The Fremantle Trust

Icknield Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 23, 24 and 30 January 2017. It was an unannounced visit to the service on the first day.

We previously inspected the service on 14 April 2015. The service was meeting the requirements of the regulations at that time.

Icknield Court provides care for up to 90 people, including people with dementia. Eighty people were living at the home at the time of our inspection. The building was divided into separate units or 'houses.' Three houses provided specific care to people whose primary care needs were associated with dementia.

The service did not have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A new manager was in post; they were in the process of applying to become registered.

People were kept safe at the service. Thorough recruitment processes were used when appointing new staff. The premises were well maintained; appropriate checks were made to ensure it was kept in good order. There had been a satisfactory fire inspection in November 2016 and the service had been awarded the highest, five star rating for food hygiene practices.

There were enough staff to support people at the time of our visit. We observed staff treated people with empathy and warmth; people we spoke with were complimentary of staff. Comments included "The staff are really lovely, very kind," "Everyone is ever so kind to me. I love it, I really love it" and " The staff are lovely." A relative said "I couldn't have found a better place. The staff are lovely. I've got no worries at all." They added their relative was "Always clean, never wet. If I go away I have no worries." They told us "What I like is the staff sit down with them at mealtimes and eat with them."

Staff received supervision from their line managers, to look at how they were working and discuss their development. However, they did not always receive support in other areas. For example, we found gaps to training records where courses had not been undertaken or were overdue for renewal. Annual appraisals had last been carried out three to four years ago in the files we checked. This meant staff had not received support in line with the provider's expectations for developing workers.

People's nutritional needs were met and appropriate measures were in place where people were at risk of weight loss. People received the healthcare support they required. There was good partnership working with GP surgeries and community specialists to keep people healthy and well. Two healthcare workers told us the home supported people well at end of life. One commented "I have also been impressed with the care they have offered families in the immediate aftermath of a patient passing away such as explaining the

process after death, allowing relatives time to be with their loved ones for some time afterwards and just approaching the whole situation in a very professional way."

People's needs had been recorded in care plans. These outlined the support people required and took into account their preferences. Relatives or partners had provided information about people's likes, dislikes and their backgrounds, to help ensure staff provided individualised care.

We found staff were responsive to people's changing needs. Care plans were kept under review to help keep people safe and independent. Appropriate action was taken when people became unwell.

People were supported to take part in a range of activities to provide stimulation, enjoyment and social contact. The home had a team of activity staff and local volunteers who provided a programme of activities. There were also good links with the local community to help people keep in touch with their surroundings.

Monitoring of the quality of people's care took place. However, actions were not always followed up where particular issues were identified, such as a high incidence of falls. The manager took action during the inspection to address this.

The service had informed us of incidents and notifiable occurrences, such as when people had died and any safeguarding concerns.

Records were maintained to a good standard and staff had access to policies and procedures to guide their practice.

We have made a recommendation about making the environment more stimulating for people with dementia.

We found a breach of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to staff support.

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

Good

The service was safe.

People's likelihood of experiencing injury or harm was reduced because risk assessments had been written to identify and minimise areas of potential risk.

People were supported by staff with the right skills and attributes because robust recruitment procedures were used by the service.

People lived in premises which were well maintained, to protect them from the risk of injury.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not consistently protected against the risk of unsafe and ineffective care because staff had not always been appropriately supported through training and appraisals.

People with dementia may benefit from a more stimulating environment; we have made a recommendation about this.

People received the support they needed to attend healthcare appointments and keep healthy and well.

Is the service caring?

Good

The service was caring.

People were treated with empathy and warmth. Staff knew about people's backgrounds and their histories.

People were supported to be independent. They were treated with dignity and respect and their privacy was protected.

People's wishes were documented in their care plans about how they wanted to be supported with end of life care. Staff showed compassion toward relatives of people who were dying or had passed away.

Is the service responsive?

Good

The service was responsive.

People were supported to take part in activities to increase their stimulation.

People's preferences and wishes were supported by staff and through care planning.

The service responded appropriately if people had accidents or their needs changed, to help ensure they remained independent.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider monitored the service to make sure it met people's needs safely and effectively. However, action was not always taken in response to any concerns that were highlighted.

The manager knew how to report any serious occurrences or incidents to the Care Quality Commission. This meant we could see what action they had taken in response to these events, to protect people from the risk of harm.

The manager knew about their responsibilities under the duty of candour, when things went wrong.

Icknield Court

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 checked 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 23, 24 & 30 January 2017. The first day of the inspection was unannounced. The inspection was carried out by one inspector.

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 notifications and any other information we had received since the last inspection. A notification is information about important events which the service is required to send us by law.

We contacted healthcare professionals, for example, GPs and the local authority commissioners of the service, to seek their views about people's care. We spoke with two visiting healthcare professionals during the inspection and three relatives.

We spoke with the manager and twelve staff members. This included duty managers, care workers, activity, catering and housekeeping staff. We also spoke with the regional director for the service.

We checked some of the required records. These included six people's care plans, 23 people's medicines records, four staff recruitment files and five staff training and development files. Other records included health and safety related checks and servicing, a sample of policies and procedures, staff meeting minutes and quality assurance documents. We observed two staff handover sessions between morning and afternoon shifts.

We spoke with five people who lived at Icknield Court. Some people were unable to tell us about their experiences of living at the home because of their dementia. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of

people who could not talk with us.

Good

Is the service safe?

Our findings

People were kept safe at the service. Thorough processes were used when staff were recruited. We saw the full range of required checks were undertaken. These included a check for criminal convictions, written references and proof of identification and residency. Any gaps to employment history had been accounted for, to make sure a full record was held of the prospective member of staff's work history. This helped ensure only staff with the right skills and attributes supported people with their care. Advice was given to the manager to add a photograph to each staff member's file, to complete the records. There were photocopies of identification documents to refer to in the meantime.

There were procedures for safeguarding people from abuse. These provided guidance for staff on the processes to follow if they suspected or were aware of any incidents of abuse. Training on safeguarding was part of the provider's mandatory courses and was included in the induction of new workers. The local authority's safeguarding procedures flow chart was displayed around the building for staff to make use of, if needed. Managers alerted the local authority and the Care Quality Commission about any safeguarding concerns. From these records we were able to see appropriate actions were taken to protect people from harm.

We also noticed the provider's whistleblowing poster was displayed in the entrance hall. Whistleblowing is raising concerns about wrong-doing in the workplace.

People's safety was maintained during the provision of their care. Risk assessments had been written to reduce the likelihood of injury or harm to people. These included the likelihood of developing pressure damage, supporting people with moving and handling and their risk of falling. We noticed one person's moving and handling care plan and falls risk assessment said they needed to walk with a frame to reduce the risk of falls. It said staff were to remind the person about this. However, we saw the person walking steadily without a frame whilst we were at the home. We did not hear staff prompt them to use a frame. We mentioned this to the manager as an area to follow up, to check if the person still required the walking aid to help them mobilise safely.

We saw emergency evacuation plans had been written for each person. These outlined the support people would need to leave the premises. Equipment to assist people with moving had been serviced and was safe to use.

People were kept safe from the risk of unsafe premises. There were certificates to confirm it complied with gas and electrical safety standards. Appropriate measures were in place to safeguard people from the risk of fire. A fire inspection in November 2016 confirmed the measures in place at Icknield Court were satisfactory to protect people from the risk of fire. The home had been awarded the highest, five star rating for food hygiene practices.

People received the care and support they needed. Staffing rotas were maintained and showed shifts were covered by a mix of care workers, senior staff and duty managers. We observed there were enough staff to

meet people's needs. Call bells were answered promptly. A distinctive call tone was used for emergency situations. We saw staff, which included duty managers, checked display panels to see which room the emergency was in and rushed to attend. Staff we spoke with told us they supported the same group of people each time they were on shift. This helped to ensure people received continuity of care.

There were procedures to ensure people's medicines were managed safely. We looked at medicines practice in two parts of the home. Medicines were kept securely. For example, trolleys and medicines rooms were kept locked when not in use; the keys were held by the member of staff responsible for medicines administration during the shift. We saw staff had signed alongside prescribed dose times to show when medicines had been given. The reverse of the record sheets were used, as intended, to explain why a dose had not been given. This ensured a clear audit trail was maintained.

We noticed some potentially unsafe practice regarding one person's medicines. Their care plan showed they managed some of their prescribed medicines themselves; staff were responsible for administering the rest. Medicines records stated the person had been putting their tablets in their pocket after staff had handed them to them. There was then a written instruction to 'observe'. We asked staff about this. They told us the person would usually take their medicines later on. However, there was no formalised method of checking this or making sure there were safe intervals between medicines taken more than once a day, to prevent an overdose. The manager had not been made aware of this situation; when we mentioned our concerns about possible risks, action was taken straight away to manage the person's medicines more safely.

Checks were carried out of room and fridge temperatures where medicines were stored. We noted some records showed medicines rooms sometimes exceeded 25° Celsius by a degree or two. This meant some medicines could deteriorate if kept too warm. Staff had not always noted what action they had taken when the temperature had become too warm, to make sure people's medicines were stored as recommended by the manufacturers. This was mentioned to the manager to follow up.

The manager took action where there were concerns that staff may not have provided safe care for people. For example, where errors had occurred. Records were kept of meetings held with staff following incidents of this nature, to determine what had happened and to prevent recurrence.

Requires Improvement

Is the service effective?

Our findings

People did not always receive their care from staff who had been appropriately supported. The provider had a system of assessing the performance of new staff at ten and 20 weeks after their start date, before they were confirmed in post. We checked three files for these assessments. One file did not contain either of the assessments, another contained only the first assessment at ten weeks. Staff were unable to locate further records to show the assessments had been completed. This meant systems for assessing the performance of new staff were not always followed at the service.

There was a system for staff to receive annual appraisals or development reviews. However, we found these had not been carried out at the frequency expected by the provider. In four files we looked at, the last appraisals took place in 2013. In a fifth file, the last appraisal took place in 2012. The manager checked with staff who would have carried out the appraisals who said more recent appraisals had not been conducted.

There was a programme of training the provider expected staff to complete. We found gaps to training in some files. For example, in one file there was no record of the member of staff completing training on the care of people with dementia. They had last attended a course on fire safety in April 2013. This was due to be updated after two years. A second member of staff had last attended moving and handling training in October 2014. The provider expected staff to update this type of training each year. The member of staff attended training on medicines in March 2013. This was due to be updated after two years. There was also no record of the member of staff completing training on the care of people with dementia or basic food hygiene. These were courses the provider considered mandatory for the role they undertook.

In a third staff file, we saw there had not been an annual update to moving and handling training since October 2014. The member of staff had not updated medicines training since March 2012; they last attended safeguarding training in June 2014. Both of these courses were expected to be completed every two years. We spoke with the manager about deficits to staff training. They told us courses had not always been kept up to date in the past couple of years, with poor follow up to ensure mandatory courses were completed.

These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff had not received appropriate support, training, professional development and appraisal as is necessary to enable them to carry out the duties they are employed to perform. This had the potential to place people at risk of harm.

There were further education courses staff could undertake. Three staff had completed Business and Technology Education Council (BTEC) awards in dementia. A further three staff were enrolled for this course.

Staff received supervision from their line managers. Notes were kept of these meetings to record the areas discussed about their performance and professional development. In the files we looked at, four staff had received supervision five or more times in the past year, in a fifth file there were notes of three meetings.

People's nutritional needs were met at the service. Care plans included information about dietary needs and

any special requirements people had. Catering staff told us they were made aware of people's needs when they were admitted to the service. On-going needs were reported to them by staff, such as after people's swallowing needs had been assessed by the speech and language therapist. There was information in the kitchen about people who were at risk of weight loss. Catering staff said they were kept informed of whether people at risk of weight loss were maintaining a stable weight or required further support. They described the ways in which food was fortified and other foods were prepared which were high in calories for those who needed them. We saw snacks and drinks were served to people throughout the day, to supplement main meals. This helped to ensure people ate and drank enough.

People had a choice of meals and where to eat them. Staff checked with each person what they would like; options were selected the day before but people were given the opportunity to change their mind if they wished for something different. Catering staff said they prepared more than the amount people selected for this reason.

We saw lunchtime was unrushed and gave people time to enjoy their food at their own pace. Staff gently assisted people who needed support. Encouragement to finish meals was given where necessary. For example, we saw a care worker smile and say "You're doing so well" as they assisted someone with lunch.

People told us they enjoyed the food. One person said the food was "Very nice" and told us they had plenty to eat. Another person told us they were vegetarian and their needs were catered for. They told us "Lunch was quite nice today." A relative commented "What I like is the staff sit down with them at mealtimes and eat with them." We saw this created a social occasion where staff and people who lived at the home could spend time together.

People's healthcare needs were met at the service. Care plans identified any support people needed to keep them healthy and well. Staff maintained records of when they had supported people to attend healthcare appointments or received visits at the home and the outcome of these.

We heard duty managers as they engaged with healthcare professionals. They clearly described information about people's needs and circumstances and knew about their histories. Healthcare professionals told us the home worked well with them. Comments included "Our impression was that they were offering a good level of care to their residents in difficult circumstances given the current pressures in the health and social care system." They added "The care home do communicate and interact with us appropriately regarding medication queries and seem to have a well-functioning system with regards to managing medication requests and liaising with us and their pharmacy." They said "The care home have also responded positively to a new telemedicine service…which offers them nursing support via a video conferencing link at the patient's bedside. Other care homes have been less quick to embrace change and make the most of the new service."

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. We saw appropriate referrals had been made to the local authority to deprive people of their liberty. Copies of lasting power of attorney documents had been obtained to verify people's relatives or other persons had the legal authority to act on their behalf. This ensured the right people were involved in making decisions on residents' behalf. We saw records of best interest meetings were contained in people's files, where appropriate. These showed consultation had taken place with appropriate people to act on behalf of residents who lacked capacity.

We spoke with the manager about the design of the building and whether it met the needs of people with dementia. For example, although there were seated areas at the end of corridors and some items of interest in places, large sections of corridors were quite bare and did not provide much stimulation for people. For example, tactile objects, things they could look at and more items to engage in reminiscence. We also noted information was not readily accessible to people. For example, there was no information about the meal choices for the day.

We recommend the service follows good practice guidance on creating more dementia-friendly environments for people.

Good

Is the service caring?

Our findings

We received positive feedback from people about how staff treated them. One person told us "Everything is done here for us, it's lovely." They added "The staff are really lovely, very kind." Another person told us "I like it here, I'm free. They don't interfere. I like to be independent." A visitor told us "I couldn't have found a better place. The staff are lovely. I've got no worries at all." They added their relative was "Always clean, never wet. If I go away I have no worries."

We observed some good interactions between staff and people who lived at the home. For example, one person noticed a housekeeper vacuuming the carpet and offered to help them. The housekeeper smiled and said "Oh that's kind of you, but no thank you." We saw another member of staff smiled and said a warm "Hello, how are you?" as they passed someone by. In another example, a care worker went and got some chocolate to go with a person's cup of tea. They said "I know she likes it so I thought I would bring her some." This made the person smile and we saw they clearly enjoyed eating it.

People told us staff were respectful towards them and treated them with dignity. Staff knocked on people's doors and waited for a response before they went in. All personal care was carried out in private. Each person had a single bedroom with an en-suite bathroom to promote their privacy and dignity when their personal care needs were attended to.

People's wishes were documented in their care plans about how they wanted to be supported with end of life care. Two healthcare professionals told us the home managed end of life care well. One said "They were extremely proactive in supporting the patient and their family's wishes that they should end their life in the care home and worked very effectively with myself and the local adult community healthcare team (district nursing team) to make sure that happened." They added "There seems to be a good understanding of the importance of discussing and developing advanced care plans in this situation and involving patients and their families in this process and also the important role they play in communicating this effectively to other organisations such as the 111 helpline, ambulance service or out of hours GP service when they become involved in these patients' care."

The healthcare professional told us about how staff cared for people's relatives too. They said "I have also been impressed with the care they have offered families in the immediate aftermath of a patient passing away, such as explaining the process after death, allowing relatives time to be with their loved ones for some time afterwards and just approaching the whole situation in a very professional way."

Staff spoke with empathy and warmth about the people they supported. They were knowledgeable about people's histories and what was important to them, such as their family and what they liked and found difficult. One member of staff was able to tell us how someone acquired their preferred name, which went back to the person's working years.

People's visitors told us they could come to the home when they wanted to. We saw visitors were encouraged to make themselves drinks and to feel 'at home'. A member of staff we spoke with said it was

important families felt they could be relaxed when they visited their relatives. They said "It's not always easy for them, so we try and make everyone feel welcome."

People were supported to be independent. The premises were fitted with aids and adaptations to help people move around independently. This included grab rails, accessible baths and a passenger lift between floors. One person was supported to care for their dog; staff had put a care plan in place to make sure it was well cared for.

People's rooms had been personalised with items such as ornaments, pictures, plants and whatever they wished to bring in. In one particularly homely room, we asked the person if their room was comfortable. They said it was and added "I've got everything that's important with me here."

People were involved in making decisions about their care. For example, they were included in review meetings about their care and their views were sought and recorded in the minutes. Staff involved people in day to day decisions such as meal choices, what they would like to wear and the activities they took part in.

Good

Is the service responsive?

Our findings

People were supported to take part in a range of activities to provide stimulation, enjoyment and social contact. The home had a team of activity staff who were supported by volunteers from the local community. We saw craft activities took place, for example, to celebrate Chinese New Year. A bowls game was also enjoyed. Posters were displayed around the building with the week's activities listed. The home was supported by visiting clergy to meet people's spiritual needs.

We read a compliment the home had received from a relative. It included "I must also mention the activities team who provide such a great programme of fun activities." They described the garden as a "wonderful oasis" during the summer. We heard the home had reached the final of the National Dementia Care Awards last year for the garden. Activity staff described how they had involved people's families and friends to create a stimulating outdoor space. This included a butterfly walk where pictures of butterflies were laminated and placed among the flowers for people to find. A bus stop with a bench was also added and staff had enabled someone to grow vegetables. Another relative praised staff and volunteers for "All the hard work and effort put in to the Queen's 90th birthday celebrations" last year.

People's support needs were recorded in care plans. These took into account people's preferences for how they wished to be supported. People's preferred form of address was noted and referred to by staff. Care plans included assessment of people's physical and emotional needs. Information was included about meeting cultural and religious needs. Care plans were personalised and each file contained information about the person's likes, dislikes and people who were important to them.

We saw people's relatives or partners had completed information to build up a personal profile of the person. This included details of what people enjoyed and how to reassure them if they became distressed.

The care plans we read showed evidence of regular review of the changes to people's circumstances, such as their mobility. This helped ensure staff provided appropriate support to people.

Information about people's health and well-being was communicated effectively at the service. A staff handover took place between shifts. This included updates about people's needs and any areas which required follow up. Daily notes were also written for each person to provide a summary of the support they had received and any concerns about their well-being. We heard a member of staff as they came to speak with the duty manager. They asked if a person could have their pain relief as they appeared to be in pain. This was attended to straight away.

Staff took appropriate action when people had accidents or became unwell. We saw paramedics and GPs were called to the home promptly when people needed medical attention. Duty managers got information ready, such as copies of medicines records, in case people needed to be admitted to hospital. Families were kept informed of what had happened.

There were procedures for making compliments and complaints about the service. We read records of five

complaints. These showed appropriate action was taken in response to concerns. For example, a concern about the approach of a member of staff was addressed in supervision with them. A relative told us they were very happy with standards of care. They said if they had any concerns they mentioned them to the management and action was taken. Numerous compliments had also been received, thanking staff for the care they had given.

Requires Improvement

Is the service well-led?

Our findings

The service had a new manager in post. They were in the process of applying for registration with the Care Quality Commission. Staff told us they could go to managers if they had concerns. For example, one member of staff told us "They're very supportive here. You can talk to managers if you've got any worries. They're good like that."

Staff were supported through supervision. However, other elements of staff support were not embedded in practice. For example, annual appraisals had not taken place at the frequency the provider expected and training was not always kept up to date. We saw general staff meetings had not been held regularly but were now arranged for the coming year. Staff meetings for each house had fallen by the wayside in some parts of the building. In some houses they were held regularly and recorded discussion about people's needs and any concerns staff had. In one house there was no record of a meeting since December 2014; in another since August 2015. We mentioned this to the manager to suggest regular meetings be re-established.

The service had new visions and values which had been shared with staff and were displayed in the entrance area. These included celebrating the uniqueness in everyone and putting care and kindness at the heart of all staff did. We found staff demonstrated these values when they interacted with people and when they spoke with us about people's support needs and their backgrounds. For example, one member of staff when speaking about person centred care said "You've got to put yourself in their place" to understand what it may be like to experience being in a care home. They also spoke with respect about people's backgrounds and told us they felt a "debt of gratitude" for what the previous generation had done for us.

The home had links with the local community, for example, local schools and churches visited the service. The home also took part in local events such as the village entry for Britain in bloom and attending local concerts.

The records we looked at were well maintained. There were policies and procedures on areas of practice such as safeguarding, safe handling of medicines, supporting people who challenge and whistleblowing. These provided staff with up to date guidance.

Providers and registered managers are required to notify us of certain incidents which have occurred during, or as a result of, the provision of care and support to people. There are required timescales for making these notifications. Managers had informed us about incidents and notifications and from these we were able to see appropriate actions had been taken.

There were systems for monitoring the quality of care people received. Visits by senior managers and audits were carried out. We found action had not always been taken when issues were raised as a result of monitoring. For example, a service monitoring report from July 2016 noted a high number of falls at the home. It recommended an audit be undertaken to look at this. In discussion with managers we found this had not been completed. Prompt action was taken during the inspection to arrange for an audit to be carried out within a few days.

In a medicines audit in April 2016, it was recorded that 236 recording errors had occurred. We asked if any action had been taken at the time to look into this further. It was thought, but not confirmed, that the person who carried out the audit may have been looking at a much wider time frame. We acknowledged a repeat audit in October 2016 identified improvements to medicines practice.

A check was made around the premises for any defects to equipment and the fabric of the building. We noted defects were recorded in each report but it was not clear if any action was taken to remedy matters. We saw some issues were repeated from one report to the next and were evident during the inspection. For example, a missing call bell lead in a bedroom and a call bell lead tied up in a bathroom. Through discussion with the manager and other staff, we noted there were reasons for these two examples. However, it was not clear if information from these checks had been passed to the right staff so that action could be taken or the risks assessed; the manager had not been made aware of the defect reports. They assured us they would look into this.

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

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 18 HSCA RA Regulations 2014 Staffing Staff had not received appropriate support, training, professional development and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2) a.