Anchor Trust

Buckingham Lodge

Inspection report

Culpepper Close
Aylesbury
Buckinghamshire
HP19 9AD

Website: www.anchor.org.uk

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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

Buckingham Lodge is a care home that provides accommodation for up to 64 older people. There were 41 people using the service at the time of our inspection. The last inspection took place in March 2016 where the overall rating was requires improvement. The provider had not met the regulations and there was a breach of regulation 12.

At the time of our inspection, there was 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.

On the first day of our inspection, the registered manager and the deputy manager were not at the service. Staff told us they did not know of their whereabouts or why they were not available. There was not a designated member of staff in charge of the home. This left the building unsafe in the event of an incident. The regional manager was contacted and arrived at the service later that day.

Medicines were not always ordered administered or recorded appropriately. This meant that people were at risk of not receiving their medicines safely. We advised the provider to seek guidance to ensure medicines were managed safely. For example, following the National Institute for Health and Care Excellence (NICE) guidelines on managing medicines in care homes.

People told us staff were caring; although, we did not always observe this during our inspection. We observed that some staff were focused on tasks and did not engage with the people they were caring for. People's privacy was protected, but their dignity was not always supported. However, some staff demonstrated kindness and compassion when assisting people. There were enough staff to meet people's needs at the time of our visit.

People were protected against abuse and neglect. Staff we spoke with were knowledgeable of the process to follow if they suspected abuse had occurred. People told us they felt safe living at Buckingham Lodge.

Staff received training support and appraisal. However, staff supervisions were not always carried out on a regular basis. The service complied with the Mental Capacity Act 2005. Staff understood mental capacity, best interest decision making and deprivation of liberty. People had the ability to voice their concerns and had regular 'residents and relatives' meetings where they could discuss any concerns they had. However, we saw some complaints had not been responded to with outcomes. We did not always see evidence that complainants were kept informed of the status of their complaint.

Risk assessments were in place for most people's needs. However, some people who had been identified at risk of weight loss did not have a plan of care to address this. There was a risk that people were not always provided with adequate nutrition and hydration. We discussed this with the regional manager who

immediately put food and fluid charts in place for people who were assessed as being at risk of malnutrition.

Staff told us the workplace culture could improve and they said if they voiced an opinion or idea, they were not always listened to.

We found several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

People were at risk because of unsatisfactory management of medicines. Risk assessments were in place, however, identified risks did not always have a management plan.

Communication was not effective to ensure people were safe.

People told us they were happy and felt safe. Relatives commented they felt their family member was well looked after and safe.

Is the service effective?

Requires Improvement

The service was not always effective.

People who were at risk of malnutrition did not have a plan in place to manage this.

People had access to appropriate healthcare professionals. However, advice was not always sought.

Some staff had not received regular supervisions and training. However, they told us they felt supported by the deputy manager.

Is the service caring?

Requires Improvement

The service was not always caring.

People did not always receive kind and compassionate care from staff.

People lacked involvement in the care planning process.

People's dignity was not always respected.

The majority of staff showed kindness and respect towards people. People told us they were happy with the care they

received.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care needs were not always documented.

The provider's complaints process was not always followed

Meetings were held to allow people and their relatives to share their views and suggestions about how the service was run.

Is the service well-led?

Requires Improvement

The service was not well led.

Staff felt the workplace culture required improvement. Risks were assessed but not always acted upon.

The management's presence or whereabouts was not always communicated to staff. Staff told us management were not always visible and they were not informed of important information in relation to the management of the service.

Communication was in need of improvement to ensure the safety of the people at the service.

People told us they knew who the manager was and sometimes saw them during their 'walk round' in the morning.

Buckingham Lodge

Detailed findings

Background to this inspection

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

This inspection took place on 4 and 5 April and was unannounced.

The inspection team comprised of an inspector, a rating review inspector and an expert by experience on the first day of the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second day one inspector completed the inspection.

Before the inspection, we reviewed notifications and any other information we had received since the last inspection. A notification is information about important events, which the service is required to send us by law. The provider completed a Provider Information Return (PIR).A PIR 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 spoke with the regional manager, the deputy manager, the area manager and eight staff members. We looked throughout the service and observed care practices and people's interactions with staff during the inspection.

We checked records including five care plans, medicines records, and five staff files containing recruitment checks and induction procedures. We also viewed the training records for staff. We spoke with ten people who used the service and six relatives.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Buckingham Lodge. We spoke with ten people who used the service and six relatives about how safe they felt the service was. One person told us, "I feel safe because I've got my buzzer and my door is closed at night." Another person told us, "I'm safe because there are lots of people around." Relatives we spoke with felt their family members were safe. One relative said, "I feel he is safe and watched, he has had a few falls but hasn't hurt himself they have put a pressure mat by the bed."

During our previous inspection, we found the provider did not meet the regulation and was in breach of regulation 12; medicines were not managed safely and effectively.

During our inspection, we looked at systems in place for managing medicines. We saw that some people had been without their medicines. Due to insufficient stock, one person had been without their medication for a total of five days. The particular medicine was used to manage the person's dementia. Being without the medicine for this amount of time may have caused any benefits from the treatment to diminish. Another person had been without their laxative medicine for one day and another person without their medication for diabetes for one day. We also saw that some staff were not giving the correct dose of analgesia to one person. The prescription was for two tablets to be taken for pain relief; some staff had documented on the medicine chart that only one tablet had been administered. This meant that the person may not have received adequate analgesia to manage their pain. We spoke with the deputy manager on the second day of our inspection about this and they said they would discuss this with the staff involved.

Medicine audits had not identified lack of stock or incorrect dosage. We also found that there was no evidence of six monthly medicine reviews for people over the age of 75 who were taking four or more medicines. This is an action advised by the National Service Framework for Older People.
We discussed our findings during feedback with the regional manager they said they would conduct an investigation into the incidents.

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

Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. Staff told us they would not hesitate to report any concerns to the relevant authority. We saw the service had a 'safeguarding adults and preventing abuse' policy which was in line with procedures for keeping people safe. This meant there was a clear process for staff to follow to protect people.

The service followed safe recruitment practices. We looked at recruitment files for four staff and found the service had completed the necessary checks for new staff. Files included proof of identity, job histories and references. We saw the provider completed Disclosure and Barring Service (DBS) checks to make sure people were suitable to work with vulnerable adults.

We found people's safety was compromised due to lack of communication within the service. For example,

on the first day of our inspection staff were not aware that both the registered manager and the deputy manager were not on duty. A senior member of staff was not available to manage the service. This meant that in the event of an incident within the service there would not be a designated senior member of staff. Furthermore, people's safety may be at risk without clear direction and management of any such event. The regional manager was contacted and they arrived later that day to assist with the inspection. We discussed our concerns with the regional manager regarding lack of communication and the absence of both managers. They told us they would look into this as a matter of urgency.

We looked at people's nutrition and hydration. The service used the 'malnutrition universal screening tool' (MUST) to assess people who may be at risk of malnutrition. However, we found the screening tool was not used correctly. For example, body mass index (BMI), unintentional weight loss and the likelihood of future impaired nutritional intake was not recorded on two people's files we looked at. When people had lost weight a nutritional assessment was not completed or input from relevant health professionals sought, for example, dieticians, and nutritionists. We saw one person weighed 70.65 kg in March 2016 and noted their weight in March 2017 was 54.45 kg. There was no evidence of any management of the person's weight loss such as food charts or any involvement with health professionals to identify the cause of the person's weight loss. Another person who had been identified at risk of malnutrition and was losing weight, did not have a food chart in place or a nutritional assessment completed. We noted the person's weight to be 43.5kg. We spoke with the regional manager during feedback and they told us they were not aware the person did not have any nutritional assessment in place. They confirmed this should have been in place to ensure the person was receiving adequate nutrition and requested staff to monitor the person's dietary intake by way of a food chart with immediate effect.

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

Not all care plans were reviewed on a regular basis. Of the five care plans we looked at, two had not been reviewed regularly. For example, one person's care plan had not been updated since December 2016.Staff told us the person now requires assistance with their mobility. Staff were aware that the persons needs had changed, however this was not recorded. This puts the person at risk of inappropriate and unsafe support if new staff were not aware of the person's current mobility. Another person's care plan had not been reviewed since June 2016; the care plan stated the person requires morphine for anxiety. We spoke to staff about this and they told us this is no longer required.

Sufficient numbers of staff were available to meet people's needs. Staffing levels were assessed and monitored by way of a dependency tool. Where staffing levels were not sufficient, agency staff were used.

Requires Improvement

Is the service effective?

Our findings

People were being supported by staff who did not always have the opportunity to maintain their skills and knowledge. For example, staff we spoke with gave differing opinions regarding their training. One member of staff who had worked at the service for some time said they had not been given the opportunity to complete their care certificate. Another member of staff who had worked at the service for over one year told us they had not completed training in dementia care. However, other members of staff told us the training was good. Topics staff had completed were safeguarding adults, nutrition and hydration awareness, moving and handling and fire awareness. We saw the training matrix, which indicated what the paperwork showed and what staff said was different. However, we were aware the training matrix had not been fully updated to show the staff that had completed training. We discussed training with the deputy manager who told us staff that had not completed training in dementia awareness were booked on the next available course.

Supervisions were not always carried out on a regular basis. The services policy was to carry out supervisions every six to twelve weeks. One member of staff told us they could not remember when they last had supervision. Records showed that six staff had not received supervision since January 2017.However, all staff we spoke with told us they felt supported by the deputy manager and they could always speak to them about any concerns. Comments included, "[Name] is very approachable, I feel supported" and "Yes I can speak to them at any time." New staff were supported to complete an induction programme before working on their own. They told us, "We work alongside experienced staff until we are assessed as competent to work alone." We spoke with an agency member of staff who told us, "I feel supported."

We recommend the service review training and supervisions to ensure this is carried out and completed in accordance with the policy and procedures.

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 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 interest and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when it 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 principals of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff we spoke with had a good understanding of the MCA and DoLS they told us "We assume people have capacity, if we have concerns we would carry out a mental capacity assessment." We spoke with the deputy manager during feedback regarding standard DoLS authorisations. We were told that there were two people subject to a standard DoLS authorisation. We saw that when a person had been assessed as lacking mental capacity to make decisions a 'best interest decision' was formulated.

Some people who had been initially assessed and identified at risk of malnutrition did not have a full

nutritional assessment in place to determine they received essential nutrients to ensure they were not malnourished. One person we saw who had been identified at risk of malnutrition, did not have a food and fluid chart in place to ensure they received adequate nutrients. We were aware the person had not eaten any breakfast and their lunch had been left in left in front of them untouched. We observed the person to be asleep for most of the day. We could not confirm if this was a result of insufficient food and fluids. Staff we spoke with were unable to clarify why the person was sleepy or comment if this was their usual routine. We did not see staff offer the person an alternative meal or snack. Staff had not taken any action to raise this with more senior staff in order for the person to be closely monitored. We raised our concerns with the regional manager during feedback and they immediately requested for staff to offer the person an alternative meal.

The service did not have arrangements in place for people to have access to dietary and nutritional specialists to meet their assessed needs. Another person had significant weight loss and did not have a nutritional assessment in place or any involvement of other health care professionals to investigate the cause. This puts the person at risk of deteriorating health. Causes in relation to their weight loss had not been investigated.

We spoke with the regional manager about this and they asked staff to ensure people who had been identified at risk of malnutrition to have their food intake monitored by way of a food chart with immediate effect.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the Chef and they said that the food delivered was of good quality. People had different opinions about the standard of food. Comments included, "The food leaves a lot to be desired but has improved in the last few days" "I eat what I'm given and it's OK" and "The food is excellent and nicely dished up and well presented."

People had access to healthcare within the service, which included visits from the GPs, speech and language therapists and chiropodists. However, referrals were not always timely.

Requires Improvement

Is the service caring?

Our findings

We asked people and their relatives if they felt the service was caring. One person told us, "They [staff] are very kind and caring, I am happy here." Relatives commented, "We are happy with everything, there's a good interaction between residents and staff."

We asked people about their care plans and several people said they knew of them or had left their relatives to review them. However, from the care documents we viewed we did not see involvement of people in making decisions about their care. We found the service had taken no steps to invite people to participate in the care planning process.

We observed interaction between staff and people who used the service. We found people were not always treated with dignity and respect. For example, during lunchtime we saw one person sitting in an armchair and did not join others who were sitting at dining tables. We asked a member of staff why the person did not join the other people at the tables. They told us the person needs hoisting now and it was difficult to get the person to the table. Due to communication difficulties, we were not able to confirm with the person if it was their preference to sit in the armchair for lunch. We did not see any documented evidence in the person's care plan in relation to the person's lunchtime arrangements.

During our observation the person had fallen asleep and a member of staff left the person's meal on a side table in front of them and said, "Come on eat your food, you didn't have any breakfast". The plate of food was left in front of the sleeping person. We remained in the dining area and noted the person was left with their untouched food. We did not see any interaction from staff with the person or any attempt to wake them to eat their food. The food was left in front of the person at12.30 and the food remained there until 13.30 until it was taken away. The person had not been assisted or encouraged to eat their meal or offered an alternative.

The person was observed to wake up and started shouting for help. A member of staff went over to the person and said, "Stop shouting you have just been to the toilet". However, we were aware that the person had remained in the chair with their food in front of them for over an hour and had not moved from the chair. We then overheard a member of staff ask another member of staff to sit with the person; we heard them tell the member of staff, "Just sit with [her] you don't have to talk to [her]".

This did not take place and the person remained in the chair without any interaction from staff. The care plan documented the person walked with assistance and did not require a hoist to assist them to move as we had been advised by staff. We asked a senior member of staff about the person's mobility and they confirmed they are able to walk with assistance. This demonstrated some staff were task focused and did not treat people with dignity and respect at all times. We raised our concerns with the regional manager during feedback. They told us they would carry out an internal investigations into our findings.

During a different observation, we saw one person walking unattended along the corridor with only their underwear on. We spoke to staff and asked them to attend to the person. The member of staff told us, "They

always get up at this time". We saw the same thing happen on the second day of our inspection. This demonstrated the service did not anticipate people's needs effectively. The relationship between staff and people receiving support did not consistently demonstrate dignity and respect.

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

Staff did not always show concern for people's well-being in a caring and meaningful way. For example, we heard people complaining they were cold as the window was open. A member of staff was sitting nearby writing notes and did not respond to people's request to close the window.
We asked the member of staff to close the window on behalf of the person.

However, we saw the majority of staff treated people with kindness and compassion in their daily routine. Comments we received from people included, "I have coffee at 11.0'clock and I chat to the staff" and "They are kind and caring, I am very happy here." "The staff are never disrespectful, my dignity is preserved."

Relatives commented, "He has been extremely well looked after, I've seen good interaction between staff and residents. In addition "I think it's wonderful here."

Requires Improvement

Is the service responsive?

Our findings

People told us, "I don't usually wait a long time when I ring my bell." "I've had falls, but they come within minutes usually" and "Some programmed activities do not take place". Relatives told us, "It's quite a nice place; I get a better welcome here." We found the overriding view of people and their relatives was positive. However, we found evidence that did not always support this.

Care plans were not always personalised and did not detail daily routines specific to each person. Speaking with staff, they were able to explain people's routines however; this was not always documented in people's care plans. One example was when speaking with one member of staff they were able to tell us about the routine of a person during the afternoon period. They told us the person became agitated and walked around the home in a specific way. The member of staff told us, "[Name] has 'sun downing'." Sun downing is a term used for people with dementia it is also known as 'late day confusion'. However, we could see no reference to this particular behaviour in the person's care plan or how staff managed this. Furthermore, referring to a term used for a particular behaviour does not imply care was person centred. This meant that there was a risk the person would not be appropriately supported by staff who did not know them well.

People's needs were not always reviewed regularly or as required when people's needs had changed. For example one person's mobility had deteriorated between December 2016 and our inspection, this had not been updated in their care plan. The service had not been responsive to their changing needs. They were at risk of receiving inappropriate support that did not meet their needs. Advice was not sought from healthcare professionals when people had lost weight. We saw examples of two people who had significant weight loss and had not been reviewed by healthcare professionals.

People were not supported to have care that reflected their preferences on how they would like to receive care and support. For example, a member of staff told us that one person had specified that they only wanted female care staff to support them. However, the member of staff told us this did not always happen and male agency staff had carried out personal care on occasions. We asked why this was and the member of staff told us, "It never gets communicated". This demonstrated effective communication does not always take place to ensure people's wishes were respected. This may cause the person undue anxiety if male members of staff carry out personal care. We saw the person's preference to only having female care staff attending their support needs documented in the person's care plan.

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

People did not have a wide range of activities they could be involved in. The service employed two part time activity coordinators. Who worked at the service over four days. However, they were not present on both days of our inspection and people were not able to attend any activities. Staff told us, the activities were poor and said there have been several activity coordinators who had worked at the service but left. Another member of staff told us they tried to arrange an activity when the activity coordinator was not there but it was very difficult. We saw a member of staff had organised a singing session in the lounge on the first day of

our inspection, which was well attended, and we saw most people joined in with the singing.

People had a chart that showed the planned activities for the month. One person we spoke with told us that the activities did not always take place. We saw in one person's care plan that they would like to attend church services but found no evidence this took place. Another person's care plan said they would like to go out more as they felt 'hemmed in'. However, we did not see any documentation in the person's care plan or in the activity coordinators log this had taken place. We saw a complaint from the person's family in relation to lack of activities for the person. This demonstrated there were lack of personalised activities for people to enjoy.

There was a complaints process and system people and their families received when first joining the service. However, we found complaints were not been managed in accordance with the services policy and procedure. The policy stated complaints were to be closed within 10 days of receiving the complaint. Some complaints we saw had no evidence they had been closed or actioned. One example we saw was a complaint that had been raised on 22/03/2017 did not show any actions in relation to the complaint and was still open. Another complaint raised by a person's family on 23/01/2017 in relation to staff not following hospital advice for their relative. The complaints log documented actions to be completed, such as discuss with staff and retrain in report writing. However, we could see no evidence this had taken place. We discussed our findings with the deputy manager and the regional manager during feedback and they acknowledged this and said they would look into it. We received further information following our inspection from the regional manager. They confirmed the complaints we saw during our inspection had not been followed up with the complainant at the time of our inspection. However, we are aware this has now been actioned by the deputy manager with an acknowledgment of satisfaction from the complainants.

We recommend complaints are monitored and responded to in a timely manner.

Relatives told us the service had an open door policy, which allowed them to visit at any time.
The service held monthly meetings for people and their relatives to air their views about how the service was run. Several people said they attended them. We saw one meeting dated 17 February 2017, which stated that people would like a hot drink at night. However, the following meeting dated 20 March 2017 said people still were not getting a hot drink at night. This demonstrated the service did not always listen to and respond to people's requests. However, other comments we saw from following meetings demonstrated people were happy with the service. Comments from people were, 'It is lovely to see our garments fresh clean and folded' and 'we approve of the main meal being served at lunch time rather than in the evening.

Requires Improvement

Is the service well-led?

Our findings

We asked people, relatives and staff whether they felt the service was well led. We received mixed feedback from all parties. Some people said they often saw the deputy manager and the registered manager during their daily 'walk round'. Staff told us the deputy manager was very approachable but they did not feel the registered manager was always approachable.

The registered manager had not developed the staff team to consistently display appropriate values and behaviours towards people. We saw examples of this on both days of our inspection. The service did not have a clear vision and set of values that included involvement, compassion and dignity. Staff did not have confidence the registered manager would listen to their concerns and would be received openly and dealt with appropriately. Some staff expressed dissatisfaction with the service and with the workplace culture. They told us when they gave feedback about the way the service was run and improvements that could be made it was often ignored and not acted upon. For example, one member of staff told us, "They keep moving me; I have told them people need a regular face, but they don't listen." They were referring to lack of continuity for people living with dementia and how constant changes in staff may cause confusion for people.

One member of staff told us, "You come in and don't know what's going on from one day to the next. Communication here is awful, there needs to be a proper structure." We saw evidence of poor communication on the first day of our inspection when staff had not been informed of the registered manager and the deputy manager's absence. One member of staff told us, "In my opinion we need more direction."

An effort was made to hold regular meetings with staff. We saw minutes from meetings with staff, one dated February 2017 had undertones of how unsupported staff felt about the way the service was run. Comments included that the registered manager does not pick up their phone when they are on call. No actions were documented from the staff meetings to demonstrate what steps would be taken to address issues raised. We discussed this with the regional manager during feedback; they said this would be investigated with immediate effect.

There were systems for monitoring the quality of care people received however; they were not always fully completed or effective. Senior managers visited the service to carry out audits which comprised of medication audits, care plan audits and operational observations. Where issues with any of the audits were found, an action plan was put in place by the visiting senior manager for completion by the registered manager. However, we saw this had not always been carried out. For example, actions to be addressed were. Medicine errors should be reported the local authority and the providers' internal safeguarding team. We were aware that on two occasions this had not been done.

We found some internal audits, which were the responsibility of the registered manager, not fully completed. Ones that had been completed had not identified shortfalls around stock of medicines and that some care plans had not been reviewed and updated to reflect people's changing needs. This may cause

potential risks to people if new staff or agency staff are unaware of people's current support requirements. We discussed this with the deputy manager and regional manager during feedback. They told us they would investigate this as a priority.

The service worked in partnership with other healthcare professionals such as district nurses and GPs. However, we saw that referrals had not been made to relevant healthcare professionals when people had been assessed at risk of malnutrition and had significant weight loss.

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

The provider has a legal duty to inform the CQC about certain changes or events that occur at the service. There are required timescales for making these notifications. We had received information about notifications and we could see from the notifications appropriate actions had been taken.

Providers are required to comply with the duty of candour statutory requirement. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The regulation applies to registered persons when they are carrying on a regulated activity. Due to their absence, we were unable to discuss this requirement with the registered manager. However, we discussed this with the deputy manager who told us they were aware of the requirement.

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 Care plans did not relate to care provided

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The service failed to put measures in place to manage people's weight loss. People's nutritional and hydration needs were not met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Good governance. There was lack of managerial structure and staff did not know if the managers were on site or not. A designated member of staff was not available o manage the service. Audits were not fully completed to show shortfalls.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment This was a continued breach of this regulation. Safe management of medication. The provider did not ensure medication was managed effectively. People did not receive their prescribed medication due to insufficient stock.

The enforcement action we took:

Warning notice