however staff were not in all cases clear about the type of medicine incident they should report. Some incidents relating to medicines such as missed dose, or refusal by a person to take medicines had not been documented as an incident. This meant the service did not have an oversight of medicines incidents to enable them to review if appropriate action had been taken and to consider patterns and lessons learned. The medicines related concerns found during the inspection had not in all cases been picked up as part of the homes medicines audits and other quality assurance processes.

There were suitable arrangements for ordering, receiving, storing and disposal of medicines, including medicines requiring extra security. Staff monitored storage temperatures to make sure that medicines would be safe and effective.

Following the inspection we asked the provider to send us assurances that people were safe. The provider sent us an action plan and told us they would take immediate action to review people's medicines and ensure risks were minimised. They told us this would include re-training and competency tests to ensure staff had the skills and knowledge required to administer and handle medicines safely.

A system was in place to assess risks relating to people's health and lifestyle. For example, people's records contained risk assessments in relation to falls, moving and handling, nutrition, using the call bell and choking. However, we found the quality of information regarding people's risks and how they should be managed varied across the service. For example, when risks had been identified, records did not in all cases included action staff should take to mitigate the risks and to keep people safe. For example, one person suffered from epilepsy. Although epilepsy was referred to in their medicines records in relation to medicines prescribed, there was no detailed plan about how to recognise and manage the seizures. Another person had a catheter in place, but did not have a detailed plan on how their care should be managed. Although, staff were able to tell us about how they managed these people's needs on day to day basis the absence of clear written information meant there was a risk of people's need and risks associated with their care not being met consistently and safely.

Following the inspection the provider wrote to us and told us they had reviewed people's risk assessments to ensure the information was up to date and accurate.

Staff undertook safeguarding training delivered by the organisation and with the local authority. All staff spoken to said they would not hesitate to raise any concerns to management and outside the organisation if required. Systems were in place for staff to report and escalate incidents. However, these had not in all cases been followed by staff to ensure people's health and well-being were protected. For example, during the inspection one person's health had deteriorated and medicines prescribed to help with their health condition had failed to be delivered. The person's health deteriorated significantly over a twenty four hour period resulting in the need for an emergency admission to hospital. Although a senior staff member had made attempts to follow up on medicines needed for this person with the supplying pharmacy, the issue had not been escalated to management at the time or until after the person's health had seriously deteriorated.

The registered manager told us a staffing dependency tool was used to determine the number of staff needed across the residential and nursing unit. They said staffing numbers were kept under regular review and at the time of the inspection some changes had been made due to a number of empty beds and some people in hospital. At the time of the inspection six care staff and a lead nurse were supporting people in the nursing unit, and five care staff plus a senior supported people within the residential part of the home. In addition the staff team were supported by the registered manager and newly appointed deputy, an activities

coordinator, chef, kitchen assistant, cleaning and maintenance staff an administrator and a receptionist. We were told some people had one to one staffing levels in place to meet their needs and to keep them safe. We saw these staffing levels were in place during the inspection.

Staff on the nursing unit said they felt staffing levels were sufficient to meet people's needs and to keep them safe. However, staff on the residential unit said when the service was at full capacity they did not always feel staff were sufficient in numbers to support people, particularly when people wandered due to dementia or needed extra observations due to risks of falls. They said two staff on the residential unit at night was not always sufficient particularly when some people required two staff to support them with personal care tasks and to transfer. Comments included, "One of the night staff also has the responsibility of medicines, so the two staff are often busy, people do have to wait, and call bells are not always answered promptly". A person on the residential unit said they did not always feel safe. They told us, " I don't want to stay in the lounge sometimes as I feel vulnerable and I get worried about others when staff are not around". A relative said they felt people sometimes went to bed early as they did not feel safe staying in the communal areas if staff were not present, and if some people with higher needs and dementia were agitated. We raised these concerns with the registered manager at the time of the inspection, and they told us a staff member should be situated in the communal lounge area at all times. They told us they would address this issue as a matter of priority.

Following the inspection the provider sent us a report stating that the registered manager had been instructed to undertake a dependency tool for staffing on the residential unit.

People were placed at risk because medicines were not always administered as prescribed. Staff did not always have the information required to ensure risks associated with their care were managed consistently and safely. People were not always protected as staff did not in all cases escalate incidents appropriately. The organisation of staffing did not always ensure people felt safe.

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

We asked people if they felt safe living at the home. One person said, "I feel safe because everyone looks after me" and "Yes, I feel safe, the staff are lovely and look after us well". A relative said, "It reassures me that my dad feels safe here" and another said "Mum is safe here because she is looked after well". However one relative said that she worried about one person in the home who had managed to use the keypad to leave the lounge, and then was unable to get back in. They said, "They manage to use the key pad to leave the room, but then I don't think they can remember how to get back in", and another was "worried about her relative rolling out of bed". Both these issues were raised with the registered manager at the time of the inspection and we were told they would look into the concerns and provide assurances where possible.

Where people had been assessed as being at risk of developing pressure areas, special equipment, such as air mattresses were in place. Wounds and pressure areas had been photographed so staff could monitor and respond to any changes to people's skin. Visiting healthcare professionals told us people's skin conditions were mainly managed well by the service.

People's risk of abuse was reduced because the provider had suitable recruitment processes for new staff. Staff recruitment records showed that new staff were not allowed to start work until satisfactory checks and employment references had been obtained. Nursing and Midwifery Council registration status was also checked for the qualified nurses. The home was supported by agency staff and profiles were held to ensure their suitability to work in the service.

People and their relatives told us they lived in a home that was clean and warm. We looked around the home and saw that all areas were clean and free from odours. There were supplies of disposable gloves and aprons clearly visible around the home. Cleaning staff were employed, and all had received training on infection control. A laundry assistant was employed who ensured great care was taken to ensure all laundry was returned to the correct owner, clean, and neatly ironed. Good systems were in place to ensure soiled laundry was washed safely to prevent the risk of infection. The laundry was clean, tidy, and well equipped. An inspection of the kitchen had taken place in November 2017 by the Environmental Health Department. They found the kitchen hygiene and food safety processes were entirely satisfactory (five stars).

Maintenance and health and safety staff were in the home during the inspection undertaking routine maintenance work and environment checks. Records confirmed all equipment such as gas, electrical and fire safety equipment was regularly serviced and checked. Hoisting equipment and lifts were maintained and checked regularly. There were security measures in place to monitor all visitors to the building, and to prevent access into, or out of the building, by people without authority to do so. Keypads allowed people access around the home, whilst ensuring the safety of people where risks had been identified if they left the building unsupervised. There was information around the home and in their bedrooms reminding people of what to do in the case of a fire.

Requires Improvement

Is the service effective?

Our findings

The service was not always effective.

At the last inspection on the 14 and 15 April 2016 we rated this key question as Good. At this inspection it has been rated as Requires Improvement, because information about people's health needs and systems to monitor people's health were not in all cases up to date, accurate and sufficient in detail. Appropriate action had not always been taken to ensure people had access to health services when their health needs changed and/or deteriorated.

At this inspection we saw staff were mainly able to recognise changes in people's health and had escalated concerns to other agencies when required. For example, a staff member on the nursing unit escalated a concern about a person's catheter, which was not running well. The lead nurse responded immediately when they saw the person was experiencing pain and discomfort by contacting the GP. A visiting ambulance crew said staff were good at providing information about people's state of health, which helped them make a judgement on the best course of treatment required at the time. The registered manager said the service had often found it difficult to get responses in a timely manner from other health agencies. We saw from daily records that staff had often persisted in making calls and referrals to other agencies to help ensure people's healthcare needs were met.

However, staff had not always recognised how rapidly a person's health could deteriorate if appropriate treatment and medicines were not sought in a timely manner. For example, one person's health had deteriorated during the night at the time of our inspection. Medicines had been prescribed, but had not arrived in the home as requested. Although carers and senior staff had made efforts to chase up the prescription, no other action was taken to respond to this person's deteriorating health resulting in a hospital admission. We raised this concern with the provider and the local authority at the time of the inspection.

The quality of information about people's healthcare needs varied across the service. People's care plans did not in all cases provide staff with sufficient information about their healthcare needs. For example, one person with breathing difficulties was supported to breath with the use of oxygen. Although staff were able to tell us how they supported this person in relation to their oxygen use and breathing, there was no written plan in place. Written information was not available to staff about the person's oxygen level setting, the suppliers, or how to administer it. We were told that the person had capacity and would be able to instruct staff on how to support them. However, staff did not have written guidance to instruct them if the person became unwell or if staff were not familiar with this person's needs. This was raised with the lead nurse at the time of the inspection and they said they would take action to ensure this information was available to the staff team. Another person had healthcare needs associated with diabetes. Although the medicines part of the person's care plan mentioned the person's condition, stating, " Staff should monitor for symptoms of hyperglycaemia/hypoglycaemia the plan provided staff with no other guidance on signs, symptoms and action to take if the person themselves were unable to recognise a deterioration associated with this condition.

There was a system in place to review people's care plans. However, some of the reviews lacked clarity on people's changing needs, and were not always reflected in people's care plan information. For example, one person had an eating and drinking plan in place. The most recent plan stated the person was independent with eating and drinking. However, reviews of the person's care in relation to their eating and drinking stated they had lost weight and additional monitoring had been required and put in place. The person's care plan had not been updated to reflect these changes. Although monitoring of the person's eating and drinking had taken place staff would not be able to obtain an accurate update on their needs from reading the person's care plan. This could mean people's health needs would not be met consistently and effectively by the service.

The provider had not ensured care plans and systems to monitor people's health were up to date, accurate and sufficient in detail. The provider had not always ensured staff had sufficient guidelines and information to meet people's health needs consistently.

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

Relatives we spoke with at the inspection were positive about how the service met their loved ones healthcare needs. Comments included, " [….] has very complex nursing needs, the staff keep us fully updated, information about their health and progress is always available and they let us know straight away about any changes.

A person who was staying at the home for a period of respite following an operation told us, "The staff have been really good at making sure I attend all my appointments and am seen by the district nurse".

A visiting district nurse said the lead nurse and care staff were very responsive to any advice and support provided. Comments included, "The lead nurse is very keen to make sure systems are good and work well for people. They went off straight away to implement something we had suggested".

New staff undertook an induction when they first started working in the home. Staff who had recently started working in the home said the induction had been thorough and had given them time to understand their role and familiarise themselves with the service. A new deputy manager had recently been recruited and was in the process of their induction at the time of the inspection. They told us they were spending time observing, getting to know people and familiarising themselves with records and processes. Staff new to care also undertook the care certificate. The care certificate is a national induction, and aims to equip health and social care support workers with the knowledge and skills which they need to provide safe, compassionate care.

Each staff member had a training plan, which included a range of mandatory training such as health and safety, safeguarding adults, and infection control. In addition staff undertook training relevant to their role and the needs of people they supported. For example, one person had a specific bowel condition. Staff and the registered manager had attended training about this person's care needs at the local hospital. Staff who looked after veterans had attended training delivered by army services. The registered manager told us a learning and training business partner from within the organisation visited the service and undertook an annual training needs analysis. This was completed by speaking to the registered manager and staff and taking information from people's care plans and staff supervision sessions. A training matrix enabled the registered manager to have an oversight of the training attended and when training was due to be updated. The registered manager said following a recent concern staff had attended Sepsis training to help ensure they recognised and responded appropriately to this potentially serious condition. The provider informed us

that 'dementia pathway' training was available for all staff, as well as a leadership in Dementia Course for some staff.
All staff said training was regularly available and most said the training was good and relevant to their role and needs of people they supported. Two staff in the residential unit said they felt some of the training needed to be more in-depth, particularly as people's needs progressed with conditions such as dementia. Comments included, "We have some dementia training as part of the induction, but it is quite basic. We could do with more training about people's individual needs and behaviours".

An incident which occurred on the residential unit during our inspection suggested staff may not always have the skills and knowledge to recognise when a person's health is deteriorating. This could mean people's health needs were not always met effectively. This concern was raised with the registered manager at the time of the inspection. Following the inspection the provider informed us that all staff on the residential unit would be attending clinical risk workshops to develop their skills in this area of care.

All the staff we spoke with said they felt well supported by their colleagues and management. Staff on the nursing unit were supported by a clinical lead who was a qualified nurse and had regular supervision, handovers and staff meetings. Staff on the residential unit were supported daily by a senior staff member. They said they felt well supported during the week by the senior although at weekends when a senior was not available roles and responsibilities were less clear. Staff on the residential unit said they felt the lack of leadership at weekends could at times result in staff not feeling confident and clear about making decisions and escalating concerns.

People were supported to eat a nutritionally balanced diet. Care plans included eating and drinking plans to guide staff about the support people needed. Dining areas were attractive and provided a calm and welcoming environment for people to enjoy their meals. Menus were available on tables with information and pictures so that people knew what they could choose to eat. Some people required their meals to be served at a specific consistency to minimise the risk of choking and an appropriate meal was provided. People who required support to eat were assisted in an unhurried and sensitive manner, which helped to preserve their dignity.

Risks in relation to people's diet were understood by staff. For example, in one person's plan it was documented that they needed a high calorie diet due to weight loss. Staff had asked the GP to review the person and they had subsequently been prescribed some food supplements. We looked at another person' plan who had complex nutritional needs. The Speech and Language therapist had reviewed them and recommendations had been made to staff on how best to support the person. When we spoke with staff they were knowledgeable and knew the care that had been planned for the person.

The chef had worked in the home for a number of years and had attended relevant training such as food hygiene and dementia training. They said this had helped them better understand people's specific dietary needs. Specialist plates and cutlery were available for people living with dementia and other physical health conditions.

People and relatives were very positive about the food provided at the service, comments included, "The food is tasty and there is plenty of it" and another said "the food is marvellous, enough to eat and a good choice". One relative commented that their mum had put weight on as she enjoyed the meals and was encouraged to eat and another said "Dad likes the food here because it is freshly prepared". A person staying for respite said, "The food is excellent, the tables are always laid with table cloths and flowers".

People only received care and support with their consent. We heard staff asking people if they required help

and taking account of their responses. For example, we observed a staff member asking one person if they would like to go downstairs and join other residents for an activity. During lunch, we observed another staff member asking a person if they were happy to have a clothes protector to prevent spills on their clothes.

People's legal rights were upheld. Consent to care was sought in line with guidance and legislation. The manager and provider understood their responsibility in relation to the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (Dols). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires as far as possible people make their own decisions and are helped to do so when needed. When a person lacks the capacity to make a particular decision, any made on their behalf must be in their best interest and be the least restrictive. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People's care records demonstrated their capacity had been assessed when planning care and that DoLS applications had been made when necessary to the supervisory body. Best interest's discussions had taken place when people had been assessed as lacking capacity to make a particular decision. For example, one person's file detailed a meeting, which had taken place with relatives regarding the person's placement and plans in place in the event of a fire. The person had been assessed as lacking the capacity to make decisions in these areas and the views of relatives and other professionals had been documented.

People lived in a service which was adapted to meet their needs. The entrance to the service had wheelchair access, and bathrooms and toilets had assisted equipment to help people with mobility difficulties. Communal areas were large and attractively decorated with plenty of space for people to partake in activities and enjoy visits from family and friends. Signage was available around the home to help people orientate themselves and to maintain their independence as much as possible. People's bedrooms were nicely decorated with plenty of personal belongings to create a warm and homely environment. The outdoor space was well maintained with large, accessible garden areas, which people said they enjoyed during the summer months.

Requires Improvement

Is the service caring?

Our findings

At the last inspection on the 14 and 15 April 2016 we rated this key question as Good. At this inspection it has been rated as Requires Improvement. People were supported by staff who cared about them and who were respectful and kind. However, some of the systems, processes, and overall running of the service did not always ensure the quality of care was consistent across the service. For example, staff said they worked hard to get to know people and to understand and respond to their daily routines and preferences. We saw staff mainly knew people well. However, some of the information about people's needs lacked detail and was not in all cases accurate. This could mean care was not always provided consistently, particularly when staff were new or did not work regularly in the home. This potential for inconsistent care had not been picked up and addressed by the providers over-site and auditing processes.

Comments from people included, "The staff do a lot for me they are very kind and caring" and another said "staff are caring - I get VIP treatment". One person said the staff showed they cared in different ways, they said, "When the weather was bad and it was snowing they came in and stayed the night, they were brilliant".

Relatives were also positive about the care their parents received. One relative said "they are caring towards dad and me" and another said "she is looked after brilliantly – put on weight, more mobile and happy". Another relative mentioned that the "staff are incredibly patient and pleasant".
Following the inspection two relatives wrote to us and said they were very happy with the way their loved ones were cared for.

We saw some compliments cards received by the service. Comments included, "Thank you for giving dad the best possible care" and "Thank-you for the excellent care and attention given".

We saw many positive interactions between people and the staff supporting them. Staff knew people by name and spent time sitting and chatting whenever they could. Staff who were busy with a task smiled and acknowledged people as they went about their work.

Staff responded promptly and sensitively when people were distressed or unwell. For example, one person was beginning to get distressed as they were unsure about where to find certain items of their clothing. Although this person was living with dementia and had some repetitive behaviours the staff provided them with kind words and gentle reassurance every time they asked. One staff member linked the person's arm and said, "Come on let's go and find your coat". This immediately helped the person relax and they went with the staff member chatting and smiling. Another person had been feeling unwell. A staff member sat with them and talked about the local news and events happening in the community. This conversation clearly relaxed the person and distracted them from feeling unwell.

People were provided with opportunities to share their views and to be involved in their care arrangements when possible. People said they were listened to and that they were able to give feedback on the care they received. One person said "If I have any niggles I can raise them" and another said "I can give feedback because the staff are friendly". Another person mentioned that routine meetings were held in the home and

provided the opportunity for people to give feedback to management and this led to changes and improvements. People were provided with information about advocacy services if they needed to support to make certain decisions in relation to their care or lifestyle.

People were supported to maintain relationships with family and friends. During the inspection several members of one family joined their relative for lunch. We heard lots of conversation and laughter as they all sat around the table together for the lunchtime meal. One relative told us that the staff had arranged a celebration for their relatives 90th birthday and family and friends were invited.

People's privacy and dignity was promoted and maintained. All personal care took place behind closed doors, and people were able to see visitors and healthcare professionals in private. Staff knocked on people's doors and waited for them to answer before entering. We saw one of the cleaning staff knock on a person's room and asked if it was ok to clean their room. A person staying for respite said the staff always spoke to them respectfully, "They call me dear, darling, love, but I really don't mind". A person said they liked to spend time on their own. They said the staff understood them and gave them the space and privacy they wanted. One person was being supported on a one to one basis by an agency member of staff. They said they recognised that they had to spend a lot of time supporting the person in their own personal space. They said they tried hard to protect their privacy by closing curtains, standing outside the bathroom door and ensuring the person's personal belongs were looked after and kept just how the person liked.

Following the inspection the provider informed us that they awarded 'Kindness awards' in recognition of staff within the organisation who had gone the 'extra mile' to provide care. We saw examples of certificated awarded to staff at the home.

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive.

At the last inspection on the 15 April 2016 we rated this key question as Requires Improvement, because some of the information in people's care plans was inconsistent and out of date. At this inspection we continue to rate this key question as Requires Improvement. We found that people's care plans were not always personalised and continued to not always provide staff with sufficient information to meet people's needs consistently and in a way they chose and preferred. Care plans were not in all cases updated to reflect people's changing needs.

An assessment of a person's needs was completed prior to people moving into the service. This helped ensure the service had the information they needed to decide if they could meet people's needs. If people moved in due to an emergency or crisis situation the assessment was competed as soon as possible after the admission date.

Following admission a plan of care was completed covering different areas of people's health and social care needs. We found the quality of information regarding people's needs and how they chose and prefer to be supported varied across the service. People's care plans were not in all cases personalised and did not always provide staff with sufficient information about people's needs. For example, one person's plan stated "Needs full support with personal care", but did not describe how this person needed or preferred this care to be delivered. Staff said they worked hard to get to know people and to understand their daily routines and preferences. We observed that staff mainly knew people well. However, some staff were new to the service, or had only worked in the home occasionally. Two staff members said they thought the care plans lacked detail and it was difficult to have time to really get to know people. The absence of written information could mean people's care would not be delivered consistently and in a way they preferred.

People said staff mainly responded promptly to their requests. For example, "I can have a shower if I feel up to it" and another said "If I want a shower I just ask". However other people commented that this wasn't always the case. One commented "they get me up for a shower at 6 o'clock which is very early" and another said "sometimes they shower me too late in the day for my liking". Three people mentioned that sometimes they had to wait for a long time to go to bed. One person said "I like to go bed by 10.30 but sometimes I have to wait until midnight because staff are busy with others" and another said "sometimes if it's busy or not enough staff I have to wait ages to go to bed". Two relatives mentioned that they were pleased that their parents were now having showers which hadn't happened when they were living at home. Care plans did not in all cases describe people's preferred daily routines. The absence of this information could mean people's care was not always provided in a way people chose and preferred.

We recommend that the service seeks advice and guidance from a reputable source about personalised care planning.

Prior to the inspection we had received some concerns that staff did not always respond promptly to the call

bell and people had to wait long periods of time to have their requests met. During the inspection the call bell system was being tested by maintenance staff. The registered manager had responded to a recent complaint about call bells by checking people were able to reach bells and adjusting where calls bells were positioned if necessary. A call bell auditing system was in place, which was reviewed regularly by the registered manager to help ensure responses were timely, and any action needed could be addressed. The registered manager said audits had not picked up any concerns in relation to response times but would be addressed if this was the case.

People gave mixed responses regarding the call bell system. One said "they were with me so fast" and another said "I pressed the red button and I could hear people running to me within seconds". Three people said that call bells weren't always answered quickly. One person said "some days it takes time for staff to respond and some days it's really quick – depends on who's on duty", another said "I have had to pull the call bell to get extra help for someone in lounge when staff already seeing to another person" and another said "changeover times are not a good time to ring your bell". This information was passed to the registered manager at the time of the inspection.

Prior to the inspection we had received some concerns relating to end of life care. Investigations into these concerns were on-going at the time of the inspection. The registered manager said they had used the information received from the local authority to undertake their own investigation, this was also on-going. Although the service supported people with complex nursing needs, at the time of the inspection no people were receiving end of life care. People's support plans did include information about end of life care, including advanced decision forms and specific wishes from people and relatives. Staff undertook end of life training within the organisation as well as externally via a local hospice. The service held a certificate for completion in 2017/18 of a six steps end of life training programme. The registered manager said evidence of care provided was reviewed and submitted annually to the local hospice and accredited training provider. Staff had also undertaken syringe driver training to help ensure they had the skills required if end of life pain relief was needed.

Staff mainly understood how people communicated and were able to use this knowledge to respond to their needs. Information was available around the home to help people make decisions and to understand their environment. For examples, pictures of daily activities were available on notice boards in communal areas and pictorial signage was posted on doors and cupboards so that people could find their way around. It was noted that people's care records contained a form to include information about how the person needed information to be provided to them. In most cases this information had not been completed.

We recommend that the provider takes account of the Accessible Information Standard (AIS) to help make sure people with a disability or sensory loss are given information in a format they can understand, and the communication support they need.

People were supported to follow their interests and partake in activities to occupy their time. When people moved into the service information was gathered about their past, including their younger years, adulthood and any particular achievements and hobbies. This information was used to help plan activities in the home.

An activities coordinator was employed in the service and we saw them and other staff members spending time with people and organising activities throughout the inspection. For example, people in the residential unit played skittles and enjoyed a reminiscence activity, which encouraged some lively conversation about household items people remembered from their past. A musician entertained people on the nursing unit and we could hear people and staff joining in with the singing and entertainment.

Information was available to people about activities and events happening in the home and local community. Notice boards in communal areas included photos of activities planned for each day. A notice was posted at the entrance and around the home about a planned Easter fayre and raffle prizes were on display for people to see. People said they were either able to read this information or staff told them each day what activities were planned.

A wishing tree was placed in the reception area. People had hung a leaf on the tree with a personal wish attached. One leaf said the person wanted to go to a local beauty spot to enjoy an ice-cream. The registered manager said the person had their wish fulfilled with a few other residents who had asked to join them.

Most people were positive about the activities in the home. One person said "We have chair exercises, quizzes and entertainers" and another said "the choice of activities is good". Another person said "We are asked what activities we would like to do and we can make suggestions". Two people said that they wished there was a greater variety of activities on offer and one commented "I'd like to go out more and do trips if I could" and another said "I get bored some times as there's not enough to do, need to mix it up a bit".

People were able to maintain contact with family and friends. We saw lots of people spending time with family and friends during the inspection. The home had plenty of space for people to be able to sit comfortable with their visitors. Seating, cups of tea and greetings from staff were provided to make visitors feel welcome.

A complaints procedure was available to people, relatives and visitors to the service. Information about how to make a complaint was posted clearly on a notice board at the entrance to the service. Residents meetings were held, which provided people with the opportunity to raise any concerns. On the first day of the inspection a customer relations manager employed by the organisation was spending time in the service speaking to people. They said they visited the service once a month and spoke with people and relatives about the service, which included any concerns or complaints they may have. They said any issues would be passed to the registered manager as well as being used as part of the on-going auditing and quality monitoring of the service.

The registered manager said they aimed to respond to complaints and concerns promptly to avoid issues escalating. For example, they said a person had raised a concern about their laundry not always being returned. They said they had responded by changing systems so that laundry staff returned laundry rather than care staff. They said this had a positive impact and there had been no recent concerns.

The registered manager had followed the complaints process when complaints and concerns had been raised about the service. Copies of investigations into complaints had been sent to CQC when requested. One of the complaints looked at during the inspection had demonstrated an investigation had taken place and evidence of the concerns had not been found. Three people mentioned that they had raised issues with management and that they were happy with the outcome. One said "I needed a new mattress, I mentioned this to the Manager and got a new one" and another said "everything got sorted quickly".

Most of the relatives said that the management and staff responded promptly to any concerns they had about their relatives. One relative commented ''we've had a couple of issues since [ ] has been here but this has been sorted swiftly each time" and another relative said "I am confident that if we have concerns they will be resolved ". One relative commented that "sometimes there are delays as management and staff aren't as responsive as they could be".

Requires Improvement

Is the service well-led?

Our findings

The service was not always well-led.

At the last inspection on the 15 April 2016 we rated this key question as Good. At this inspection we rated it as Requires Improvement because, systems in place to assess and monitor the safety and quality of care were not always effective. Systems to ensure the quality and safety of people were not consistent across the service.

During this inspection we identified a number of concerns and breaches of regulation. We found people were being supported by staff who cared and who wanted to provide a good quality service and meet people's needs. However, systems, processes and leadership had failed to ensure safe and good quality care was consistently provided to people.

We found serious concerns in relation to people's medicines. People were not always receiving their medicines in the way they had been prescribed. Staff had not always escalated concerns appropriately about people's health. For example, during the inspection a person's health had significantly deteriorated. Although this person had been monitored by staff, staff had failed to effectively raise concerns about the person's medicines not arriving in the home and the impact this was potentially having on their health.

The registered manager was not always aware of incidents in the home. For example, although a morning handover took place, which the manager attended they had not been informed about the incident regarding a person's missed medicines and significant deterioration in health.

The provider had a system in place for reporting and escalating incidents that occurred in the service. However, they had not ensured all staff understood their responsibilities for escalating concerns and reporting incidents. Staff were not in all cases clear about when incidents relating to medicines needed to be reported and escalated in line with the services reporting procedures. This could mean the provider did not have an accurate oversight of medicines incidents and if they had been managed appropriately.

A programme of audits was in place to review the quality and safety of the service. These included regular audits and checks completed by the registered manager and staff, including audits of medicines, records and the environment. We also saw audits and checks completed by the provider, including regular visits by the regional manager and other staff within the organisation. However, these had not identified concerns found during our inspection, particularly in relation to medicines, risk management, incidents and care planning. For example, checks and audits were in place to review medicines and although the registered manager and provider had assured us improvements had been made to the medicine management systems, medicines errors and inconsistencies were still found.

People's care records were not always accurate and up to date and did not always provide staff with sufficient information about how people needed and preferred care to be provided.

At the time of the inspection Plymouth City Council were in the process of undertaking investigations relating to concerns about the care of people using the service. A safeguarding meeting had been held and members of the local authority safeguarding team had met with the provider and requested an improvement plan to demonstrate how they would address the concerns raised and to meet the regulations. He provider had completed the plan and CQC had received a copy prior to the inspection. At the time of the inspection the regional manager and a deputy manager from a similar service located close by were also working in the service. They said they had been asked to support the registered manager as part of the current improvement plan, which included reviewing areas of care they had been informed about as part of the current safeguarding investigations. For example, the deputy manager from the different location was reviewing end of life care due to the nature of some of the concerns raised.

The Care Quality Commission had also spoken to the registered manager and written to the registered provider on two occasions since the last inspection about concerns raised by relatives about people's care and medicine issues in the home. The registered manager and registered provider had responded to requests for information about these concerns at the time and had provided us with assurances about people's safety. However, despite these assurances further concerns had been raised and issues relating to people's safety were found during this inspection.

Two visiting health care professionals said staff worked hard and wanted to meet people's needs effectively. However, they said care was sometimes inconsistent, "Some people received good care, and other aspects of care could be neglectful".

The provider's visions and values were displayed at the entrance to the service. They told people, "We deliver personalised care, treat everyone with dignity and respect, employ staff who strive to be best and are committed to deliver the highest quality service, and are committed to ensuring we truly understand our residents so we can support them to live happy, contended lives". The practices we observed demonstrated that staff understood these values and were committed to practicing them in their day to day work. However, some of the systems did not always ensure this standard of care was delivered for every person, and the governance and oversight of the service did not always ensure that these inconsistencies were identified and addressed.

People and staff were mainly positive about the registered manager and said they were approachable and listened to their concerns. Relatives also praised the registered manager and said they were approachable and supportive. However, we found inconsistencies in the way the service was managed across the service. We found all the staff were caring and keen to make improvements and provide good quality care. However, staff said management and systems across the nursing and residential unit were different, which at times made providing consistent care difficult. For example, some staff said they felt management support in the residential unit was good during the week, but at weekends when a senior was not available roles and responsibilities were less clear. One staff member said they felt this could be why mistakes were made and staff did not respond consistently or confidently to incidents that occurred. Staff said they felt the registered manager was under a lot of pressure to run a large service and they hoped this would be helped by the recruitment of a new deputy manager.

Visiting healthcare professionals said there were some inconsistencies in the way the service was managed and this did at times affect the quality of people's care. Comments included, "Some people received good care, and other aspects of care could be neglectful". One healthcare professional said, "Some care plans are better than others, there is a lot of duplication and you sometimes have to hunt for information" and another said "They are really good at providing the information we need so we can assess people's health and make a plan".

We saw some examples of improvements made to the service as a result of audits and feedback from people and / or complaints. For example, changes had been made to the laundry system to help ensure people received their correct laundry and checks had been undertaken to ensure all people could access and use their call bell system effectively. However, concerns found during the inspection suggested the provider was not always proactive in ensuring that people's needs were effectively met. For example, the registered manager told us they had re-occurring problems with a local pharmacist, which had at times meant people had not received their prescribed medicines when required. Although the registered manager said this had happened on a number of occasions and they had spoken to the pharmacy concerned they had not taken further action to ensure people's health and medical needs were met. This was raised with the registered manager at the time of the inspection and we were told they would address the issue as a matter of priority.

Systems in place to assess and monitor the safety and quality of care were not effective in monitoring the quality and safety of the service. Records were not always accurate and up to date. Management and systems to ensure the quality and safety of people were not consistent across the service.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection we told the provider to provide us with immediate assurances about people's safety in relation to medicines, the management of risk, escalation of incidents and leadership. The provider sent a plan as requested, which included action to review care plans, risk assessments, staffing levels, incident reporting, and management. The action plan also included additional training staff would receive due to the recent concerns, which included, behaviour management and updated medicines training.

At the time of the inspection the service had a registered manager in post. They had responsibility for the day to day running of the service. In addition the nursing unit was supported by a lead nurse and qualified nurses were available on each shift to support staff. The residential unit was supported by a senior carer between Mondays and Fridays. The regional manager said the provider had recognised that the registered manager required additional support and a new deputy manager had been appointed for the service. The deputy manager was in the process of completing their induction at the time of the inspection.

The registered manager said they kept themselves updated with best practice by attending all mandatory training provided by the organisation. They said they also attended the local authority dignity in care forum when possible, although this was at times dependent on workload. The importance of attendance at these forums was discussed with the registered manager and the regional manager during the inspection. The regional manager stated that the provider would commit to supporting the registered manager to attend these important events. Following the inspection the provider also sent an action plan stating "Whilst the Registered Manager has been supported throughout the period of being without a deputy manager, now that this post has been recruited into, the Registered Manager has been enrolled onto our Well Led Leadership course. We are committed to building and improving the leadership skills in our home managers across our entire portfolio". The provider had been awarded the Dementia Quality Mark in May 2017 to May 2018. This is an award by Plymouth City Council in recognition of the quality of care provided to people with dementia.

People, staff and relatives said they were kept informed about events happening within the service and the organisation and had the opportunity to share their views. Regular staff and residents meetings took place and minutes confirmed a range of topics relating to the service and people's care were discussed.

During the inspection a customer relationships manager for the organisation was spending time in the

home. They said they visited once a month and spoke to people about the service and any issues they may have. A report was completed for the provider as part of their quality auditing process and any issues passed to the registered manager to address. Annual satisfaction questionnaires were sent out to people and relatives and results of surveys were posted on notice boards for people to see.

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 12 HSCA RA Regulations 2014 Safe care and treatment People were placed at risk because medicines were not always administered as prescribed. Staff did not always have the information required to ensure risks associated with their care were managed consistently and safely. People were not always protected as staff did not in all cases escalate incidents appropriately. The organisation of staffing did not always ensure people felt safe. The provider had not ensured care plans and systems to monitor people's health were up to date, accurate and sufficient in detail. The provider had not always ensured staff had sufficient guidelines and information to meet people's health needs consistently.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to assess and monitor the safety and quality of care were not effective in monitoring the quality and safety of the service. Records were not always accurate and up to date. Management and systems to ensure the quality and safety of people were not consistent across the service.