Havering Care Homes Limited

Abbcross Nursing Home

Inspection report

251 Brentwood Road
Romford
Essex.
RM1 2RL
Tel: Tel: 01708 438343
Website: www.haveringcare.co.uk

Date of inspection visit: 3 & 10 December 2014
Date of publication: 17/04/2015

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**

Overall summary

This unannounced inspection took place over two days on 3 and 10 December 2014.

Abbcross is a purpose built 28 bed care home providing accommodation and nursing care for older people, including people living with dementia. The service is accessible throughout for people with mobility difficulties and has specialist equipment to support those that need it. For example, hoists and adapted baths are available. 23 people were using the service when we visited.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

During this inspection, we found that the arrangements for managing medicines were not safe. Staff did not have information to enable them to make decisions about

Summary of findings

when to give certain medicines. People were therefore placed at risk of not receiving these medicines safely. Medicines were not robustly monitored or audited to ensure that they were being appropriately administered.

Staff had not received sufficient training to provide a safe and appropriate service that met people's needs.

Staff supported people to make some choices about their care but did not have a good working knowledge of the Mental Capacity Act 2005 or the Deprivation of Liberty Safeguards. They were therefore unable to put this effectively into practice to ensure that people's human and legal rights were respected.

Although care plans contained information about people's needs and wishes they were not comprehensive. They did not contain specific or sufficient detail to enable staff to provide personalised care and support in line with the person's wishes.

The provider had systems in place to monitor the service and to obtain people's feedback. However issues identified as part of this were not addressed in a timely way. This placed people at risk of receiving a service that was not responsive or effective.

People told us they felt safe at Abbcross and that they were supported by kind, caring staff who supported them and treated them with respect. One person said, "Splendid place if you need it. Everything's perfect." However our findings were contrary to this as outlined above. Relatives felt welcome when they visited and told us that Abbcross had a 'nice atmosphere.

We saw that staff supported people patiently and with care and encouraged them to do things for themselves. Staff knew people's likes, dislikes and needs and provided care in a respectful way.

People said that they were happy with the activities offered. We saw that people were encouraged to participate in activities of their choice.

People lived in a clean, safe environment that was suitable for their needs.

People told us that the food was good and that they had a choice of food and drinks. We saw that their nutritional needs were met. If there were concerns about their eating, drinking or weight this was discussed with the GP and support and advice was received from the relevant healthcare professional.

People were happy to talk to the manager and to raise any concerns that arose.

You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Not all aspects of the care provided were safe. People were placed at risk because the system for administering and recording medicines was not robust. Medicines records were not accurately or consistently kept and guidance was not available to staff to ensure that people received their medicines safely.

People's care and treatment did not reflect relevant research and guidance. It was not always planned and delivered in a way that was intended to ensure people's safety and welfare.

Staff were trained to identify and report any concerns about abuse and neglect and knew how to respond to emergencies to keep people safe.

The premises and equipment were appropriately maintained to ensure that it was safe and ready for use when needed.

Requires Improvement

Is the service effective?

Not all aspects of the care provided were effective. Staff did not have a good working knowledge of the Mental Capacity Act 2005 or the Deprivation of Liberty Safeguards. They were therefore unable to put this into practice effectively to ensure that people's human and legal rights were respected.

The staff team had not received all of the training they needed to ensure that they supported people safely and competently.

People told us that they were happy with the food and drink provided. They were supported by staff to eat and drink sufficient amounts to meet their needs.

People's healthcare needs were identified and monitored. Action was taken to ensure that they received the healthcare that they needed to enable them to remain as well as possible.

Requires Improvement

Is the service caring?

The service was caring. People told us that the staff team were kind, caring and respectful. We observed that staff supported people in a kind and gentle manner and responded to them in a friendly way.

At the end of their life people, and their relatives, were supported with kindness and compassion. A relative had written, "Thank you for all you did each day in caring for our [relative]. The peace, rest and tranquillity you provided for their last year of life was remarkable."

Good

Summary of findings

Is the service responsive?

Not all aspects of the care provided were responsive. People's care plans did not contain sufficient or detailed information to enable staff to provide a personalised or consistent service.

The service had a complaints procedure and action had been taken to address concerns and complaints.

People were encouraged and supported to take part in a range of activities and to maintain their interests and links with the community. They told us that they were happy with the activities that were on offer.

Requires Improvement

Is the service well-led?

Some aspects of the service were not well led. People's views were sought by the provider and quarterly quality audits carried out. However, identified shortfalls were not addressed in a timely manner by the manager.

The registered manager did not robustly monitor the quality of the service provided to ensure that people had received a safe and effective service.

People, relatives and staff said the registered manager was approachable and available to speak with if they had any concerns.

Requires Improvement

Abbcross 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.

This inspection took place on 3 and 10 December 2014 and was unannounced on 3 December.

The inspection team consisted of an 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 service.

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 contacted the commissioners of the service to obtain their views about the care provided in the home and we reviewed the information we held about the home.

We last inspected this service on 12 November 2013 under the old methodology and we found it to be compliant at that time.

We spent time observing care and support in the communal areas, lounges and dining rooms.

We spoke with people who used the service, relatives and staff. Overall we spoke with five people who used the service and four relatives. We also spoke with the manager, provider, operations director, chef, handyperson, activities coordinator, one nurse and five carers. We looked at four people's care records and other records relating to the management of the home. This included four sets of recruitment records, duty rosters, accident and incident records, complaints, health & safety and maintenance records, quality monitoring records and medicine records.

Requires Improvement

Is the service safe?

Our findings

Not all aspects of the care provided were safe. At this inspection we looked at the medicines records for five people. We also looked at medicines storage, stock levels, medicines administration and medicines monitoring. Medicines were administered by qualified nurses. We found that there was no guidance for staff about the administration of medicines which were prescribed on an 'as required' basis. There was no information about the circumstances under which these should be administered or the gap required between doses. There was no information to enable staff to make decisions as to when to give these medicines to ensure people received these when they needed them and in way which was safe. People were therefore placed at risk of not receiving these medicines safely.

Medicines were securely and safely stored in two medication trolleys with controlled drugs stored in a separate controlled drugs cupboard. The trolleys were kept locked and attached to the wall to ensure they could not be moved or opened by unauthorised persons. Only senior staff had access to the medicines keys.

We looked at the storage, recording, administration and recording of controlled drugs. We found that these were stored safely and a controlled drugs record was kept. We checked the amounts of controlled drugs held against the register. This was correct for one drug. However, for another drug, diamorphine, the record had not been correctly completed. This had been signed by two members of staff on 11 November 2014 and had not been checked since that date. Therefore the service did not have an accurate record of controlled drugs held on the premises.

For other medicines we saw that the medicines administration records (MARS) included the name of the person receiving the medicine, the type of medicine and dosage, as well as the date and time of administration and the signature of the staff who administered it. However the MARS were not always appropriately completed as the administration coding's were not used consistently. For example, when people were not given 'as required' medication some staff recorded 'w' meaning withheld, others recorded 'r' meaning refused or not required. This meant that there was not an accurate record of why people had not had their medication and therefore would not provide the necessary information to assess the ongoing need for the medicine to be prescribed.

We found that the registered person had not protected people against the risks associated with the unsafe use and management of medicines. Systems were not in place to ensure that they safely received all of their medicines when they needed them. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (f) & (g)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 this report.

We looked at the records for people with nasogastric tubes and found that nurses recorded what had been administered via the tube. However, there was not a consistent record that the necessary safety checks had been carried out before they started this process. The service did not have guidance or protocols available describing how and when the tubes should be inserted and the on-going care and checks required. In some instances we saw that the results from the tests were not always within the safe range but fluids had still been passed through the tube. This placed people at risk as checks must be made before anything is passed through the tube to ensure that the tube is in the correct position i.e.in the person's stomach and not their lungs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 (3) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they felt safe living at Abbcross. One person said, "Splendid place if you need it. Everything's perfect." A visitor told us that they felt their relative was safe there. We saw that staff were kind and caring and did not rush people to complete tasks. When staff were using the hoist to transfer people from a chair to a wheelchair we saw that they were careful and spoke to the person to reassure them.

Staff were aware of the safeguarding policies in place in order to protect people from abuse and were aware of different types of abuse. They knew what to do if they suspected or saw any signs of abuse or neglect. They were also aware of the whistleblowing policy and what this

Requires Improvement

Is the service safe?

meant. Our records showed that the provider had told us about any safeguarding incidents and had taken appropriate action to make sure people who used the service were protected from abuse.

The provider had appropriate systems in place in the event of an emergency. Staff were aware of the evacuation process and the procedure to follow in an emergency. They told us they had received fire safety training and knew how to check the equipment. Systems were in place to keep people as safe as possible in the event of an emergency arising.

People were cared for in a safe environment. Equipment such as hoists, slings, mobility aids and pressure relieving aids were available. Records showed that equipment was serviced and checked in line with the manufacturer's guidance to ensure that they were safe to use. Gas, electric and water services were also maintained and checked to ensure that they were functioning appropriately and were safe to use. The records also confirmed that the maintenance person carried out weekly checks on alarms, call points, hot water temperatures and pressure relieving mattresses, to ensure that they were safe to use and in good working order.

The provider had a sufficient recruitment process in place to ensure that staff were suitable to work with vulnerable adults. This included prospective staff completing an application form and attending an interview. We looked at three staff files and found that the necessary checks had been carried out before staff began to work with people. This included proof of identity, two references and evidence of checks to find out if the person had any criminal convictions or were on any list that barred them from working with vulnerable adults.

People told us that 'generally' there enough staff on duty and that staff usually came quickly in response to call bells. However, some people also told us that at times they had to wait to use the toilet which caused them distress. They felt that this was more likely to happen when people needed to use the hoist to transfer to a wheelchair as this required the support of two staff. The manager told us that only two people were independently mobile and the remainder needed support from staff. We noted that on weekdays until 2pm additional support and supervision was provided by the activities organiser who assisted with drinks and at lunchtime. We also noted that at times the nurse was the only person in the communal area and in addition to supervising and supporting people was administrating medicines. When we arrived for the inspection the nurse had interrupted her medicines round to answer the door. Staff told us that they 'chatted' to people when they had time but that this was not usually possible during the mornings as this was the busiest time. They felt that it would be 'helpful' to have an extra member of staff in the morning particularly at weekends when the activity organiser, administrator and manager were not on duty.

We recommend that the service assess this further with people, their relatives and the staff team to ensure that people receive consistent and safe support at all times.

Requires Improvement

Is the service effective?

Our findings

The service was not always effective. Staff were clear that people had the right to and should make their own choices and most had received Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training in 2013. The MCA is legislation to protect people who are unable to make decisions for themselves and DoLS is where a person can be deprived of their liberty where it is deemed to be in their best interests or for their own safety. People's mental capacity and ability to make informed decisions about their care and treatment was not appropriately tested or acted on.

In one person's file there was a Do Not Attempt Resuscitation (DNAR) instruction. The record said that this had been completed whilst the person was in hospital. However, there was no information or evidence to confirm this. In another file there was a 'resuscitation' form stating that a mental capacity assessment showed that the person did not have capacity but there was not a capacity assessment available. Additionally the form had been signed by a nurse but not by the GP. There was no record of any best interest discussion. People's human and legal rights were not sufficiently maintained because staff did not have a good working knowledge of MCA & DoLS and were therefore unable to put this effectively into practice. This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by registered nurses and by care staff. Staff received appropriate training to enable them to provide a service that met people's basic needs. This included moving and handling, safeguarding vulnerable adults, infection control and first aid. Two recently appointed staff confirmed that they received an induction when they started working at Abbcross. They told us that this included a week of shadowing an established member of staff which gave them the opportunity to observe how people needed and wished to be supported. However, a senior member of staff told us that they were supposed to have three days induction but only received one. The quality monitoring report from October 2014 had also recommended that staff undertake training in record keeping, risk assessment and behaviour that challenges but this had not happened. Nurses were responsible for managing the care of people who had nasogastric tubes (tubes going into the stomach via the nose) inserted for the administration of fluid, nutrition and medication. Nurses had received theoretical training for this but had not had a practical assessment to ensure that they were competent to carry out this task this. Therefore people were not always supported by suitably trained or competent staff. This placed them at risk of receiving poor or unsafe care and treatment. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People responded positively about the home and the care provided. One person told us, "[My relative] is well cared for. If I wasn't happy with the care, I would move them". We saw that another relative had written to the service saying, "Thank you. You enabled [our relative] to communicate for the first time in months. This was due to the time and effort the team made to talk to them."

People were provided with a choice of suitable nutritious food and drink. They told us they thought the food was good and plentiful, especially since the new cook had arrived. One person said, "food is generous actually. Surprised how much food there is." A visitor commented. "[My relative] eats all the food. It looks nice." People also told us that they had a choice of food and drinks. At lunchtime most people had roast chicken but others had chosen salad or a sandwich. We saw a member of staff asking people for their choices for meals the next day. There were two choices for breakfast, lunch and dinner and soup was offered as an alternative. We noted that the staff assisted people to make their choice by patiently explaining what the options were.

People's menu choice and dietary needs were recorded on a colour coded chart. This enabled the cook and care staff to quickly and easily identify what people needed and wanted and lessened the risk of any errors being made.

People were supported to eat and drink sufficient amounts to meet their needs. We saw that they had drinks throughout the day. Some people ate independently and others needed assistance from staff. We observed that staff appropriately supported people to eat and that they were not hurried. We saw that some people required a pureed diet and each food was pureed and served separately to

Requires Improvement

Is the service effective?

enable them to enjoy the different tastes. Staff recorded what people had eaten and drunk and how much. When there were concerns about a person's weight or dietary intake we saw that advice was sought from the relevant healthcare professionals.

At the time of the inspection none of the people who used the service had a specific dietary requirement due to their culture or religion. However, the cook told us that the service was able to cater for a variety of dietary needs. At the time of the visit this included diabetic, vegetarian, soft diet and pureed diet. Therefore people were able to have meals that met their needs.

People were supported to maintain good health and enabled to access healthcare services as needed. This included the speech and language therapist, dietitian and falls prevention service. We saw evidence that the GP visited weekly and that opticians, podiatrists and dentists also reviewed people regularly.

We saw that the environment met the needs of the people who used the service. There was a lift and the building was accessible for people with mobility difficulties. There were adapted baths and showers and specialised equipment such as hoists were available and used when needed. We saw that Abbcross was clean and adequately maintained. In addition to individual bedrooms there was a large combined lounge and dining area where most people spent their time. This area had a Christmas tree and other decorations and there was also a display of poppies that people had made for Remembrance day. The service had been successful in securing funding for a 'dementia friendly' gardening project. The local Havering Museum had visited and built up histories of 'residents' and gardens. The report from them had influenced the design as had the input from a dementia specialist. This meant the people had access to a 'dementia friendly garden' for use when weather permitted.

The manager told us that the services' procedure was that staff received supervision (one to one meeting with their line manager to discuss work practice and any issues affecting people who used the service) four times a year and an annual appraisal. There was a computerised system to record information from supervisions and appraisal and this system also flagged up when these were due. We saw that when there were overdue supervisions the operations director had carried out the supervisions to ensure that staff could bring up any issues, give and receive feedback and discuss their training and development needs. Staff told us that the manager was flexible, approachable and listened to them. People were cared for by staff who received support and guidance to enable them to meet their assessed needs.

Good

Is the service caring?

Our findings

The service was caring. People were positive about the care and support they received. They told us that staff were kind, caring and respectful. One person said," I could not wish for a better level of care. I am amazed at the level of care." Relatives also felt that the service was caring. A relative told us, "Brilliant load of girls. Nice to see my [relative] so relaxed." Another said, "my [relative] needs constant care and cannot move. Staff are friendly and nice."

We observed that staff supported people in a kind and gentle manner and responded to them in a friendly way. We also saw staff talking to people and explaining what they were doing before transferring them from chair to wheelchair. Staff discreetly explained to people that they were going to assist them with their personal care needs.

People said that their privacy and dignity was maintained. Staff we spoke with were clear on the importance of respecting people's privacy and dignity and how to do this. One member of staff told us that they would always ensure that when washing people they kept their top half covered when washing the bottom half of their body, and vice versa.

The staff we spoke with knew the people they cared for. They told us about people's personal preferences and interests and how they supported them. There was a stable core staff group and this helped to ensure that people were consistently cared for in a way that they preferred. Relatives told us they were always made welcome and were able to visit whenever they wanted to. One relative told us, "The place was nice the first time I walked in."

People were supported to make daily decisions about their care. We saw that people chose how to spend their time, what they ate and where they spent their time.

Staff provided caring support to people at the end of their life and to their families. This was in conjunction with the GP and the local hospice. We saw letters from bereaved relatives. One said, "Thank you for your dedication in looking after our [relative]. Their last year was made so much better due to your commitment and care." Another commented, "Thank you for all you did each day in caring for our [relative]. The peace, rest and tranquillity you provided for their last year of life was remarkable." People benefitted from the support of a caring staff team.

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive. People's individual records showed that a pre admission assessment had been carried out before they moved to the service. The assessments had been completed with input from the person, their relatives and relevant healthcare professionals. We found that although care plans contained information about people's needs and wishes, they were not comprehensive. They did not contain specific or sufficient detail to enable staff to provide personalised care and support in line with the person's wishes. For example, one plan stated that the person needed one or two staff to assist them with personal care and moving in bed. However, there were no further details or guidance to tell staff how they should decide if one or two people should assist the person. Another person's care plan stated that their position should be changed frequently. It did not specify how often this should happen. For a third person, who at times exhibited behaviours that challenged, there were not any strategies for staff about how to handle the situation when this occurred. The only guidance was that two staff should provide care for the person. People were positive about the staff and staff spoken with were knowledgeable about people's needs. However, the lack of detailed and specific information about people's needs placed them at risk of not consistently receiving the care that they required. This was additional evidence of a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One member of staff gave us an example of how the service tried to be responsive to people's individual needs. They told us that there had been a 'resident' who due to their dementia had forgotten English. Staff were using gestures to communicate with her and then the manager went to the local school and arranged for one of the French teachers to visit to communicate with the person.

People were encouraged to make choices and to have as much control as possible over what they did and how they were cared for. They told us that they chose where to sit, what to eat, when to get up and what to do. We saw that people were consulted and staff asked their permission before doing things for them.

The service was responsive to people's healthcare needs and we saw that appropriate requests were made for input from specialists such as a speech and language therapist, dietitian or palliative care practitioners.

Good arrangements were in place to meet people's social and recreational needs. People were happy with the activities that were on offer. There was an activities organiser each weekday. They discussed with people what they would like to do and then arranged activities based on their preferences. They had recently made poppies to celebrate Remembrance Day and were preparing for Christmas. The activities schedule for December included a church visit, Christmas tree decoration making, cup cake decorating, Christmas card making, making gingerbread angels and a Christmas with an entertainer. We saw that one lady had made mince pies with the activity organiser and was taking them round to people to have with their morning tea or coffee. The activities organiser told us that volunteers, staff on their days off, often took people to the pub, the park or to Romford shopping centre. Children from the local school did work experience at the service and people had been to the school to make bookmarks to be sold for a teenage cancer charity. People were encouraged and supported to take part in a range of activities and to maintain their interests and links with the community.

We saw that the service's complaints procedure was displayed on a notice board in a communal area. People informed us that they felt comfortable that if they raised any concerns that they would be listened to and acted upon. People and their relatives told us said they would talk to the manager if they wanted to make complaint. A nurse told us that care staff could go directly to the manager if they had a concern but sometimes they asked her opinion about whether they should mention it to the manager or whether she could deal with the concern. This was confirmed by care staff who said that it would depend on what their complaint was as to whether they would go to the nurse or the manager. The manager told us that most complaints were informal and were 'nipped in the bud 'and that relatives often approached staff directly on minor issues. For example, they spoke to the laundry person if there was an issue re a missing item of clothing. We saw a record of complaints that had been 'investigated' by the manager. People had received written explanations of what had been found and what action had been taken to

Requires Improvement

Is the service responsive?

address the concern. For example, a commode was changed in response to a person's complaint. People used a service where their concerns or complaints were listened to and addressed.

Requires Improvement

Is the service well-led?

Our findings

Some aspects of the service were not well-led. The provider sought feedback from people who used the service and their relatives through quarterly quality assurance surveys. Feedback was formally sought from staff twice yearly. The relatives and resident surveys were undertaken by external consultants. In addition the consultants and the operations director also spoke to people during their visits. We saw that the consultants also carried out quality audits and made reports of their findings and recommendations for improvement. Therefore people used a service which sought their opinions. However, we found that recommendations made as a result of the surveys and audits had not been addressed by the manager. For example, the quality assurance report from October 2014 made 10 recommendations all of which had been made previously and had not been addressed. This therefore had a negative impact on the service that people received as shortfalls in the service were not addressed in a timely manner.

The manager told us that monthly medication audits were carried out and that nurses 'checked charts periodically'. However, we could not find any evidence of regular medication audits or of audits carried out by the manager. For example, the recording error regarding the amounts of a specific controlled drug had not been identified. The external consultant's quarterly report concluded that the service needed to review its systems for monitoring the service. It also stated that there was a lack of a robust and effective auditing process for the service. Due to the lack of robust management monitoring people were placed at risk of receiving a service that was not safe, effective or responsive to their needs

The issues highlighted above evidence that there was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 (2) (a)-(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a registered manager in post. In addition to the manager the nurse on duty was responsible for the management of the shift and also for the overall service when the manager was not on site. Staff told us that the manager was approachable and listened. One member of staff told us that the management of the service had improved during the time they had worked there. People informed us that they were happy with the management of the home. They knew the manager and had spoken with them. They told us that they would be comfortable raising any concerns with them. People were positive about the caring approach of the manager.

We found that meetings were held with people who used the service to find out what they liked and wanted. These were mainly focussed on menus and activities and were facilitated by the activities organiser. The manager told us that relatives meetings had not been successful as attendance had been very poor. Therefore they met and talked to relatives informally when they visited and sought feedback from them.

Care staff received one to one supervision from one of the nurses and nurses from the manager but staff meetings were not held. Some staff told us that they thought staff meeting would be beneficial as they really only spoke to other staff at shift handover. The manager told us that they met with staff informally during the course of the day. This meant that the staff team did not have the opportunity to collectively discuss work practice and issues that affected the people they supported.

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 People who used the service were not protected against the risks associated with the unsafe use and management of medicines. Systems were not in place to ensure that they safely received all of their medicines when they needed them. Regulation 12 (f) & (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People who used the service were not protected against the risks of receiving care and treatment that was inappropriate or unsafe. The planning and delivery of care did not ensure their welfare and safety. Regulation 9 (3) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider did not have adequate systems in place to obtain consent from people who used the service. Their legal rights were not protected. Regulation 11.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing People who used the service were not supported by staff who had received appropriate training to enable them to safely meet their needs. Regulation 18 (2) (a).

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Issues identified as requiring improvement were not addressed in a timely manner and this placed people at risk of not receiving a service that safely and effectively met their needs. Regulation 17 (2) (a)-(e).