Dibcan Limited

Witnesham Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 26 July and 16 August, 2016. The first visit was unannounced.

Witnesham Nursing Home provides care and support for up to 30 people. On the day of our inspection there were 29 people living in the service.

There was a registered manager in 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 2008 and associated Regulations about how the service is run.

The service was not safe. Inadequate assessment of people's needs and inadequate risk assessments meant that people were risk of harm or receiving care and support which did not meet their needs.

People did not always receive personalised care that met their needs. Care plans were muddled and did not always show how people's preferences as to how they received their care and support were met.

Medicines were stored safely. However, where people were prescribed their medicines on an as required basis there were no protocols in place to ensure this was given correctly.

The environment required updating and was cluttered with a lack of space for essential equipment to be stored. This meant that it presented a trip hazard and also increased risks when providing some aspects of people's care. The design and decoration of the service did not always recognise people's needs, for example those living with dementia. Plans in place by the provider to improve the environment were superficial and did not show a drive to improve the service.

Staff did not always receive the training they required to provide an effective service particularly with regard to specialist equipment such as hoists. Staff training was not monitored effectively to ensure that all staff were up to date with training.

People received adequate nutrition to meet their needs. However, due to the cluttered nature of the service the dining was not an enjoyable and social experience.

Activities and outings were organised by the service and a group of relatives. The service had recently employed an activities co-ordinator who was working towards ensuring that activities provided were appropriate to the individual and reflected their expressed preferences.

The management of the served was not pro-active in identifying problems. There was significant scope to improve care practices within the service and improve people's daily experiences
Staff were recruited in a manner which ensured they were suitable to work in this type of environment.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risk assessments were not effective and did not put in place procedures to mitigate the risk to people of receiving care and support.

There were no protocols in place to ensure people received medicines prescribed 'as required' in a consistent manner.

There were sufficient numbers of staff to meet people's needs. Safe recruitment practices were followed.

Staff were aware of the processes involved in safeguarding vulnerable adults from harm.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff were not trained to provide effective care and support.

People had their individual food and nutrition requirements met. However, the dining experience was not an enjoyable and social experience.

The environment was cluttered and the garden was not easily accessible and safely accessible to those living in the service.

The service acted in line with current legislation and guidance when people lacked the mental capacity to consent to aspects of their care.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Care staff were not supported by systems and processes in place to provide compassionate care which respected people's choices.

People were involved in decisions related to daily living.

People's privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans were not person centred and did not always address the needs of the individual.

People were involved in their care planning.

People were encouraged and supported to maintain relationships with people who were important to them.

Is the service well-led?

Inadequate

The service was not well-led.

Quality assurance processes were not effective and did not demonstrate a drive for improvement.

Shortfalls were not always identified and where they were action plans did not demonstrate an understanding of the risk and timely measures for improvement.

Witnesham Nursing Home

Detailed findings

Background to this inspection

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

The first inspection visit took place on 26 July 2016 and was unannounced. Following receipt of concerning information a further visit was carried out on 16 July 2016. The inspection was carried out by 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. Our expert had experience of dementia care.

Before the inspection, the provider completed 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 information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about and information that had been sent to us by other agencies. We also contacted health care professionals such as the GP and social workers regarding their views of the service provided.

During our inspection we spoke with seven people who lived at the service, five relatives, four members of care staff and the registered manager.

We carried out informal observations of care in the service. We looked at eight people's care plan records and other records related to the running of, and the quality of the service. Records viewed included staff files and audit reports.

Inadequate

Is the service safe?

Our findings

The assessment of risks to people from receiving care was inadequate. Where completed, risk assessments were difficult to follow and did not always effectively assess and put in place actions to mitigate risks.

We had received information that a person had been injured whilst staff were supporting them using a piece of moving and handling equipment. Records did not demonstrate that the person had been assessed for their suitability to use the equipment staff were supporting them with. The risk assessment was unclear as to how many care staff were required to support the person whilst using the equipment. In some places it referred to two staff and in other places to three staff. The use of this equipment by this person had not been assessed correctly, neither had all possible action been taken to mitigate risk and distress whilst using the equipment.

We looked at the risk assessments relating to moving and handling for four other people using this type of equipment. None were completed to a standard which demonstrated the risk to people had been adequately assessed and actions put in place to effectively mitigate the risk. For example one contained contradictory information regarding the size of sling the person required. This putt the person at risk of injury from using incorrectly fitted equipment. Another stated the person was at risk of exhibiting, 'Unpredictable behaviour whilst being hoisted'. The risk assessment did not state how staff should support the person with their distress or if it was safe to hoist at all.

Where people had been assessed as being at risk, actions were not always put in place to mitigate that risk. For example, the initial assessment prior to moving into the service for one person stated they had previously had a choking episode. There was no risk assessment in the care plan which put in place actions and guidance for staff to mitigate the risk of choking or what to do if it occurred. Risk assessments in care plans did not effectively assess the risk to the person relating to the use of bed rails. Neither did they consider if this was the least restrictive option to support people safely. We discussed the risks with the registered manager who told us that they had received a new type of risk assessment for the use of bedrails but this had not yet been fully implemented.

The service did not have effective protocols in place for the administration of medicine prescribed 'as required' (PRN). For example one person was prescribed a medicine to be given 'for agitation'. There was no care plan in place to describe what behaviours the person exhibited to indicate 'agitation', at what point the medicine should be considered, or any strategies that should be used before administering the medicine. This could lead to the medicine being given inconsistently by different staff. Another person was prescribed a PRN medicines relating to their continence. There was no care plan stating how long the person should go without a bowel movement before the administration of this medicine. Staff spoken with did not demonstrate knowledge of when a particular PRN medicine should be administered. This meant that there was a risk that this medicine could be administered when not required or alternatively not administered when it was required.

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

2014 (Safe care and treatment.)

People told us there were sufficient staff to meet their needs. One person's relative said, "The amount of staff on during the day is very good, I think there's adequate staff at night." The registered manager told us that the number of staff required was assessed to reflect the needs of the people using the service and that they were increased if people's needs increased. However, we did note that some parts of people's individual risk assessment fed into the assessment for the number of staff. We identified with the registered manager that in some cases part of the risk assessment had been rated as zero when it required a higher rating. Zero being low risk. This could mean that the assessed staffing levels were lower than those required.

People told us they were satisfied with the way their medicines were managed. One person said, "They'll always come and find me with my pills, I always get it." People were protected by safe systems for the storage, and recording of medicines. Medicines were kept securely in a locked trolley in a locked room. Medicines entering the service from the pharmacy were recorded when received and when administered or refused. This gave a clear audit trail and enabled staff to know what medicines were on the premises. We observed staff administer medicines safely by checking each person's medicine with their individual records, which contained a photograph of the person, before administration. This ensured the right person got the right medicine.

People told us they felt safe living in the service. One person said, "I feel reassured, the staff are nice people." We discussed safeguarding vulnerable adults from abuse with the registered manager and three members of care staff. We found that staff understood their role in safeguarding people from harm. They were able to describe the different types of abuse and actions they would take if they became aware of any incidents. All staff spoken with said they would not hesitate to report any concerns to the registered manager and / or the local authority. Staff said they received safeguarding training and records we saw confirmed this. Staff had access to internal policies and procedures on safeguarding vulnerable adults.

The registered manager had made notifications to CQC regarding safeguarding incidents. However, we are aware of a recent incident where a notification was not made. This caused us concern that we had not been made aware of other incidents. Notification of safeguarding concerns and other incidents allows CQC to monitor that the service is dealing appropriately with these issues.

The risks to people were reduced because there were effective recruitment and selection processes for new staff. The registered manager described their recruitment procedure which included seeking references from previous employers and carrying out disclosure and barring service (DBS) checks. Staff confirmed that checks had been undertaken before they started work. The DBS checks a person's criminal history and their suitability to work with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

People told us they believed staff had the knowledge and skills to carry out their role and responsibilities. A relative told us, "I'm quite surprised by the (level of) training, someone comes in from outside and they all sit in the dining room training. I feel reassured they know what they're doing." However, training records did not demonstrate that staff training was up to date. For example, we checked the training dates of two members of staff. Records did not demonstrate that their training in moving and handling was up to date to ensure people were provided with safe and effective care. We spoke with the manager who said they would book refresher training for those out of date.

Staff did not always receive appropriate training for specialist equipment which put people at risk of harm. We asked staff what training they had received to use a sling purchased by the service to meet the needs of one person. We were concerned that the sling had not been used correctly resulting in injury to the person. The registered manager told us that staff received yearly moving and handling training and the registered nurse told us that the supplier had demonstrated use of the sling when it was delivered. This did not demonstrate effective training for the use of specialist equipment.

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

People's individual needs were not met by the design and decoration of the service. The service was cluttered with a lack of storage for essential equipment such as hoists. Several hoists were stored in the dining area. Parts of the hoists were sticking out into the walkways causing a trip hazard. The signage and decoration of the service did not help to meet people's needs and promote their independence particularly those living with dementia. The amount of furniture in close proximity made it difficult for staff when assisting people with the hoist as they had to move furniture, such as chairs to make room.

During both of our visits we observed that there were four televisions located in the adjoining communal areas. They were on for the duration of both of our visits. During one visit they were on with the sound turned down, therefore no one would be able to watch and hear the television programme on at the time. During the second visit the volume was turned up on all of the televisions, which were on different channels but we saw that nobody was watching them. This did not support people to spend social time together and could have been distracting and confusing for those living with dementia. We did not see any staff ask people if they wanted the televisions on, or which channel they wanted to watch.

The service had a large garden on two levels. One person said, "I like the garden, I planted all these [planters] out." People told us they enjoyed going out into the garden and we observed people sitting on the concrete terrace during our inspection. However, this was quite narrow in places making access difficult. There was a large lawned area at a lower level; however, this was only accessible down a steep slope and through the car parking area. There was rubbish stored under the fire escape which led into the garden and window blinds were encrusted with dirt. There were only a small number of chairs on the grassed area. It did not appear to be well used. The service had three Deprivation of Liberty Safeguard (DoLS) authorisations in

place where people were not able to go out on their own. The garden area was not secure and therefore not suitable for their use unsupervised. There had been an incident in the service where a person subject to a DoLS had left the service. Giving people access to this large lawned area would enhance the enjoyment that people, both those subject to a DoLS and others, obviously derived from being outside.

This was a breach of Regulation 15 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Premises and Equipment).

People were supported to have sufficient to eat and drink and to maintain a healthy diet. People's nutritional needs were assessed and staff were knowledgeable about each person's dietary needs and preferences. One relative told us, "They do a low sugar diet, sugar free rice pudding and custard."

Opportunities were missed to ensure the mealtime experience was a positive experience. For example encouraging social interaction and encouraging people to movement during the day from the lounge to the dining room. We observed the lunch time dining experience. People remained in the chairs they had been sitting in during the morning. There were three dining tables and chairs that could accommodate people to eat their meal at a dining table but these had not been laid for the meal. One person was observed to place their plate partly on their lap to make eating their lunch easier. Some people's tables in front of their chairs remained cluttered with books and belongings during their meal making it difficult to place their plate comfortably.

Some people were supported to eat at their own pace and in a dignified, respectful and compassionate way. However, we observed one member of staff supporting two people with their meal which appeared to be usual practice. This meant one person was kept waiting for their food which was left standing for several minutes. Whilst supporting one of the people the member of staff did not initially speak with the person and was mashing their food with a fork. They asked the person if this was acceptable only after placing it into the person's mouth. This did not make the meal time experience an enjoyable experience.

Meals were served from a trolley in a small area off one of the main rooms. Serving of meals was very fragmented and slow. One meal was left covered, next to the person before staff came to support them to eat, so was not as hot as served. We observed that some people became anxious when waiting for their food.

We discussed the meal time experience with the registered manager who told us that people did not wish to sit at the dining table for their meal. However, we did not see any staff asking people for their preferences of where they wanted to eat, which could change each day. We also did not see any confirmation of this in people's care plans and this was not supported by our observations of people struggling to eat their meal comfortably. The tables in dining area were not laid for a meal to encourage people to enjoy mealtimes as a sociable experience.

We recommend that the service seeks advice from a reputable source on making meal times a dignified and enjoyable experience.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The service had made appropriate applications under the DoLS procedure and the registered manager had systems in place to monitor these. However, we were concerned that an incident report concerned one person, the subject of a DoLS, who had managed to leave the service and was found in the street. During our inspection we saw that the rear of the premises was not secure. We discussed this with the registered manager who said they had reviewed the incident and discussed it with staff. Following these discussions they were now confident that staff knew this person was not able to leave and would stop them if necessary. People told us they were supported to make choices related to the activities of daily living. For example, one person said, "Oh yes, they staff] ask me what I want."

Care staff also told us that they were supported to obtain nationally recognised qualifications relevant to their role. Newly appointed care staff completed an induction programme and worked alongside more experienced care staff. During their induction, care staff completed a range of mandatory and service specific training.
Nursing staff, who had been recruited from abroad, were supported by the registered manager to register with the appropriate professional body in the United Kingdom. The registered manager was aware of national systems in place to check nurse competency and was putting systems in place to ensure requirements were met.

Staff received regular supervision and told us they felt supported by the registered manager. The supervision sessions enabled staff to discuss their performance and provided an opportunity to plan their training and development needs. Staff told us they found the sessions constructive and that any suggestions they made were acted upon. One member of staff gave us an example of a suggestion they had made that had been adopted by the service.

People's health needs were met and where they required the support of healthcare professionals, this was provided. One relative told us, "The GP calls every Friday." Another relative said, "A practice nurse or doctor come in on a Friday and they see [person] if the nurse wants them to be seen."

The registered manager told us that they had positive relationships with health professionals, including the GP. They said that if an issue arose, they always felt supported by the health professionals in ensuring that people were provided with the health care support they required. Feedbacks from health professionals who visited the service told us that they had a good working relationship with the service that sought and acted on advice where needed to make sure that people were provided with the right care to be healthy. Records showed that people were supported to maintain good health, have access to healthcare services and receive on going healthcare support.

Requires Improvement

Is the service caring?

Our findings

People told us that they were treated with kindness and compassion in their day to day care. One person said, "They're all very good, there's not a bad one amongst them, a great attitude, they'll do anything for me. Another relative said, "They're all good, I think [staff member] is their key worker."
Staff were compassionate and caring. However, systems did not support staff to meet people's preferences. We are aware of a situation where a person's preferences were not met and this had caused them distress. Staff had been unable to take practical action to address this because the systems in place in the service did not allow them to do so.

The environment did not support people to be independent. It was cluttered with pathways not always clear. The major part of the garden was not easily accessible to the majority of people restricting their choice. The service dining area did not encourage people to sit at a dining table for their meals. This would have encouraged movement and independence.

People's care files were kept in locked cabinets which ensured that information about people was not easily accessible to those who were not entitled to view it. We did note that some phrases used in the care plans were not respectful. For example one care plan referred to 'toileting'. We discussed this with the registered manager who told us that they believed this may have arisen as English was not the first language for all care staff. They told us that they would address this issue.

The registered manager told us that each person had a 'keyworker' who was responsible for getting to know the person and their preferences in more detail than other care staff. A relative said, "They'll make birthdays a special occasion, they'll have pizzas and put party food together." The service also had a 'Resident of the Day' where care staff, the cook, domestic staff, and the maintenance person spoke with the person. This helped ensure people felt they mattered and were able to express their views.

Staff involved people in decisions related to the activities of daily living. For example one relative told us, "Staff will ask, 'Shall we help you to get up now?' ask what [person] wants to wear, they give them lots of time and it's all done with humour."

There was a relaxed and friendly atmosphere in the service. Staff communicated with people in a caring and respectful manner. They communicated in an effective way by making eye contact with people and listening to what people said. People responded in a positive way to staff by smiling and talking with them. Staff talked about people in a caring and respectful way. They knew people well and understood people's specific needs, and how they were met.

Staff responded promptly to people's needs. One relative told us, "They [relative] had broken their watch strap last week, someone's mended it for them"

When asked about their involvement in their care planning one person said, "If I feel I need to, I'm aware that there is a care plan and I'm quite happy with how the care is carried out." A relative said, "Their care plan,

yes they ask me to come and discuss it about once a year."

One person's relative told us that they were always kept informed about any changes in the person's condition and that if they required changes in their support this was discussed and agreed with them. Records showed that people and their relatives, where appropriate, had been involved in planning their care and support. This included their likes and dislikes, preferences about how they wanted to be supported and cared for. People's bedrooms were personalised reflecting their choice and individuality.

People told us that staff respected their privacy and dignity and treated them respect. A relative said, "They [staff] treat all the residents with respect, I've seen them kneel down and took to [person], [staff member] has a laugh with them, a big bug and a kiss, it all sounds too good to be true." They also said, "They cover them up when they use the hoist. The curtains are always drawn and their body covered up when washing. I feel quite part of the care team actually, it's quite nice."

Requires Improvement

Is the service responsive?

Our findings

Care plans were not person centred and did not always reflect the person as an individual. The service was in the process of developing care plans to address this issue but it was not complete. As a result the amount of information about people's history and background varied greatly between care plans. Information was fragmented and in different formats. For example some care plans had photographs of people's hands and an explanation of what people had done with their hands in their life time. However, this was not related to other personal background information in the care plan. This made it difficult to get a full picture of a person's history. Information about a person's history supports care staff to provide person centred care. We noted that people were being involved in this area of improvement. One relative said, "They are going through me to learn about [person], they're very good."

The registered manager told us they had a good relationship with local hospitals and visited people before they were discharged to carry out an assessment to ensure that the service could meet their needs. However, one person returned to the service before a full assessment of their needs had been carried out and this had resulted in an injury. We discussed this with the registered manager who said that on this occasion they had felt under pressure to accept the person into the service and as the person was returning to the service they had not carried out as thorough assessment of the person's needs as they usually would have done. Without an assessment the service could not be assured that they had systems in place to meet the person's specific needs which may have significantly changed.

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

Despite the improvements needed in care planning, people told us that their care plans reflected their needs and preferences. One relative told us, "I asked for a female carer to be present, [person] was getting a bit confused over male carers, and they do." One person said, "I'd rather be doing something, they involve me in things because they know I enjoy it." Another person told us, "They promote us sitting together, if they see people not getting on they'll change people's seats. They say [person] what's your view on things, is there anything I can do."

The service had recently employed a person to carry out activities. They were enthusiastic and explained to us plans they had to develop activities which reflected people's individual interests. They had attended a course to develop their knowledge of the provision of activities in care homes and told us how they intended to develop activities to meet people's individual needs. However, this had not yet developed far enough to demonstrate how people were involved in daily activities to give them purpose and form to their day. A shopping trolley had been introduced recently which was taken around the service so that people could buy small items they may need such as toiletries. The activities coordinator explained how this supported and gave opportunities for people to remain independent. There was an activities planner on display providing details of activities and events planned for the week. These included board games, exercises, a ball game and bingo. An outing was also advertised. The service was supported to provide activities and outings by a group of relatives collectively called 'Friends of Witnesham'. The registered manger told us how

this group supported the service and arranged regular outings to local places of interests. This prevented people becoming socially isolated.

We saw that people were supported to maintain meaningful contacts with people who were important to them. During our inspection that there was a regular flow of visitors both friends and relatives to people living in the service. Some people were going out with their relatives and others were sitting and talking in the communal areas.

During our inspection we observed that the registered manager was approached regularly by people and their relatives with day to day queries or issue of greater concern. One person said, "If you're ever worried about anything you just speak to matron and she'll see it's sorted out." A relative said, "Matron is very good, I've always felt able to express any concerns."

The service had a complaints procedure which was displayed in the reception area. However, some parts of this were out of date referring people who wished to take a complaint further to the CQC to make a complaint. This is no longer correct. People told us they knew how to make a complaint and would do so if they felt it was necessary. We were unable to test the effectiveness of the way in which the service used these to improve the service because there had been no complaints.

Inadequate

Is the service well-led?

Our findings

The provider had not ensured that they had robust systems to continuously assess, monitor and improve the quality and safety of the services provided including the quality of the experience of people. This linked to the assessment, monitoring and mitigation of the risks relating to the health, safety and welfare of people in their care.

Legal obligations to notify CQC of information were not being met. For example a recent safeguarding had not been notified to the CQC and a statutory notification had not been made promptly with the full information required. We are also aware of another incident which was not notified to us as required. Statutory notifications allow us to assess if the service had taken appropriate action to support people following an incident.

The provider sent us an audit of the service they had carried out in May 2016. This had failed to identify the issues with both the external and internal the environment noted previously in this report. On our second visit some of the issues with the environment, and which we had fed back to the registered manager on the first day, had been addressed. These had not been identified independently by the service prior to our inspection and demonstrated leadership which was re-active rather than pro-active. An action plan to improve the service showed cosmetic improvements such as re-painting and a new carpet. It did not demonstrate that the service was using this opportunity to improve the service to meet the needs of people. For example, decorating the service to better meet the needs of people living with dementia or to improve the dining experience.

The management team did not demonstrate an understanding of good quality assurance processes leading to a lack of any overall drive for improvement. For example, the provider sent us an audit of the service they had carried out in May 2016. This had identified that care plans were, 'Not easy to navigate' and 'full overhaul of care plans to be commenced in September 2016'. The time scale for improvement did not demonstrate an understanding of the potential ongoing risks of poor quality care planning or a drive for improvement. There was no planning for how risks could be reduced in the interim whilst improvements were being made. Additionally, the registered manager showed us a spread sheet of how they monitored staff training. A sample of staff records identified two staff were not up to date with their training. The service audit process had not identified this. Audits by the provider and registered manager had not identified the problems with risk assessments also highlighted in this report. Risk assessments in care plans were generic and not always tailored to the needs of the individual. This had led to an incident in the service where a person had suffered harm. This incident was described by a health care professional as, 'an accident waiting to happen'.

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

People and relatives were able to express their views about the service. We saw, on both days of our inspection, that the registered manager was available to visitors to discuss any concerns. We saw that

visitors felt able to approach them freely. Formal quality assurance surveys were also carried out and the results analysed. Feedback from these surveys had resulted in improvements to the service laundry and a review of menus.

Whilst comments from people using the service, their relatives and others were positive about the service we found that generally expectations were not high and there was significant scope for the service to provide a higher quality of care. There was a need develop a culture and focus in the service to benefit from the positive relationships and support it received from the local community

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments were not effective, any assessed risk was not mitigated. PRN protocols were not adequate.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had not been established and operated effectively to enquire compliance with regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive appropriate training.