Bramlings Limited

Brambling Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection was carried out on 13 June 2017 and was unannounced.

Brambling Lodge is a large detached residence, providing accommodation and care for up to 27 older people, some of whom may be living with dementia. Accommodation is set over two floors. There is a lift to assist people to get to the first floor. Bedrooms are situated on the ground and first floor and there are separate communal areas. It is located in the village of Shepherdswell on the outskirts of Dover. At the time of the inspection there were 23 people living at the service.

There was no registered manager working at the service. 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 and associated Regulations about how the service is run. We were supported during the inspection by the manager, operational director and the quality and compliance manager for the provider. The current manager had started working at the service in November 2016 and had just started the process of applying to be the registered manager with the Care Quality Commission.

We last inspected the service in September 2015. We made a recommendation that the provider use dependency assessments to ensure that enough staff were deployed effectively. At this inspection, there were not enough staff on duty, to provide effective and person centred care. Staff were not always available to provide support to people when they needed it, for example at meal times.

Staff spoke with people in a kind and compassionate way; there was a warm and caring relationship between people and staff. Staff knew people well and how to support them if they were anxious or upset. However, people were not always treated with dignity and respect due to not having sufficient numbers of staff on duty.

People's medicines were not managed and recorded accurately. People did not always receive their medicines when they needed them.

When people lacked mental capacity to make decisions, the principles of the Mental Capacity Act (MCA) 2005, were not always followed. When a person lacks capacity to make a decision, any decisions should be made in the person's best interests and be the least restrictive available. Decisions had been made when people lacked capacity but there was no evidence that best interests meeting had taken place or why the decisions had been made and if it was the least restrictive option.

The staff asked people for their consent before providing them with care and support. The manager understood their responsibility to gain authorisation to restrict people's liberty under the MCA and Deprivation of Liberty Safeguards (DoLS), applications had been made in line with current guidance.

Staff knew and understood their roles and responsibilities. Staff had received training relevant to their roles; however, this needed to be updated. Staff had not received regular, planned one to one supervisions to discuss their training and development. Regular staff meetings gave staff the opportunity to voice their opinions. Staff were recruited safely.

Staff told us that they had not always felt supported by the manager; however, this was improving as the manager was settling into their role. Staff told us that the manager was approachable and listened to them.

People and relatives told us they felt safe at Brambling Lodge. Systems were in place to protect people from harm and abuse and staff knew who to report any concerns to if they felt they were not being dealt with. Accidents and incidents were reported and analysed to identify any patterns or trends to help reduce the likelihood of the incident or accident happening again. Staff completed checks on the environment and equipment to ensure people were kept as safe as possible.

Care plans and risk assessments were detailed and person centred. The care plans included people's preferred routines, wishes, preferences and abilities. Staff knew people well and understood different people's needs and how to keep people as safe as possible. Care plans were reviewed and if people became unwell or their health deteriorated the staff contacted their doctor or other health professionals.

People told us that they liked the meals. People had a choice of meals and specialist diets were catered for. People were supported to eat a healthy, balance diet. Staff understood people's likes and dislikes and dietary requirements.

There was an activity programme for people to enjoy; however, not everyone was able to take part. Some people were not always supported to maintain their interests. People and their relatives said they had no complaints but felt they were able to raise complaints with the staff and manager. There were systems in place for monitoring the quality of the service and an action plan had been developed for any shortfalls identified.

Staff told us that they worked as a team and felt that the manager was now starting to lead the team. Staff were aware of their roles and responsibilities. The staff had worked as a team for a long time and had a clear vision of the person being at the centre of everything they do. However, they felt that the lack of staff meant that they were not always doing this and people were not always getting the support they needed.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. CQC check that appropriate action had been taken. The registered manager had submitted notifications to CQC in an appropriate and timely manner in line with CQC guidelines.

We found three 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.

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's medicines were not managed and recorded accurately. People did not always receive their medicines when they needed them.

There was not always enough staff on duty to meet people's need and provide person centred care.

Risks to people had been assessed and there was detailed guidance for staff to follow to keep people safe.

Staff were recruited safely.

Staff knew signs of abuse and had received training to ensure people were protected from harm.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not always working within the principles of the Mental Capacity Act 2005. Decisions made on behalf of people who lacked capacity had not been recorded.

Staff had not always received regular and planned supervisions.

Staff had received training to complete their roles; however, the training required updating.

People were provided with food and drink to meet their needs and were able to access healthcare professionals when required.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with dignity and respect.

Staff were attentive, kind and caring when providing support.

Staff supported people to be as independent as possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had not been involved in the development and review of their care plan.

Care plans were detailed and reflected people's wishes and preferences. The care plans were reviewed regularly.

Some people were not able to take part in the activities programme, these people were not always supported to maintain their interests and hobbies.

People and their relatives said they were able to raise complaints with staff and the manager.

Is the service well-led?

Requires Improvement

The service was not always well- led.

There was no registered manager in post.

The manager knew people well. People told us that the manager was approachable.

Systems were in place to gather feedback from people' staff and relatives to improve the service.

Checks and audits had been completed, these had not been effective in identifying some of the shortfalls found at this inspection

Brambling 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 provide a rating for the service under the Care Act 2014.

The inspection took place on 13 June 2017 and was unannounced. The Inspection team consisted of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We asked the provider to complete a Provider Information Return (PIR). This 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 reviewed the PIR and information we held about the service including previous inspection reports and notifications we had received. A notification is information about important events which the provider is required to tell us about by law.

Some people were unable to tell us about their experience of care at the service. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

We reviewed a range of records including care plans and risk assessments, medicine administration charts, staff records and audits.

We spoke with four people, four relatives, one health care professional, six staff, manager, operations director and quality and compliance manager for the provider.

The last inspection was carried out in September 2015. We made a recommendation about using dependency assessments to ensure staff are deployed effectively.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us that they felt safe living at the service. One person told us, "They look after us, yes I feel safe, they (staff) will help if anything happens."

At the last inspection in September 2015, we made a recommendation about the deployment of staff in the service. We had observed there were times when staff were busy and not able to give people enough time to support them safely. At this inspection, staff continued to be busy and people had to wait for the support they needed.

The manager told us that the agreed number of care staff during the day to meet people's needs was five. During the inspection there were four care staff on duty, this was because a member of staff had called in sick, and had not been replaced. The duty rota showed there had been a high level of sickness and the target of five care staff had not been achieved consistently. Staff told us that they tried to replace staff but this was rarely possible, they said they were used to working with four care staff.

On the morning of the inspection, two staff completed the medicines round and this meant only two care staff were providing support. There were four people who required two staff to assist them. There were periods of time when there were no staff available to support people when they needed it. People were at risk, especially on the first floor, of not receiving the support they needed. During the inspection we observed people asleep over their breakfast that had been left in front of them; they had not been given the support they needed to eat their meal. The manager, who was with us, had to help someone to the bathroom as there were no staff available.

We observed the lunch time meal; people had the choice to eat in the lounge, the 'royal' room or their bedrooms. People eating in the lounge were given their meals and left alone for 20 minutes until staff came into the room to bring the next course. Following the inspection the quality manager sent us an action plan of how the provider was going to address the shortfalls identified.

The provider had failed to deploy sufficient staff to meet people's needs. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were policies and procedures in place to make sure that people received their medicines safely. However, these were not always followed as people were not receiving their medicines consistently. When staff gave people their medicines this was not being recorded accurately and procedures were not being followed.

Some medicines had specific procedures which should be followed with regards to their storage, recording and administration. The administration of these medicines was not being recorded in line with current guidelines and best practice. The medicines needed to be recorded in a separate book and required two staff to administer and sign the book. On the day of the inspection, staff had not followed this procedure; only one member of staff had gone to the person with the medicine and signed the book. The book had not

been signed by two members of staff on six other occasions and on one occasions the staff had not entered the administration of the medicine in the book at all.

One person was prescribed Alendronic Acid 70mg which is medicine to strengthen bones. This had been signed as being given on 12/06/2017 but the tablet was still in the blister pack. Some medicines had not been administered as prescribed and remained in the blister pack, the member of staff had not recorded the reason why the medicine had not been given. Some staff had not signed the medicine administration record (MAR) sheet to confirm that medicines had been given, however, the medicines were not in blister packs so had been dispensed.

The manager had completed a medicines audit the day before the inspection and had identified some of these shortfalls and had put in place an action plan. We will follow this up at the next inspection.

The provider had failed to ensure the safe management of medicines. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed part of a medicines round, staff were patient and allowed people the time they needed to take their medicines. Staff were encouraging and prompted people to take their tablets. Some people were prescribed medicines on an 'as and when' such as pain relief. There were guidelines for staff to follow about when to give these medicines.
Risk assessments detailed potential risks and gave staff guidance on how to reduce risks to keep people safe. For example, there was individual guidance to support someone with a behaviour that may be challenging. There was guidance for staff about how to approach the person; what might trigger their behaviour and how to reduce the risk of this happening. There was additional guidance about how to manage a situation if the person was being verbally aggressive and how to calm the person down.

When people had difficulty moving around the service there was guidance for staff about what people could do independently. This included what level of support people needed and any equipment they needed, such as a walking frame, to help them stay as independent and safe as possible.

Risks to people's skin, such as development of pressure sores, had been assessed. When people were at risk of developing pressure sores special equipment, including mattresses and cushions, were used to help prevent this. This equipment was regularly checked to make sure it was set correctly and working properly.

Staff knew what to do if they suspected any incidents of abuse. The provider had systems in place, including policies and procedures, for staff to refer to. Staff told us that they had completed training about how to keep people safe. Staff told us they were confident that any concerns they raised would be listened to and fully investigated to ensure people were protected. The manager knew their responsibilities in reporting incidents in line with current guidance. The provider had provided staff with a confidential email address to report any concerns anonymously and key cards to give them guidance about their responsibilities.

Staff were aware of the whistle blowing policy and that they could take concerns to agencies outside the service if they felt they were not being dealt with properly.

Staff knew their responsibilities for reporting accidents, incidents and concerns. The quality manager monitored, reviewed and analysed accidents to identify any trends and what measures needed to be put in place to reduce the risk of them happening again.

Staff completed checks on the environment and equipment used by people to ensure they were safe such as

fire risk assessment and hoists. People had a personal emergency evacuation plan which set out their specific physical and communication needs, to ensure they could be safely evacuated from the service in an emergency.

Staff were recruited safely, checks were completed to make sure staff were honest, trustworthy and reliable to work with people. These checks included written references and a full employment history. Discussions held at interview were recorded and held on staff files. Disclosures and Barring Service (DBS) criminal records checks had been completed before staff began working at the service. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care services.

Requires Improvement

Is the service effective?

Our findings

People told us that they liked staff and they were able to do what they wanted. One person told us, "Yes, they always explain what they are going to do and ask us what we would like."

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 make 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 Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager understood their responsibilities in relation to DoLS. At the time of the inspection DoLS applications had been made as required.

People were supported and encouraged to make decisions about their day to day care. We observed that staff asked people what they would like to eat or drink and where they would like to spend their time. Staff sought people's consent before supporting them with their care. Care plans included mental capacity assessments for some decisions but not all the day to day decisions that people lacked capacity to make. Some people had bedrails on their beds to keep them safe. An assessment as to whether the person required bedrails had been completed; this included if they had capacity to consent to the bedrails. One person had been assessed as not having capacity to make the decision about having bed rails to prevent them for getting out of bed, there was no record that a best interests meeting had taken place, including family and health care professionals to decide if the use of bedrails was the least restrictive option to keep the person safe. The manager confirmed that a best interest meeting had not taken place.

During the inspection we found that when some people were not in their rooms the door had been locked. The manager told us this was because one person went into other people's rooms and took sweets. The people who lived in these rooms were not able to access their rooms without the support of staff, however, the manager had not consider if this was the least restrictive way of managing the situation for all the people concerned. There was no record of the decision to lock the doors or best interests meetings to decide that this was the least restrictive option.

Since the inspection the quality manager sent through an action plan address the shortfalls identified.

Staff told us that they received training appropriate to their role; however, some training required updating according to the provider's policy. There had not been a structured training programme or analysis of staff training until May 2017. A new e-learning programme had started for staff to complete and some face to face training had been arranged. Staff who needed to complete training had been identified and were being

supported to complete the training required as soon as possible. Staff were able to access policies and procedures including a care manual and dementia manual developed by the provider to give guidance on best practice.

We observed staff using equipment safely to support people. Staff responded to people living with dementia in accordance to best practice, to give them emotional support when they were upset or confused.

When staff started work at the service, they were supported to complete the Care Certificate; a competency based induction programme that ensured new members of staff had the skills and knowledge to support people with their needs. New members of staff shadowed more experienced members of staff when they first started work so they could get to know people and learn about their preferences and choices. Staff were given key cards to refer to; these cards give guidance to staff to help them make decisions and the standards of care they are expected to meet.

Staff had not received regular supervision from their manager. Some staff had not received supervision this year and other staff had attended three supervision meetings. Staff told us that they were not given a date for their supervision so had not had the opportunity to plan for their supervision to discuss their training and development needs and any areas for improvement. Staff told us they would discuss something informally with the manager and the discussion would be recorded as supervision.

The quality manager had identified that some staff were overdue supervision and annual appraisals. A system for team leaders to complete the supervision and appraisal of care staff had recently been introduced. However, the staff who were expected to provide supervision had received training for the role.

People told us that they enjoyed the food and had a choice of meals. One person told us, "They come round with a menu, they have a nice choice of puddings such as cheesecake and apple crumble."

People were encouraged to eat a balanced diet and were given a choice of healthy meals. The meals were designed to meet people's needs for example people who required a diabetic or pureed diet. The cook had up to date information about people's nutritional needs, choices and preferences. Meals were fortified with additional supplements such as double cream and butter to help people maintain a healthy weight. People had a choice of meals; staff asked people what they wanted on the day.

Staff monitored people's health and took appropriate action if they noticed any changes. For example, when people had lost weight they were referred to the dietician for additional supplements. People had access to specialist health professionals when they needed it. Staff worked closely with health professionals such as district nurses. The district nurse told us, "The staff always raise issues promptly, take my advice and follow the guidance given."

Requires Improvement

Is the service caring?

Our findings

People and relatives told us that staff were kind and caring. A relative told us, "Cannot do enough, I always feel (my relative) is treated with respect." One person told us, "When you press the bell the staff come fairly quickly." However, there were occasions when relatives and staff felt that staff were not able to perform their duties to the standard they would like as they were not enough staff available.

One relative told us, "Yes, they are caring, always very busy and not sure if there seems to be enough staff, always rushing." In the relative's survey, several relatives commented that they did not think there were enough staff on duty at the weekend. Staff told us that if there were only four staff on duty, it was difficult to provide the level care they would like.

During the inspection we observed that staff did not have the time to sit and talk with people. Some people spent their time in the main lounge or 'royal' room. People were left, by themselves in both rooms for periods of time. On one occasion, staff were not present for over half an hour. When staff did come into the room it was to check people were safe.

At lunch time one person became upset. Staff did not go to the person to speak to them and offer reassurance until they had finished serving the meals. Another person was sitting with their hand in their dinner, falling asleep, the member of staff did not call someone else to help but waited until the other person had settled and then helped the person with their meal which was cold.

During the activities in the afternoon, the music being played became very loud. Some people were not comfortable and put their hands over their ears. Staff saw this but did not offer to help them to leave the room or suggest that the music be turned down.

The provider had not ensured people were treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When staff were engaging with people on a one to one basis, they were kind and compassionate. When one person had become upset; staff supported them and offered reassurance so that the person felt safe. Staff were able to describe how they maintained people's dignity. We observed them close doors to people's rooms when giving care. We observed staff knock on people's bedroom doors before entering, and asking people for their consent before giving care. Staff spoke with people in a discreet way when offering them support, for example, assisting them to the bathroom.

Staff and relatives told us visitors were welcome at any time. During the inspection there were friends and relatives visiting. Staff had knowledge of people's needs, likes and dislikes. Staff spoke with people in a warm and friendly way as they went about their day.

People's rooms were personalised with their own belongings, so that they felt at home, people had photos of their loved ones up on the walls.

People had their end of life wishes recorded in their care plan. The GP and practice nurses had completed an advanced care plan for people so that staff knew what to do if people became unwell, for example whether to send them into hospital.

People's care plans and associated risk assessments were stored securely and locked away so that information was kept confidentially.

Requires Improvement

Is the service responsive?

Our findings

Relatives told us that they were kept informed of changes in their relative's care. One relative told us, "Well, we came in here for respite care for 16 days but they chatted away to us and the staff listened to us and our needs and I think that is why we are still here." Another relative commented, "They listen and keep us informed, no problems."

When people were thinking about moving to Brambling Lodge, the manager met with them and their relatives to complete an assessment, to check that staff would be able to meet their needs. The information from the assessment had been used to develop a care plan, to give staff the guidance they needed to support the person in the way they preferred. The care plans included a life story and information about people's family and people who are important to them.

Staff developed care plans which included details about people's communication, nutritional and mobility needs. For example, one person needed to be prompted to join in conversations, staff were guided to stand at eye level in front of the person and speak softly.

Each person's care plan, contained information about their health needs and risk assessments were in place and applicable for each person. Records were regularly reviewed and updated. When people's health declined or their needs changed the care plans and risk assessments were amended to make sure staff had up to date guidance on how to provide the right care. However, there was no evidence that people had been involved in the development of or reviewing their care plan. Relatives told us that they were kept informed of any changes to the care their relative received but were not aware of the contents of the care plan.

Staff communicated well and held a handover each shift to make sure they were up to date with any changes to people's needs. Staff told us they were informed of any changes quickly.

People were not consistently supported to follow their interests and take part in social activities. An activities co-ordinator worked at the service each afternoon. They organised for outside activities and entertainers to come to the service, these included musicians and chair exercise The activities co-ordinator spent time with people in the afternoon to complete activities including painting and reminiscence. People who required minimal support from staff maintained their own interests, we observed people knitting and reading and staff brought in a newspaper and magazines for people. Following the inspection the provider told us that they belonged to National Activity Providers Association (NAPA). NAPA is an organisation that provides information and advice on meaningful activities for older people.

During the morning of the inspection, people who needed support with activities were not supported by staff. Staff passed through the lounge and quiet room but did not engage with people, or spend time supporting them with any activity. People were left without activities to stimulate them. Other people stayed in their rooms, we observed that they had little or no stimulation from staff.

People and relatives told us that they had no complaints or concerns about the service, and knew how to

complain if they needed to. One relative told us, "We would say if we were not happy." Another told us, "They are always open and happy to chat with us, all of them really." However, in the resident survey completed in March 2017, three people said they did not feel they were listened to. The quality manager had developed an action plan to address this, by speaking to people individually about their concerns.

The provider had a complaints policy and procedure, which was displayed in the service. There had been no complaints in the last year. The manager told us that they would investigate any complaints and share the outcomes with staff as a learning opportunity.

Requires Improvement

Is the service well-led?

Our findings

People and relatives told us that they thought the manager was approachable and they were able to talk to them.

There was no registered manager at the service; the previous registered manager had left the service in July 2016. The current manager had started working at the service in November 2016 and had just started the process of applying to be the registered manager with the Care Quality Commission.

People, staff and relatives told us that the manager had taken time to settle into the role and get to know people. One relative told us, "I think it is getting better, it does take a while to get used to new people." The manager told us that they had been supported by the provider while they settled into the role. The manager had managed other services before but said they had not been as big as Brambling Lodge and they had taken time to adjust.

People knew the manager. The manager spoke to people during the inspection, and there was a warm relationship. The manager knew people well and the care that they needed. The manager supported people during the inspection to go to the bathroom and find their way around the building.

Staff said the manager had needed time to get to know people, staff and the service. Staff told us that they had not always felt supported by the manager, especially, when the manager first started but this was starting to improve. Staff told us that they worked as a team and felt that the manager was now starting to lead the team. They felt they were able to take any concerns to the manager and these would be dealt with appropriately. The manager had not completed regular supervisions with the staff, they told us that this was a priority and a schedule was being developed.

Staff were aware of their roles and responsibilities. The staff had worked as a team for a long time and had a clear vision of the person being at the centre of everything they do. However, they felt that the lack of staff meant that they were not always doing this and people were not always getting the support they needed.

People, relatives and staff had been asked their views and experiences of using the service. Surveys had been sent out in March and April 2017. The responses had been reviewed and a summary written. There was a "You Said, We Did" response to the survey included; however, an action plan had only been completed to address the feedback from people. The response from the staff survey had included three negative responses, these had not been included in the feedback and analysis as no reason or name had been given so that concerns could be addressed. There was no action plan in place to approach staff to investigate why some felt that they had to give an anonymous response when they had given negative feedback.

Regular audits and checks were carried out in order to ensure the safety and quality of the service by the manager. These included infection control, health and safety, medicines, staff training and care planning. The quality manager reviewed the audits and developed an action plan for any shortfalls identified. The provider carried out monthly audits of the service. The audits had not identified all the shortfalls found at

this inspection for example, documentation of any best interests' decision. Records of medicines being administered were not all accurate.

The provider had failed to use feedback from staff and relatives to improve the service. Audits had not been effective in identifying some shortfalls within the service. Records were not always accurate and complete. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

There were regular staff meetings where staff were able to express their views and make suggestions. Resident and family meetings were held regularly. The last meeting in March 2017 had included a dementia awareness session for relatives, one relative commented that they found the session helpful with their understanding of dementia. One relative told us, "Yes, they do ask for suggestions and they have meetings, not sure how much happens afterwards." The manager attended management meetings organised by the provider to share information.

At the monthly staff meetings an employee of the month was announced, this recognised members of staff who had 'gone the extra mile' in their role. The provider recognised the long service of staff with a gift and certificate after 10 years. Staff also had access to a 'Perk box' a reward scheme that enabled them to take advantage of special offers at shops and cafes.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. CQC checks that appropriate action had been taken. The manager was aware of this and reported events appropriately.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure the safe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to use feedback from staff and relatives to improve the service. Audits had not been effective in identifying some shortfalls within the service. Records were not always accurate and complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to deploy sufficient staff to meet people's needs.