Cornwall Care Limited

Blackwood

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

Summary of findings

Overall summary

This comprehensive inspection took place on 19 and 21 October 2016 and was unannounced. The last inspection took place on 10 June 2015 when we identified a breach of the legal requirements relating to the management of medicines. Gaps in Medicine Administration Records (MAR) meant we were unable to establish if people were receiving their medicines as prescribed. Following the inspection in June 2015 the provider sent the Care Quality Commission an action plan outlining how they would address the identified breach.

Blackwood is a care home which offers care and support for up to 47 predominately older people. At the time of the inspection there were 44 people living at the service. Some of these people were living with dementia.

The service is required to have 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 the time of the inspection the service was being overseen by an interim manager. We discussed the arrangements for the management of the service in the future and were satisfied appropriate measures were being taken to help ensure the service was well managed.

Before the inspection we had concerns about how people were protected from harm. We checked to see if the service was safe. We found some people sometimes acted in a way which could put staff and other people at risk. Although this had been identified and risk assessments were in place there were occasions when people felt unsafe. Risk assessments did not accurately reflect the actions staff were taking to keep people safe.

We looked at how medicines were managed and administered. We found Medicine Administration Records (MAR) showed people were receiving their medicines as prescribed. Systems for the administration of medicines were not robust and we have made a recommendation about this in the report.

The service had identified the minimum numbers of staff required to meet people's needs, these were not being consistently met. Staff told us they often felt rushed and were not always able to meet people's needs, particularly social needs, in a timely manner.

Staff were supported by a system of induction, training and supervision. All staff had recently completed safeguarding training or were booked to do so in the near future. Training to support people when they were agitated and might behave in a way which was difficult for staff to manage, was not routinely provided. Staff meetings were held regularly. These allowed staff to air any concerns or suggestions they had regarding the running of the service.

The interim manager had an understanding of the requirements laid down in the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DoLS). They were taking action to check applications for DoLS authorisations were made appropriately. Decisions regarding the administration of covert medicines were not consistently made and recorded in line with the legislation and we have made a recommendation about this in the report.

People and relatives told us staff were caring and supportive. Staff spoke fondly of people and demonstrated a concern for their well-being. People's dignity and privacy was respected and care was taken to protect people's personal information.

Care plans were well organised and contained accurate and up to date information. Care planning was reviewed regularly and people's changing needs recorded. Where appropriate, relatives were included in the reviews.

People did not have access to meaningful activities in line with their interests and preferences. Although events were arranged for special occasions such as Halloween there was no day to day schedule of activities in place.

Prompt action was not always taken to ensure improvements were made, because the processes and systems used to assess and monitor the quality of care people received, and to determine if people's needs were being met were not effective. Action was being taken to address these shortfalls. As the systems in place were still being embedded it was too early for us to evaluate their effectiveness at this inspection. The interim manager was supported by higher management at Cornwall Care. Managers meetings took place on a monthly basis. Members of the senior management team visited the service at regular intervals.

We identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the end 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 entirely safe. There were not always enough staff to help ensure people's needs were met.

People did not always feel safe in their environment. Risk assessments did not accurately reflect the action staff should take to protect people from harm.

Medicines were stored safely and securely. However, systems for administering medicines were not robust.

Staff had recently had face to face training in safeguarding.

Is the service effective?

Requires Improvement

The service was not entirely effective. Decisions regarding the covert administration of medicines were not consistently recorded or reviewed in line with legislation.

Staff received a thorough induction and regular training. Staff did not routinely receive training in how to support people whose behaviour could be difficult to manage.

People had access to a varied and nutritious diet.

Is the service caring?

Good

The service was caring. Relatives told us they found staff to be caring in their approach.

People were treated with dignity and confidential information was respected.

People's rooms were decorated to reflect their personal taste.

Is the service responsive?

Requires Improvement

The service was not entirely responsive. People did not have access to meaningful activities.

Care plans covered a range of areas and were reviewed regularly.

There were systems in place to help ensure staff were up to date with any changes in people's needs.

Is the service well-led?

Requires Improvement

The service was not entirely well led. Systems in place to monitor the quality of the service provided were not effective.

Action was being taken to improve staff morale.

There was an interim manager in place who had a comprehensive oversight of the service.

Blackwood

Detailed findings

Background to this inspection

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

This inspection took place on 19 and 21 October 2016 and was unannounced. The inspection was carried out by one inspector.

Before the inspection we reviewed the information we held about the home. This included past reports and notifications. A notification is information about important events which the service is required to send us by law.

Not everyone we met who was living at Blackwood was able to give us their verbal views of the care and support they received due to their health needs. We looked around the premises and observed care practices and interactions between staff and people.

We spoke with the interim manager and Cornwall Care's Operations Director. We also spoke with six people, two visitors and twelve members of staff. Following the inspection we spoke with two relatives, two members of night staff and two external healthcare professionals.

We looked at care documentation for three people living at Blackwood, medicines records, four staff files, training records and other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

Staff told us they were often understaffed due to staff absences and even when fully staffed, it could be difficult to support everyone effectively. We discussed staffing with the interim manager. They told us there was one staff vacancy at the service and three people on long term sick leave. The service had calculated the minimum number of care staff required during the day was eight care staff and one senior care worker. At night it was four care workers. The service was spread over two floors and, during the day, four care staff worked on each floor with the senior care worker covering both floors. Staff told us this could sometimes leave them stretched as some people needed two carers to support them when mobilising. One commented; "If two staff are supporting someone with a hoist and two supporting someone else there's no-one outside [in the corridor] to respond if anyone needs help. If you're dealing with equipment it takes your full attention, you can't just leave it." Care staff told us senior care workers were often occupied with medicine rounds or other responsibilities and weren't routinely available for advice. One commented; "It would be better if they were on the floor more." During the inspection we saw staff worked to meet people's needs in a timely way. This sometimes meant they needed to leave one person in order to support another. For example, a member of staff was supporting someone who needed assistance to eat their lunch. When they noticed another person was struggling with their meal they left the first person to attend to the second.

Staff from Cornwall Care's internal agency, 'Flexicare', and external agency staff were being used to attempt to maintain the staffing levels. The staff rotas showed minimum staffing levels were not always met during the day. We looked at the rotas for care staff for the week commencing 9 October. Shifts were split between morning and afternoon meaning there were 14 shifts in all. On six of these shifts there had been seven or less care staff on duty. Staff told us things were particularly bad at the weekends. One commented; "Sometimes you feel like you're going at 100 miles an hour." An external healthcare professional commented; "I went to find a member of staff which took a while. I find that they do not have enough staff members."

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

Care plans contained risk assessments for a range of circumstances including moving and handling and likelihood of falls. Where a risk had been clearly identified there was guidance for staff on how to support people appropriately in order to minimise risk and keep people safe. The risk assessments were updated regularly to reflect people's changing needs.

Some people were at risk of becoming distressed or confused which could lead to behaviour which staff might find difficult to manage and could cause anxiety to other residents. Care records contained some information on what staff should do when incidents occurred. For example one person's care records stated; "Do not engage in a power struggle" and "Take threats seriously and get assistance." Incidents involving this person occurred regularly. For example, during September eight incident reports had been completed. In the week between 12 October and 18 October 2016 the daily notes recorded three occasions when the person had become verbally aggressive and one when they had become physically aggressive. These occasions had occurred on four separate days. The aggression was usually directed at staff but could

also be directed at other people. The behaviour meant people and staff were at risk of being harmed. Guidance contained in risk assessments did not reflect the actions we saw being taken to protect people. For example, we observed staff closed the doors in the corridor to prevent people walking past the area where the person was when they were particularly agitated. Staff supported people to take an alternative route through the building at this time. There was no reference to these actions in risk assessments. Times when the person was more likely to become agitated were recorded in their medicines care plan but not in the risk assessment. This meant staff unfamiliar with the person might not have known how to keep people safe.

Records showed other people had been distressed by these incidents at times. For example, an incident report completed on 6 September 2016 stated a service user had reported being "scared" by the person's actions. Staff confirmed the behaviour was concerning and affected other residents. Comments included; "We're all a little bit wary" and "We're a bit fearful sometimes." Records showed an external healthcare professional had offered to provide staff with training on how to manage behaviour which could be challenging. This had not been implemented at the time of the inspection. Some staff told us they were confident using diversionary techniques and this usually worked. However, staff reported the frequency and intensity of incidents was escalating and they were becoming increasingly concerned.

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

The interim manager told us they were working with other professionals to identify a more suitable environment for the person to move to where their needs could be better addressed and would not impact so negatively on others. On the first day of the inspection a consultant psychiatrist visited the service to discuss the person's needs with the interim manager.

Staff had access to support from various sources if they were concerned the situation was becoming unsafe. For example they had contact numbers for the local out of hours mental health team and the local police as well as on-call numbers to enable them to raise any concerns with the senior management team.

At our last inspection we found Medicine Administration Records (MAR) showed people were not always receiving their medicines as they had been prescribed. Gaps in the records meant it was not always possible to determine if people had received their medicines. Audits had not identified the issues in the MARs. We found the service was in breach of the regulations.

At this inspection we checked a sample of medicines records. For most people we found the MARs were completed appropriately and the amount of medicines in stock tallied with the amount recorded. On the second day of the inspection, two senior care workers were on duty and shared the responsibility for the medicine rounds. Most days this task was carried out by one senior care worker. We observed both members of staff carrying out medicines administration and noted there were frequent calls on their time which took them away from their duties. For example, a GP arrived to visit someone who had been unwell. Some people needed additional encouragement and support when taking medicines and this also impacted on the time it took to complete the rounds. Two people who required medicines at lunch time were sitting in the garden. The medicines trolley containing their medicines was on the first floor of the building. This put additional time pressures on the member of staff administering the medicines. They took the medicines down to the garden in separate pots into which they also put slips of paper marked with the person's name. This was not a safe way of administering medicines because of the risk of the medicines getting mixed up. One of these people's MAR had not been completed for the morning. We pointed this out to the staff member responsible for that medicine round. They told us it had been an error on their part and assured us the person had

received their medicine as prescribed. They then completed the MAR retrospectively. They commented; "That's the trouble when you get called away." It is important MARs are completed immediately after the medicines have been administered to help ensure the records are accurate. The problems associated with the lay out of the building and the demands on staff time meant the management of medicines was not robust.

We recommend the service identify a more robust system for administering medicines and take action to update their practice accordingly.

We observed some people being given their medicines at lunchtime, and saw they were given in a sympathetic way. Staff stayed with people until they had taken their medicines and made sure they had a drink to help them take it. Staff told us that there was nobody who looked after their own medicines at the time of our inspection, but that people could do this if it had been assessed as safe for them, and that lockable storage was provided.

Medicines were stored safely and securely. There were suitable arrangements for keeping any medicines needing cold storage, and for any controlled drugs in use. There were records that showed that room and refrigerator temperatures were monitored to show that medicines were being stored correctly and would be safe and effective for people. The home kept separate supplies of some non-prescription medicines, and had procedures in place which recorded how and when these were given to people if they needed them. An audit trail was kept of medicines received into the home and those returned to the pharmacy for destruction. We found the service was now meeting the requirements of the regulations.

Following a recent series of incidents, which had not been appropriately responded to or acted on, Cornwall Care had arranged for all staff at Blackwood to have face to face comprehensive safeguarding training. At the time of the inspection only six members of staff out of 53 had not yet had the training and this had been booked in for the next week. Plans were in place to roll out the training to all Cornwall Care locations. Staff told us the training had been informative and they; "know more now than we did before. It's made a difference." They told us they were confident of the action to take if they had any concerns or suspected abuse was taking place. Following the training they had been issued with cards detailing relevant contact numbers to use if they had any concerns. The interim manager, senior care workers and administrator had received safeguarding for managers training. In addition all staff had completed the safeguarding module contained in the Care Certificate. Cornwall Care had appropriate and up to date policies and procedures in place regarding safeguarding and whistleblowing. These outlined the different types of abuse and action staff should take if they suspected abuse. The week preceding the inspection the interim manager had raised a concern with the local safeguarding team in respect of a medicines error. This demonstrated they were aware of when they should raise concerns and the correct procedure to follow.

Recruitment systems were robust and new employees underwent the relevant pre-employment checks before starting work. This included Disclosure and Barring System (DBS) checks and the provision of references including a reference from the previous employer.

A caretaker was employed full time at the service and they carried out daily checks to help ensure any defects were attended to. Staff told us they reported any faults to the caretaker and these were addressed promptly. The environment was clean and hand washing facilities were available throughout the building. Personal protective equipment (PPE) such as aprons and gloves were available for staff and used appropriately. All cleaning materials were stored securely when not in use.

Equipment was well maintained and regularly serviced. All necessary safety checks and tests had been

completed by appropriately skilled contractors. Fire safety drills were regularly carried out and all fire fighting equipment had been serviced at appropriate intervals.

Requires Improvement

Is the service effective?

Our findings

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

People can only be deprived of their liberty so that they can 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. Some people had DoLS in place and these were recorded appropriately. Capacity assessments had been completed for people in respect of their capacity to consent to their plan of care. The interim manager was in the process of making further applications for DoLS authorisations following discussions with the local supervisory body.

One person was receiving two medicines covertly. This means it was being hidden in food because otherwise the person was likely to refuse it. Both medicines were used to treat anxiety. Where medicine is administered covertly there must be a mental capacity assessment in place to show the person is unable to understand the risks to their health if they do not take their prescribed medicines. This should be followed by a documented best interest decision which involves the relevant health professionals and family members. Reviews of regular covert medication should take place regularly, particularly where the medicines are being used to sedate the person. A mental capacity assessment had been completed in April 2016 in respect of the person's capacity to consent to their plan of care. The best interest decision to administer one of the medicines had not taken place until August 2016. This meant the person's capacity to consent specifically to the administration of medicines had not been appropriately assessed. There was no best interest process followed in light of the decision to covertly administer the second medicine. There was no management plan in place detailing how and when the decision was to be reviewed.

We recommend that the service consider current guidance on the recording and reviewing of decisions taken in respect of the administration of covert medicines with particular reference to the MCA.

People were cared for by staff who had a good understanding of their needs and were skilled in delivering care. There was a robust system of training in place to help ensure staff skills were regularly refreshed and updated. Staff told us the training they received was good. One commented; "We get plenty of training, if anything it's too much!" Training records showed staff were up to date in all areas defined by the provider as necessary for the service. As outlined in the 'safe' section of this report, some staff told us they would not be confident supporting people when they became agitated or distressed and would like training in this area. People and relatives told us they considered staff to be competent.

Newly employed staff were required to complete an induction before starting work. This included familiarising themselves with organisational policies and procedures. Staff new to care were required to

complete the Care Certificate. This is designed to help ensure care staff have a wide theoretical knowledge of good working practice within the care sector. There was also a period of working alongside more experienced staff until such a time as the worker felt confident to work alone. New staff were assigned 'buddies' who were more experienced staff members able to give support and guidance as necessary. Staff told us they received regular supervisions and were able to ask the interim manager for any additional support at other times.

People told us they enjoyed the meals and were offered a choice. Comments included; "It's very good" and "The best I could have." A pictorial menu was displayed to inform people about the meals for the day. Care plans indicated when people needed additional support maintaining an adequate diet. Food and fluid charts were kept when this had been deemed necessary for people's well-being. The service had been inspected by the Food Standards Agency and received a five star rating.

People had access to external healthcare professionals including GP's, psychiatrists, a dementia liaison nurse, opticians and chiropodists. Care records contained records of any multi-disciplinary notes.

Good

Is the service caring?

Our findings

Not everyone living at Blackwood was able to verbally tell us about their experience of living there due to their health needs. Relatives and people told us staff were very caring. Comments included; "They're all very nice", "Everyone is very matey" and "They'll do anything for you."

During the day of the inspection we spent time observing people in the lounge and dining areas. We saw staff reassuring people when they were anxious and gently distracting people from any anxieties they had. Staff spoke about people positively and with affection. As described earlier in the report, one person had frequent periods when they became distressed and could become aggressive. Despite the challenges this presented to staff they all demonstrated a concern for his well-being. One commented; "He needs some help." Another told us; "I like to think I've got a good relationship with him. I try and have a bit of banter and a laugh with him."

One person entered the dining room where a member of staff was having their lunch break. They were distressed and tearful and asking for help. The member of staff asked the person to come and sit with them and engaged them in light conversation. Their manner was reassuring and kind and the person soon became more settled and calm.

People were supported with dignity and respect. Staff discussed the importance of this with us and one commented; "One day it could be us." People's confidentiality was protected; care plans and any monitoring records were kept securely. While discussing how to help ensure care staff had easy access to body maps when giving care staff stressed the importance of maintaining people's confidentiality at all times. An external healthcare professional told us; "They [staff] allow me to see patients in a dignified manner according to the patients preferences and wishes."

Bedrooms were decorated and furnished to reflect people's personal tastes. People had personal photographs and possessions in their rooms. Bedroom doors were clearly marked with nameplates and photographs or pictures which were significant to the person. These had been chosen either with the person or others who knew them well. The interim manager told us they were encouraging staff to take a greater interest in the surroundings and had encouraged them to buy plants to make the environment more homely. Plans were in place to improve the décor and soft furnishings in the entrance area.

Some relatives told us clothing and personal items often went missing or they had the wrong clothes returned to them from the laundry. Two relatives told us their family member had been without dentures for several weeks as they had been misplaced. We discussed this with the interim manager who told us they had contacted the dentist for one of the people concerned and would look into the second incident. They also said they would look into the systems used in the laundry to see how these could be improved to help ensure people had their clothing returned after being laundered.

Requires Improvement

Is the service responsive?

Our findings

There were limited opportunities for people to take part in meaningful activities. At the time of the inspection there was no activity co-ordinator in place as the previous one had left recently. The interim manager told us this was to be addressed in the near future although they were not sure when this would happen. During the two days of the inspection we did not see any organised activities taking place. People were seated in lounges and although the televisions were switched on, no-one seemed to be interested in watching them. There was nothing else available to occupy them. Staff were busy carrying out their care duties and there was little time for them to spend socially interacting with people. Posters and information on a notice board showed events had been organised for special occasions such as Halloween, but day to day activities were not planned. People told us they had nothing to occupy them. One commented; "There's nothing much to do. Someone [an entertainer] sometimes comes in on a Sunday." An external healthcare professional told us; "There does not seem to be any recreational activities going on, every time I have found that residents just seem to be sat down without any stimulation."

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

Some people chose to stay in their rooms for most of the time. We spoke with some of these people who told us they were happy to do this and staff checked on them from time to time.

Care plans were detailed and contained information on a range of aspects of people's support needs including mobility, communication, nutrition and hydration and health. The care plans were regularly reviewed help ensure they were up to date. The interim manager was in the process of auditing all care plans to ensure they were an accurate reflection of people's needs. Care planning training was being arranged for all staff to enable them to have more meaningful and effective input into the process.

The care plans did not contain more personalised information about people's backgrounds and personal histories. This type of information can help care staff engage meaningfully with people and gain an understanding of the life events which have helped shape them. This is particularly important for people living with dementia and other conditions which might affect their cognitive abilities and memory. We discussed this with the interim manager who told us they had started talking to relatives about putting this kind of information together.

Some people had been identified as being at risk of pressure damage to their skin. Their health needs were consistently monitored and pressure relieving aids were used to help minimise the risk. Other monitoring records such as behaviour charts and weight records were being regularly completed. Where appropriate Cornwall Care's clinical nurse specialist had input into people's care planning to help ensure their needs were met. Relatives told us they believed their family members medical needs were met.

Daily notes were consistently completed and enabled staff coming on duty to get a quick overview of any changes in people's needs and their general well-being. Handovers took place between shifts and these

helped staff to keep up to date with any changes in people's health needs. Staff told us this was usually effective although night staff said they were not always aware of all changes. Senior care staff, the caretaker and the administrator all had walkie-talkies which they could use to communicate any information quickly and effectively.

Relatives told us communication with the service was good and they were kept up to date with any changes in people's circumstances. Relatives were invited to care planning reviews and felt involved in any decision making. There were no systems in place for gathering the views of people who used the service. We discussed this with the interim manager who said they would talk with staff about how this could be meaningfully achieved.

People and families were provided with information on how to raise any concerns they may have. People told us they had not had any reason to complain but would be confident to do so. There had been no formal complaints received by the service at the time of this inspection. Comments included; "I would go to the top. I would do that. It's better to get it out."

Requires Improvement

Is the service well-led?

Our findings

People had not consistently received a high standard of quality and safe care. Systems and processes in place to protect people from harm had not been effectively used and safeguarding concerns had not been acted on. A series of incidents of a similar nature had been recorded but audits had not highlighted this trend and failed to prevent further incidents from occurring. Safeguarding concerns had not been reported to the relevant authorities and people had not been protected from avoidable harm.

The systems in place to monitor the quality of service people received were not effective. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New systems had recently been introduced to improve how incidents were reported within the organisation to help ensure any safeguarding concerns were quickly identified and could be acted upon. Cornwall Care's Operations Director met with us to demonstrate how these systems would operate. The system would help ensure that any safeguarding incidents were categorised correctly and immediately forwarded to the relevant people for attention. Similarly incidents of a clinical nature would be passed directly to Cornwall Cares clinical lead. Although the system was too new to evaluate we were reassured appropriate action was being taken to address shortfalls in the system. We checked people's daily notes against completed incident forms and found incidents were being recorded appropriately.

At the time of the inspection the registered manager was not working at Blackwood and the service was being overseen by an interim manager. The service had been through a difficult period and staff morale was low. Staff told us, although the interim manager was supportive, it would take time for them to recover their morale. They said they felt unsure about the stability of the management arrangements at the service. Although they were positive in their comments about the interim manager they did not know how long the current arrangements would be in place. In addition, they were aware safeguarding concerns had not been effectively addressed in the past and this had led to a loss of confidence in the system for reporting concerns and being assured these would be acted on.

Several members of staff referred to a; "lack of trust." We discussed this with the interim manager who acknowledged it would take time to address staff worries. They told us they were arranging regular and frequent staff meetings to allow staff to discuss any anxieties. They operated an 'open door' policy and encouraged staff to talk to them at any time. Staff confirmed they felt able to do this. One commented; "She will ask if things are alright. We're listened to more." The interim manager had also arranged for supervisions to be scheduled further in advance than previously so staff would be aware of when they were due. Cornwall Care facilitated an instant recognition award which allowed managers to award gift vouchers to individual staff members in recognition of their work. This scheme had not been running at Blackwood for some months and the interim manager was planning to reintroduce it at the next staff meeting. During the inspection we observed the interim manager speaking with staff frequently and saw they were a visible presence in the service.

The interim manager told us they were well supported by the senior management team and were confident

they would be supported to make necessary changes to how the service was run. For example, they were carrying out audits on care plans, had arranged for all people to be weighed to establish baseline weights and were working through a number of DoLS applications to help ensure all who required them had been applied for. An audit looking at the prevalence of pressure ulcers had recently been completed. Staff told us sickness levels among certain members of staff was high and this had not been picked up on. The interim manager told us they were initiating a sickness absence management process with the support of the Human Resources (HR) department. A member of staff told us; "There have been more meetings, more form filling for incidents and observation charts. We don't take chances." The Operations Director told us monthly safeguarding meetings for managers were being scheduled at head office to give managers an opportunity to discuss any developments and actions and share any learning. This demonstrated action was being taken to improve the quality of people's care across a wide spectrum of areas.

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 9 HSCA RA Regulations 2014 Person-centred care People's care and treatment did not reflect their preferences. Regulation 9(1)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not being provided in a safe way for service users. Regulation 12(1)(2)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to monitor the quality of service people received were not effective. Regulation 17(1)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified staff were not effectively deployed. Regulation 18(1)