Regency Healthcare Limited

Newlands Hall

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

The inspection took place on 29 February 2016 and was unannounced. The service provides accommodation and personal care for up to 30 people, some of whom may be living with dementia. There were 20 people living at the home at the time of the inspection.

There was a registered manager in post. 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.

Newlands Hall was previously registered to another provider. A new provider, Regency Health Care, had taken over the service in 2015.

Building work was ongoing at the time of our inspection, to improve the premises for people. Risk assessments were in place but these were not always clearly illustrated for people.

Staffing levels were appropriate for people's needs and staff were suitably trained and felt confident in their roles and responsibilities.

The safe management and recording of medicines was not robustly in place.

Staff understood the legislation around Mental Capacity Act 2005 and Deprivation of Liberty Safeguards although documentation relating to this was inconsistent.

People enjoyed the food and the dining experience was sociable and pleasant, although nutritional assessments were not consistently well completed.

Staff demonstrated a friendly, caring approach and there was a happy atmosphere in the home. Staff knew people well and used this knowledge to develop caring relationships.

Care records contained regular updates of information about people's needs, although sometimes this was contradictory and unclear.

People had opportunities to engage in social activities, although not everybody said they enjoyed these. There were activities staff who had knowledge of people's social histories and preferences.

There was visible management of the service and an open door policy for staff, people and visitors to approach the registered manager at any time. Staff said morale was high and there was effective teamwork in place to meet people's needs.

Some quality assurance systems were in place although these were gaps in audits of key aspects of people's care and support.

You can see what action we told the provider to take 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.

People felt safe and staff promoted their safety in the daily routine.

Medicines were not always documented thoroughly.

Risk assessments were not consistently detailed or accessible.

Is the service effective?

Requires Improvement

The service was not always effective.

There was a lack of consistency in documentation with regard to people's consent to care and treatment.

People's dietary and nutrition needs were met, but there were gaps in the recording of how this was monitored.

Is the service caring?

Good

The service was caring.

There were friendly, caring and supportive relationships between people and staff.

People's independence was promoted and staff showed regard for people's privacy and dignity.

People were informed and involved in their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care documentation contained some conflicting information and practice was not always in keeping with care plans.

People understood the complaints procedure.
Activities were varied, although not always relevant for some

people's social needs.

Is the service well-led?

Requires Improvement

The service was not always well led

The registered manager was visible and involved in the day to day routine of the home.

Staff felt supported and motivated to do their work.

Quality assurance systems were not robustly in place.

Newlands Hall

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 29 February 2016 and was unannounced.

There were two adult social care inspectors. We reviewed information we held about the service, such as notifications, information from the local authority and the contracting team. We displayed a poster to inform people and visitors that we were inspecting the service and inviting them to share their views.

We looked around the home, in people's rooms with their permission and in communal areas. We spoke with seven people, three care staff, the activities coordinator, the cook and the registered manager as well as two visitors.

We looked at care documentation for five people, two recruitment files and records relating to the safety of the premises and equipment.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at Newlands Hall. One person said: "Well if I didn't feel safe I'd leave and go where I did feel safe". Another person said: "I do feel I'm safe". One relative we spoke with said they thought their family member was safe in the home.

Staff we spoke with said they felt people received safe care and they understood how to maintain people's safety in the daily routine. Staff knew what constituted abuse and what signs may give them concern about a person's well-being or safety. Staff told us they had received training in safeguarding and they were confident in their understanding of the safeguarding and whistleblowing procedures.

Staff had completed a personal emergency evacuation plan (PEEP) for each person. We saw staff had assessed each person's ability to leave the building in an emergency according to a 'red amber green' (RAG) system. This was designed so staff and emergency services could quickly identify who needed support during an evacuation. We saw PEEPs were stored in a readily accessible fire folder. However, some records were undated and unsigned. Some of the records did not indicate the RAG rating.

Information regarding each person's mobility was not always clearly recorded. For example, in the PEEP of one person, a member of staff had noted, "In aid of zimmer frame would need wheelchair has mobility can be poor." This person's care plan also indicated they needed a "high level of handling constraints". The lack of clarity about the ability of people to mobilise meant we were not confident PEEPs were accurate or could be used in an emergency. In another person's PEEP, staff had not completed a RAG assessment and had commented the person could walk short distances with a walking frame. This meant we could not confirm PEEPs were up to date or an appropriate member of staff had completed the assessments.

Staff had completed a mobility risk assessment for each person, which included an assessment of the person's gait, sensory capacity, medication and falls history. In the records of some people they had not documented mobility assessment criteria. For example, staff had noted if people needed a member of staff to mobilise but there was no evidence of how or when they had completed the assessment. In one person's care plan staff had documented differences in mobility risk between day and night. Staff had documented details of each person's ability to complete day to day tasks such as if they could put their own shoes on, step into a bath, put themselves to bed and make themselves a cup of tea.

Staff had completed a falls risk assessment for each person, which also included an intervention plan. For example, in the falls risk intervention plan of one person, staff reduced their risk by encouraging the person to ask for help whenever they needed it, ensuring their call bell was always within reach and orientating them to the environment.

At the time of our inspection the home was undergoing refurbishment. This meant part of the building could not be occupied by people and construction staff were working in the area. One door on the first floor led into the construction area and the lift from the ground floor led to the area of construction. We saw the registered manager had completed a risk assessment, which adhered to the Health and Safety at Work

Regulations (1999) and highlighted a high risk to people. The risk assessment indicated people would not be permitted to access the area. However, this risk assessment was posted inside the lift and there were no notices on the lift entrance doors to indicate people should not use it. This meant it was not immediately clear there was an access restriction in place to anyone who wanted to use the lift. Control measures for this risk were not robust. For example, the risk assessment stated the door to the area in which building work was taking place would be kept closed at all times. However, we saw this was not always the case and there was not always a member of staff in this area to monitor it.

Where a person had been put at risk by leaving the home without the knowledge of staff or the mental capacity to safely make this decision, staff had taken appropriate action to ensure the person was safe. For example, they had followed instructions given by the person's family when they had moved in by calling the appropriate person and alerting the police.

The registered manager maintained an annual safety check of fire and emergency systems in the home. We checked these documents and found documented up to date checks of the fire alarm, emergency lights, gas and electric systems and portable appliance testing (PAT) of small electrical items. We checked a sample of 14 electrical items in the home and found them to have up to date PAT labels on them. The manager staged a monthly fire drill, which included a scenario whereby staff on duty where monitored for their response to the alarm and were required to find the location of a simulated fire. The manager had recorded how staff on shift had responded but there was not a record of the speed of their response or of any learning from the drills. Staff had documented their response to a fire alarm activation in January 2016, noting a positive response to the situation but without a record of the outcome.

The registered manager had completed an evacuation risk assessment for the building, which we saw included details of safe 'compartments' within the home. Two evacuation mattresses and two lightweight evacuation pads were available in the home, which staff told us they had been trained to use. This equipment could be used during an evacuation to quickly move people who could not mobilise independently. The evacuation risk assessment had been completed using best practice guidance for residential care premises. The home's fire policy included a mandatory fire safety induction and an annual refresher for all staff, including those recruited through an agency or staff bank system. The registered manager had implemented a standard of three practice evacuation drills each year, with each member of staff required to participate in at least one.

Accidents and incident were reported and recorded appropriately with analysis of events to establish whether any trends or patterns occurred.

Staffing levels were appropriate to meet people's needs and we saw people were appropriately supported without having to wait long for assistance from staff. The registered manager told us they were hoping to increase staffing levels further during the afternoon. An activities coordinator was in post to support people, in addition to the care staff. Recruitment procedures were robust to ensure staff were vetted and their suitability was assessed before being able to work in the home. The registered manager told us the ongoing suitability of staff was monitored through informal and more formal checks of practice.

A senior member of staff used a daily checklist to make sure staff completed Medication Administration Records (MARs) consistently. We saw these checks had not always been completed. In the three weeks prior to our inspection, two dates had no recorded checks and there were two checks recorded without dates. Staff recorded the temperature of the medicine storage room and the temperature of the medicine fridge. This is required to make sure medicines are stored at the manufacturers' recommended temperature. In the month prior to our inspection, there were nine dates when the fridge temperature had not been recorded

and ten dates when the room temperature had not been recorded.

We found staff had not always recorded the opened date of medicine stored in the fridge. For example, one medicine had a shelf life of three months once opened but staff had not noted the date it was opened. This meant there was a risk people would be administered expired medicines because there was not a robust system in place to ensure these were used within the period recommended by the manufacturer.

Some people received medicines covertly. This meant the medicines were given to them without their knowledge, such as in food or drinks. We saw a clear policy for this practice and covert medicine was only administered to people after their GP and an appropriate family member had been consulted. Some people received medicine covertly only when they refused it. However, staff did not differentiate this in their documentation and it was not possible to tell when the person had taken a medicine willingly or when staff had administered it to them covertly.

Where a person required medicine on a short-term basis for a specific condition, we saw staff made a daily note of their condition and if they had observed any improvements.

We looked at the MARs of 20 people. We found most people had an up to date colour photograph at the front of their records to help staff easily identify them. We found there were some gaps in recording. For example, one person had not received an evening dose of a prescribed medicine. Staff had written, 'missed dose' on a note in their file but there was no documented reason or follow-up to this. Another person had missed an evening dose of a medicine on the same date and there was no record of the reason for this. Where a person had refused their medicine, staff had noted this correctly and recorded the dose had been destroyed. One person had been prescribed a course of medicine in February 2016 but there was a seven-day delay in recording this, without a documented explanation. One person's MAR indicated a missed morning dose of a medicine but this item was not in the blister pack. This meant it was not clear if the person had taken the medicine and had not recorded by staff or if the person had refused it and staff had destroyed it.

Staff used a protocol for as-needed medicine (PRN), such as paracetamol, which included a check of whether people were able to tell staff if they were in pain or not. Where a person found it difficult to tell staff they were in pain, we saw staff had compiled a list of signs they would use to determine if the person needed PRN. For example, one person could not verbalise pain to staff but would rub their leg if it was hurting.

Documentation used for pharmacy deliveries and returns was up to date but not always accurate. For example, we found some medicine was recorded as in stock for one person but the medicine was in the box ready for pharmacy collection.

We looked at the storage of Controlled Drugs (CDs). We found this adhered to NICE guidelines and CDs were appropriately secured. Documentation for CDs was not always accurate. For example, we found 600ml of Oramorph in stock but the CD documentation log indicated there was only 300ml in stock, after 300ml had been returned earlier in the month.

The above examples illustrate the provider was in breach of the Health and Social Care Act (Regulated Activities) Regulations 2014, regulation 12(2)(g) as the proper and safe management of medicines was not robustly in place.

There were containers of antibacterial hand gel in the corridors of the home but we found most of these were empty. The home's infection control policy stated a member of staff was to check the antibacterial gel

containers on a daily basis. We asked the manager about this. They said the infection control policy was being rewritten to make it more robust and to avoid some duplication they had noticed between night shift and day shift responsibilities. A weekly cleaning rota was in place to record when staff had dusted and polished bedrooms and checked soap and paper towel stocks. This rota had not been signed for the five days prior to our inspection. We found most areas in the home were clean and well maintained. However, we saw where there was an incontinent incident in the lounge, staff did not thoroughly clean the areas affected. We discussed this with the registered manager, who noted that staff were busy attending to lunch at the time, however agreed to address this.

Requires Improvement

Is the service effective?

Our findings

People told us staff were effective in their work. One person said: "They're grand lasses, they know what they're doing". Another person said: "I would think they know how to do their job, I have no complaints".

Staff training was regularly completed and staff reported feeling skilled and able to do their job effectively. The training matrix showed staff had recently completed training that was deemed to be mandatory, such as first aid, moving and handling, fire safety and safeguarding. Where there were some gaps in training for individual staff, the registered manager told us this was planned.

Staff told us they felt communication with the registered manager about their work was effective and they could approach them at any time. We found formal supervision meetings were not robustly in place and the registered manager told us this was a planned area for improvement.

Staff told us teamwork was strong and we saw evidence of close communication between staff to meet people's needs. Handover documentation contained key information for staff between shifts. Staff said morale was good and they had good working relationships with one another, which helped to create a happy atmosphere for people in the home.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We saw where a person had a Deprivation of Liberty Safeguards (DoLS) authorisation in place this was clearly indicated in their care plan. We looked at the documentation relating to the DoLS authorisation of one person. We saw a best interests meeting had taken place with appropriate people, including a psychologist, the community mental health team, a social worker and the person's relative who held a valid power of attorney. This had included a person-led assessment in which the person had been given the opportunity to express their wishes for the future. We found the information documented in a person's DoLS assessment did not always match the needs of the person identified in their care plan. For example, one person's best interests assessment indicated they were 'living with Alzheimers' but in their care plan staff had noted they had a 'short term memory problem'. This meant we could not be certain people received the most appropriate care in relation to their mental capacity because there was a lack of consistency in their assessments and care records.

Staff had completed a mental capacity assessment for each person and used this to document if they were

able to understand verbal information and whether they could retain information long enough to make decisions for themselves. Staff had also documented the response people had given when they had been asked if they wanted to continue to live in the home.

We found an overall lack of consistency in the documentation relating to the consent to care. Staff had not always indicated who had approved each person's care plan. For example, a manager or a relative had not signed off one person's care plan; instead their care plan approval record indicated it had been approved by 'the home'. In one person's care plan, a document used to indicate if they had consented to sharing their information with health authorities had not been completed. In another person's care plan, staff had noted the person was living with dementia and had completed a personal care and wellbeing assessment, but there was no evidence the person or a relative had consented to this.

We found staff had asked people or an appropriate relative if they would like to hold the key to their bedroom and whether this should be locked when they were not using it. Where this risk management plan was in place, a member of staff or the person it belonged to had not always signed it. This meant there was not always evidence the risk management plan had been implemented following an appropriate consultation.

We looked at the do not resuscitate (DNAR) authorisation of one person. We saw it was up to date and had been completed by a family member and two healthcare professionals.

Staff monitored the nutrition and hydration needs of each person. We saw this included each person's ability to eat independently and whether they had any dietary needs, such as vegetarian food or Kosher food. Staff used a monthly update sheet to document changes in dietary need but we found this did not always include a record of weight. However, we found staff had recorded each person's weight consistently on a separate weight-monitoring chart. We did not find the monthly diet records and monthly weight-monitoring records were linked. This meant it was not clear if staff used the monitoring documents available to effectively identify if a person was at risk of malnutrition. Where staff had noted weight loss on a person's weight-monitoring chart, they had not always indicated if an unplanned change had been investigated or addressed. For example, one person had experienced unplanned weight loss of 8kg in a five-month period, which staff had attributed to "ill health". There was no indication this had been discussed with a nutritionist.

As part of our inspection we observed lunch in the home. We saw people were offered adequate hydration throughout the meal, including soft drinks, juice, water and tea. People were invited or escorted to the dining room individually by staff who were caring and encouraging. For example, we saw staff hold the hands of some people until they knew where they wanted to sit and they made conversation with others who wanted to talk. There was a friendly, relaxed atmosphere in the dining room and staff encouraged people to sit next to their friends. Staff reminded each person what they had ordered and asked if this was still what they wanted or if they wanted to change their mind.

People told us they enjoyed the food. One person said: "Yes, oh yes, the food's nice here". Another person said: "The food's good. I used to be a cook so I'd know if it wasn't nice".

We saw staff knew people well and had a good sense of humour when speaking with them. For example, one member of staff asked if they could put some background music on and people enjoyed a laugh with them over their choice. One person was delighted when a member of staff said, "I'm so proud of you" when they managed to eat most of their meal. A member of staff also lightened the mood of someone who needed their food cut up by discreetly making a personal joke with them. This helped to relax people and they enjoyed the lunch experience as a result. Each person was asked if they were enjoying their meal and

staff encouraged people to eat at an appropriate pace.

We found evidence staff had worked proactively with other healthcare professionals to ensure people could continue to live safely in the home. For example, in one person's care plan we saw evidence staff had acted proactively when they noticed the person had become unsteady using their walking stick. We saw they had contacted the person's GP and arranged for them to supply a walking frame instead, which we saw had improved the person's safe mobility. In addition, staff had arranged for a physiotherapist to visit to help the person use the walking frame safely.

Staff documented regular visits from district nurses, the speech and language therapy team, the community mental health team and a chiropodist.

There was ongoing refurbishment for the improvement of the premises. We observed one of the lounges was used more as a walk-through for staff and some people, which disrupted the relaxation of those who wished to use the lounge. Also, due to the layout and location of the registered manager's office, it was difficult for the manager to hold confidential discussions without being overheard by others. We discussed this with the registered manager who said they would give some consideration to this.

Good

Is the service caring?

Our findings

People told us they felt well cared for. One person said: "This place is first class; it takes some beating". Another person said: "The care I have in here is marvellous" and another person said: "I've nothing to grumble about at all".

We saw staff engaged well with people and there was plenty of interaction and conversation. It was evident staff knew people's individual personalities, their likes and dislikes. Staff involved people in discussions around their care and support, with communication about what they wished to so, where they preferred to sit and what they wanted to eat and drink.

We saw in one person's care plan staff had documented how the person wished to be addressed. This included whether they objected to staff calling them by affectionate colloquial salutations such as "love" or "darling". We saw evidence the person had been involved in this and had indicated how they wished to be addressed.

We found evidence staff understood the personal needs of people and were able to provide emotional support for people when they were upset or anxious. For example, staff had documented one person could become confused and upset due to dementia. They had noted the person responded well to one-to-one chats about their younger life and had also noted their favourite type of television programmes to help provide them with mental stimulation. Staff had also recorded how they maintained each person's dignity and privacy. For example, each person had a continence assessment, which staff used to identify the level of support they needed to maintain their personal hygiene and cleanliness.

Staff were discreet when offering support with people's personal care needs and they were sensitive and patient with the assistance they offered. Staff promoted people's independence and ensured they managed their own needs as far as possible and at a pace that was suitable for each person.

Staff took the time where they could to engage with people and chat socially with them, with frequent checks to make sure people had what they needed. People enjoyed light hearted banter that was respectful. The activities coordinator explained how they familiarised themselves with each person's life story and we saw these were used to prompt conversation with people. Staff sensitively distracted one person when they began to show signs of being upset and engaged them in conversation about a forthcoming wedding, which made them smile.

We saw one person who arrived for their first day at the home and they were greeted warmly by caring staff who offered information about the routine and then showed the person and their family to their room. The person was given plenty of reassurance and time to adjust to the care home environment with appropriate support from staff.

Requires Improvement

Is the service responsive?

Our findings

People told us their care was responsive to their needs. One person said: "If I need them [staff] they are there, I don't have to wait". Another person said: "What I like is they [staff] know me and they're used to me by now". Another person said: "At my age, I just like to sit and watch and I can relax".

People had a personal profile in their care plan but we found these had not been completed consistently. For example, one person's personal profile was blank. However, we found evidence staff had worked with them to meet their individual needs. For example, the person liked to go out for walks in the local community and it was important to them to have their dog living with them. Staff had identified risks in this, as the person was prone to confusion when out walking alone and their dog had become distressed when moved into the home. We found staff had worked with the person and their family to help them to be as independent as possible. For example, they had agreed with the person they would be accompanied when they wanted to go out and a family member would bring their dog for a visit whenever they wanted.

We saw one person's care plan included a detailed personal profile. For example, staff had asked the person about important people in their life, about their religious beliefs and about their likes and dislikes. This helped staff to understand the person's needs but did not always include detail about how they would like to be cared for. For example, staff had not documented if a male resident would prefer to be supported with personal care by male or female staff.

Staff noted each person's preferred social activities in their care plan, such as singing, dancing and pamper days. This information was not always specific. For example, in one person's care plan, staff indicated they liked all in-house activities but there was no detail about what this included or what the person would not want to take part in. Staff recorded the activities people had taken part in, such as when they had enjoyed watching a visiting singer and tried tap-dancing. Staff had documented in another person's care plan that they did not like to take part in group activities and so should offer them one-to-one activities instead. We looked at the daily records for this person and found they had tried to participate in a group activity but had not enjoyed it and so went back to their bedroom. There was no indication staff had provided one-to-one activities for them in the month prior to our inspection. We saw there was one person living in the home who was considerably younger than most of the other people, although activities available were not always in line with their preferences.

Each person had a mental health and cognition document in their care plan for staff to use to indicate the person's level of capacity to make day-to-day decisions. We found staff had not always conducted a detailed capacity assessment of each person. For example, we saw in one care plan staff had written, "short term memory" but did not indicate what this meant or why it had been included.

Care plans we saw were not consistently reflected in the practice we observed. For example, one person's care plan said they liked a small diet, a coloured plate and a plate guard, but we saw none of these were in place. However, another care plan said a person preferred to eat without cutlery and we saw staff respected this.

Where new admissions to the home were expected we saw there was detailed information available to staff to provide appropriate care and support until more detailed assessments could be made.

Staff completed a 'daily report' for each person. We found this information was detailed and personalised, such as what time people went to bed and woke up. From these records we found staff had responded appropriately when a person was upset after someone shouted at them. We saw people were able to talk to staff on a one-to-one basis when they wanted. Staff documented appropriate checks during the night depending on the individual needs of each person, such as hourly or two-hourly.

Staff completed a monthly dependency assessment for each person to help them identify changing needs and make sure people received individualised care. This assessment included consideration of mobilising, the person's ability to dress, bathe and feed themselves as well as their eyesight, hearing, social dependency and any changes in behaviour.

People and relatives understood how to make a complaint, although the registered manager told us no complaints had been received. We saw there was a complaints procedure and staff told us they would support any person to follow this if they had any concerns they wished to raise.

Requires Improvement

Is the service well-led?

Our findings

People said they thought the home was managed well and there was clear leadership in the home. There was a registered manager in post who was visible throughout the service and knew people, staff and relatives well. One person said: "Oh we know who's the boss, but everyone's lovely here, all work together".

The registered manager told us there had been an improvement in the standards of care for people living in the home since the home had been taken over by a new provider, and confirmed improvements were ongoing. The registered manager said they aimed to offer an effective role model for staff by demonstrating good practice and being actively involved in people's care.

Staff we spoke with told us they felt the home was well run and the registered manager was approachable and involved in the day to day work, with an open door policy which helped to create a culture of close communication and transparency. One member of staff said: "[The manager] is fantastic. Things have changed for the better since [they've] been here".

Staff we spoke with were clear about their roles and responsibilities and they reported good morale and team spirit. We saw staff were happy and smiling in their work and appeared to be motivated and enthusiastic.

The home had a garden that shared a boundary with neighbouring residential properties and the registered manager told us how neighbours were welcome to join in with any fundraising or social events held outside.

The registered manager and staff team had a shared purpose with a focus on meeting people's needs. We found there was close working with other organisations, such as local authorities and other care providers to meet people's needs. Where other agencies, such as the local authority contracts team or environmental health inspectors had made visits, all recommendations were given priority for action to be taken.

We saw there was some clear documentation in place to illustrate how the home was run, such as premises and maintenance of equipment. The registered manager had oversight of practice throughout the home by being involved on a daily basis. There were some quality audits in place, such as the manager's daily walk rounds, weight, pressure care, mattress, accidents, bedrails and dining experience. However, we found some audits were not robustly carried out and there were no audits in place for key areas, such as medicines management and care records. This meant that the provider could not accurately identify where quality and/or safety may be compromised and respond promptly where necessary.

This illustrated the provider was in breach of the Health and Social Care Act (Regulated Activities) Regulations 2014, regulation 17(2)(a) as systems to assess and monitor the quality of the provision were not robustly in place.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The proper and safe management of medicines was not robustly in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems and processes were not robustly implemented.