Hampshire County Council

# Hawthorne Court Nursing Home

## Inspection report

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## Ratings

| | |
|---|---|
| **Overall rating for this service** | **Good** |
| Is the service safe? | **Good** |
| Is the service effective? | **Good** |
| Is the service caring? | **Good** |
| Is the service responsive? | **Requires improvement** |
| Is the service well-led? | **Good** |

## Overall summary

This inspection visit took place on 24 and 26 August 2015 and was unannounced.

Hawthorne Court is a purpose built nursing home accommodating up to 80 older persons, including people who are living with dementia.

At the time of this inspection the service did not have 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 2008 and associated Regulations about how the service is run.

People's care plans were not reviewed consistently and did not always reflect people's needs. Staff were kind and caring but the service was not always responsive to people's individual needs.

# Summary of findings

There were systems and processes in place to protect people from harm. Staff were trained in how to recognise and respond to abuse and understood their responsibility to report any concerns.

Medicines were managed safely as the staff responsible for administering people's medicines were suitably trained and competent.

There were sufficient numbers of staff to meet people's needs. Safe recruitment practices were followed and appropriate checks had been undertaken, which made sure only suitable staff were employed to care for people in the home.

Staff were supported to carry out their roles and received an induction and on-going training and supervision. Staff worked in a manner that respected people's privacy and protected their dignity.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which apply to care homes. Where people's liberty or freedoms were at risk of being restricted, the proper authorisations were in place or had been applied for.

People received on-going health checks and support to access healthcare services. They were supported to eat and drink enough to meet their needs.

People were confident they could raise concerns or complaints and that these would be dealt with.

There was a positive and open culture within the service, which encouraged people's involvement and their feedback was used to drive improvements. There were a range of systems in place to assess and monitor the quality and safety of the service.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

# 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?**
The service was safe.

Staff had a clear understanding of what constituted potential abuse and of their responsibilities for reporting suspected abuse.

Risks to people's health and wellbeing were assessed and monitored and risk management plans were in place.

Staffing levels were sufficient and organised to take account of people's care and support needs.

People's medicines were managed appropriately so that they received them safely.

**Good**

**Is the service effective?**
The service was effective.

Staff received training and supervision to help ensure they had the right, knowledge and skills to effectively deliver care and support.

People's consent to care and support was sought in line with relevant legislation and guidance.

People were supported to eat and drink enough to meet their needs.

People received on-going health checks and support to access healthcare services.

**Good**

**Is the service caring?**
The service was caring.

Staff were committed to building positive caring relationships with people and treated them with kindness, compassion and respect.

People and those important to them were involved in planning their care through the assessment and review process.

**Good**

**Is the service responsive?**
The service was not always responsive.

People's care and treatment plans were not being kept up to date, so there was a risk that people might not receive appropriate care.

Staff were prompt to raise issues about people's health and wellbeing and people were referred to health professionals when needed.

Complaints and concerns were recorded, investigated and the outcome fed back to the complainant in a timely manner.

**Requires improvement**

# Summary of findings

**Is the service well-led?**

Good

The service was well led.

There were plans in place to register a manager for the service, which was currently being overseen by an experienced manager.

Quality assurance systems were in place and the manager promoted a positive and open culture within the service. The involvement of people, their families and staff was encouraged and their feedback was used to drive improvements.

# Hawthorne Court 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 24 and 26 August 2015 and was unannounced.

The inspection was carried out by two inspectors accompanied by a specialist advisor and an expert by experience. A specialist advisor is someone who has experience and knowledge of working with people who are living with dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care 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 also checked other information that we held about the service and the service provider, including notifications we received from the service. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we spoke with 16 people who used the service and 12 relatives, 17 members of staff plus the manager and two deputy managers. We also spent time observing interactions between staff and people who used the service. We looked at care and treatment records for 16 people, including records relating to the delivery of their care and medicine administration records. We also reviewed records about how the service was managed, including risk assessments, staffing records and quality audits.

Following the inspection we contacted five health and social care professionals and asked for their views about the service. We received one response and their feedback is reflected in this report.

Good

# Is the service safe?

## Our findings

People living in the home told us they felt safe with the care and support being provided. Their comments included: "It's a lovely place, the staff are all kind and I always feel safe and secure". Another person said, "I do feel safe and very happy here". Comments from family members included: "We were reluctant for our relative to go to live in a care home but they are really happy here, they have settled in well and we can see they are much safer than they were on their own". Another person's relative told us "They are definitely safe in here. There are more facilities, such as bed guards".

Staff confirmed they had received safeguarding training and regular updates. They were able to describe different forms of abuse and how these might relate to, for example, people being cared for in bed or living with dementia. Staff were aware of the organisational whistle blowing policy and of their responsibility to report any concerns. This is a policy protecting staff if they need to report concerns to other agencies in the event of the organisation not taking appropriate action. Comments from staff included: "I would have no hesitation at all reporting any concerns and would go straight to the senior on duty. I would then see that it was followed up". Another member of staff said "There is no excuse at all for any abuse or unkindness. I would report firstly to the manager and if I did not think anything had been done I would contact Social Services or CQC".

Records showed that risks both to the safety of people using the service, staff and visitors were assessed and recorded. This included fire risk assessments, moving and repositioning of people, use of equipment such as hoists and the use of bed rails. The risk assessments were regularly reviewed and updated by senior staff during service audits, so that risks were monitored. People who might harm themselves or others were supported in accordance with their risk management plans. A member of staff told us about one person who "Could be physically aggressive during personal care". They said care staff would then stand back and take time to reassure the person. We saw this was reflected in the person's care plan. An external health and social care professional told us the service was able to support people with complex needs and managed risks safely and effectively. They also said the service was proactive in making sure that people were not admitted if staffing levels were not sufficient to meet their needs and those of other people using the service.

The home was divided into four large units, each of which was subdivided into two parts. The staffing arrangement was one nurse and four care staff on each unit providing care for up to 20 people. A member of staff told us each morning the nurse allocated the care staff to people who used the service and informed them of any changes or issues affecting people's care and support. They said the nurses were "No longer so hands on as they have their own roles". They told us the deployment of staff was sufficient to allow care staff to assist people with their personal care and with eating and drinking. Each unit also had a general assistant, who carried out domestic duties but had the relevant training so they would help the care staff at mealtimes. The member of staff told us on some days there was "A lot of agency staff, but they are really good, just like permanent staff". They said this occurred if for example, some staff were on leave and then others were off sick.

On the first day of the inspection, there was one regular nurse and three agency nurses on duty covering the four units. The home was short of two staff: one agency nurse had not turned up and a member of care staff had phoned in sick. The service had been unable to cover these posts at such short notice. Available staff were deployed to enable the service to continue meeting people's needs. Another member of staff told us the service usually booked the same agency staff. This helped to maintain continuity of care for people. The member of staff said "The majority of agency staff are really good. There is a bit more pressure when you're working with agency staff. It doesn't happen that often".

There was evidence in staff recruitment records to show that a robust process was carried out when employing new staff. This included informal and formal interviews, the obtaining of Disclosure and Barring Service (DBS) checks and references and formal monitoring of new staff. DBS enables employers to make safer recruitment decisions by identifying candidates who may be unsuitable to work with adults who may be at risk. Records were on file showing that checks were undertaken to ensure that nursing staff were correctly registered with the Nursing and Midwifery Council (NMC). All nurses and midwives who practise in the UK must be on the NMC register. The correct checks and

Good

# Is the service safe?

relevant documentation were also obtained for workers from overseas. Residents meeting minutes showed that people were involved in the informal part of the recruitment process by chatting with candidates and asking questions that related to their personal requirements. We saw that feedback was recorded and used in the overall process.

Systems were in place to help ensure people were protected against the risks associated with the unsafe use of medicines. There were four medicines rooms and the temperature of each room and the refrigerators were consistently recorded on a daily basis. This helps to ensure that medicines remain effective. The provider had an efficient system of ordering new stock and the home was not over stocked on any product. All the medicines were kept securely in a locked cabinet within a locked room. A medicines disposals book was maintained and products for disposal were recorded and stored safely.

The systems for recording, storing and monitoring medicines met legislative and regulatory requirements. However, we found some of the care records relating to topical medicines such as creams and lotions were not always fully completed. The provider could not be assured that people had received the medicines they required for skin protection due to the incomplete records. The provider had started to implement new systems to audit and check records to improve this aspect of medicines management.

Staff responsible for administering medicines told us they had undertaken medicines training and their competency to administer medicines safely had been assessed by the manager within the last six months. People were confident their medicines were managed safely. Their comments included: “They give me my medication and explain what it is for” and “I get my meds on time”. A person’s relatives said “There have never been any medication errors”.

Medicines administration records (MAR) were up to date and complete. Two nurses demonstrated a good knowledge and understanding of people’s medicines. For example, they were able to describe the special circumstances under which some medicines should be given and at what times. We observed the two nurses undertaking medicines administration rounds at the home. They approached people in a professional and caring manner and they explained what the medicine was for, asking for people’s consent before dispensing the medicine and then waiting for the person to swallow them. Some people had cognitive, hearing and/or visual impairments and both nurses communicated well and were patient and unhurried.

The environment was clean throughout and we observed that staff were aware of infection control issues. There was protective clothing available and in use by staff in each bedroom and when handling unclean laundry. Laundry was placed in colour coded bins and antiseptic hand gels were situated throughout the home. The training record showed that staff received training in infection prevention and control. Comments from people included “My room is lovely, it is cleaned every day and they always make it look nice for me.” A relative commented “This home is always very clean and bright and I have never noticed any unpleasant odours or unclean areas”.

Good

# Is the service effective?

## Our findings

People's comments overall confirmed that staff worked effectively as a team and had the knowledge and skills to meet people's needs. For example, "I am well cared for and the staff understand me" and "The staff are pretty good". An external health and social care professional told us the service was proactive in making sure staff had the right training, qualities and skills to deliver effective care. They said staff were skilled in understanding the range of complex cognitive impairments and supported people to maintain good health.

Records showed that following an in-house induction, new staff were booked to attend an offsite formal eight day induction entitled, 'Stepping Forward, Stepping Back'. The manager told us that this induction was linked to the new Care Certificate requirements and during the eight days staff covered all essential training including safeguarding, moving and positioning and infection control. The Care Certificate came into effect in April 2015 and sets out 15 standards that new staff in health and social care services should work to.

The training programme and records showed that staff attended training in line with their roles and responsibilities, including dementia awareness training. Nurses employed by the service were supported to maintain their professional development. This included regular competency assessments, for example on medication management, falls risk assessing and pain assessment. The competency assessments were carried out by the organisation's Practice Development Nurses (PDN's).

Staff were positive in their comments about the training they received. One member of staff told us they were up to date with all the training, which included moving and repositioning, dementia awareness, infection prevention and control, food hygiene and safeguarding adults at risk. They said the training helped to "Keep people and staff safe". They said the dementia awareness training "Makes you think more about what you're doing". They added "I think the training is very good here and very thorough". Another member of staff told us "We can also look online for extra training if we want". Staff said they received regular supervision and this was further confirmed by the records we examined. We were told that a new 'on line' system was being introduced that would assist with annual appraisal and support staff personal development plans.

Staff had received training in the Mental Capacity Act, 2005 (MCA). The MCA provides a legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision should be made involving people who know the person well and other professionals, where relevant. Staff showed an understanding of the legislation in relation to people they were supporting. Before providing care, they sought consent from people and gave them time to respond. People had signed their agreement to some aspects of care, such as staff supporting them with medicines and personal care. If people declined care and support this was respected and documented in their care records. Where people lacked capacity, best interest decisions had been made and documented, following consultation with family members and other professionals.

Staff recognised that people could make some decisions but not others and supported them to make as many decisions as possible. A member of staff told us that people who lived in the home "Can all make decisions". They were clear about people having the right to make decisions, adding: "It might be an unwise decision, but that's ok". Another member of staff said, "People can change on a day to day basis and you have to be aware how you approach them. What worked yesterday might not today so you have to be flexible and let them lead on what they want". A nurse told us "People have the legal right to make their own decisions about things that affect them for as long as they are able".

The Care Quality Commission (CQC) monitors the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. The manager understood when a DoLS application should be made and how to submit one. Following a Supreme Court judgement which clarified what deprivation of liberty is, the manager had reviewed people in light of this and submitted applications to the local authority.

Good

# Is the service effective?

People were complimentary about the food provided and told us they could choose what to eat. A person commented “We get lovely meals and they make smashing cakes and biscuits for us”. Another person said “The food is lovely here and I can make a drink if I want one. We have a shop so we can buy things’. One person told us “The food is very good. It is like a hotel, absolutely lovely, we have biscuits in the afternoon and I have milk instead of tea”.

People were asked to choose their meals the previous day as the kitchen staff required the lists by 11am each morning. For people living with dementia this could restrict the choices that they made. Staff told us that in addition to the two choices on the lunch menu, there were always alternatives available. However, the absence of pictorial menus or other prompts could mean that people living with dementia were not aware they could request alternatives. The manager was aware of this and told us the kitchen staff were in the process of producing pictorial menus in order to further support people’s choice.

Records showed that people’s nutritional needs and preferences had been assessed. Food and fluid charts were in place for people with specific needs that required monitoring. Kitchen staff had a list of people’s likes and dislikes and details of people requiring special diets, such as vegetarian, soft or pureed meals. We observed lunch being served on both days of the inspection.

Meals were brought to individual units on heated trolleys and temperature probes were used and the temperatures recorded. The food provided looked nutritious and was attractively presented. People were supported to eat where they chose, either in the dining rooms, lounges or in their own rooms. During the lunch period all staff helped with assisting people to eat and there was an effective use of teamwork, which meant people received their meals and any support they required in a way that was both timely and unhurried. Staff were patient and kind in their approach and explained to people what was on their plate.

People had access to healthcare services and, where necessary, a range of healthcare professionals were involved in assessing and monitoring their care and support to ensure this was delivered effectively. This included GP and community nursing services, speech and language therapist, chiropody, occupational therapists, opticians and dentistry. A health and social care professional who had been involved with the service said the staff supported people to maintain good health. A member of staff told us if they had any concerns about people’s health they always reported it to the nurse who would take the matter forward.

Good

# Is the service caring?

## Our findings

People told us that they liked the staff supporting them. Their comments included "It's just nice to live here, they have lovely staff". One person told us "I am well looked after and the staff are very kind". Another person remarked "The Queen could not be better looked after". A relative said, "I am more than pleased with the care, the staff are so kind and approachable, they always talk to you and make us a cup of tea when I come in". Another person's relatives told us "The staff are very kind and compassionate".

We observed that staff were kind, caring and friendly in their approaches to people's care. There was a good rapport between staff and the people they supported with lots of smiles and laughter. We saw one member of staff who was on her break was sat talking with a person who used the service. Staff told us that they were committed to providing good care for the people they supported. One member of staff said "I love my job and to make someone's day good. It takes a lot of time, effort and commitment". Another member of staff said "Top of the list should be empathy. If you understand how people feel, you can help".

People's care and support plans were written in a way that focussed on them as a person. Staff had good knowledge of individuals and knew what their likes and dislikes were. This extended to a domestic assistant who knew exactly how people liked their tea and provided this as they preferred and with a smile. We asked them how they knew what to give people and they told us "The nurses and care staff tell me, I write it down so that I get it right for people and I have got to know the residents well too". People who used the service, and those who were important to them, were involved in planning their care through the assessment and review process and discussion with staff. This included people's preferences and choices for their end of life care.

People and their relatives told us the staff respected people's privacy and protected their dignity. People's comments included: "The staff are very kind to me. They respect my dignity; they close the curtains and always knock on the door". Relatives told us "The staff do respect his dignity. They close the curtains and ask us to leave when they change him; they are very professional".

We observed staff knocking on people's doors and asking if they could enter rooms. They spoke with people in a respectful manner and gave people time to reply. When providing personal care, a small notice was hung outside the door so that people's privacy and dignity could be respected. Staff told us they talked to people when giving personal care and explained what they were doing. Staff respected people's independence. One person told us "I can watch TV as late as I want and go to bed when I want". Another person said "I am treated very kindly, I am never rushed". Another person commented "I like my privacy but I mix with the others if I want to". A member of staff said they encouraged people to be as independent as they wished with their personal care and "Try to make it a comfortable and nice experience".

Requires improvement

# Is the service responsive?

## Our findings

A summary care plan was kept in people's individual rooms. We saw that these were very user friendly and recorded information about how staff should support the person with their personal care needs, mobility, communication and nutrition. However, when cross checking the summary care plans together with the main care plans for 13 people we found there were discrepancies in the information they contained, as the plans had not been fully reviewed and updated. For example, when a person's diet had changed their care summary was not always updated. One person's communication care plan had not been updated since 24 April 2015 despite significant changes in their ability to communicate. Another two people's records showed they had pressure sores on their toes but their skin integrity care plans had not been updated, in order to provide information for staff about the care and support they should provide to treat or provide comfort for them.

Two care staff told us they did not have time to read the main care plans and relied on the summaries in people's room for care guidance. This increased the risk of people receiving inappropriate care and treatment as staff were relying upon out of date information about how to meet their needs. This was of concern as there was a high level of agency use within the service, which meant that staff were not always familiar with the people they were caring for. The manager showed us an action plan to demonstrate that this concern had already been identified and full reviews had recently been started for all care plans.

We noted that a number of call bells were out of reach for people. We checked their summary care plans, which highlighted whether the person could use their call bell or not. Not all people who had been assessed as being able to use the call bell had access to them. Examples of this were that the bell had fallen on the floor, been tied up behind their chair or was tucked down the side of the bed rails. One person told us "I usually have it across my lap but I don't know where it is now". A family member said, "I am very pleased with the care here but my relatives bell is on the wall behind him and I have told them that he can't reach it". We brought this to the attention of the manager.

People did not always receive support in line with their care plan or which was responsive to their needs. We saw two people in their rooms with windows open. The rooms and the people felt cold. One of the people used a tambourine rather than a call bell to call for assistance, but this was out of reach. They would not therefore have been able to ask staff to close their window. The other person's care plan stated they would like staff to 'keep me warm and comfortable at all times'. Staff had not taken this person's preferences about how their care and support should be delivered into account.

People told us they did not always receive continuity of care. A number of people and their relatives remarked about frequent use of agency staff. People's comments included "I don't know the staff that care for me, they change all the time" and "You can't choose your carer you get all different ones, I don't know a lot of them". One person's relatives told us "The carers are definitely caring; we are not sure who they are and who are agency and who are not". Other relatives said "They have quite a few agency staff in here. Last weekend there were three agency staff with one permanent member of staff; she couldn't let them go on their own, they didn't know what to do. We have never made a complaint but we always know when agency staff shave him, he always has some cuts on his face".

The failure to maintain and review care and treatment plans and provide staff with up to date information relating to changes in people's needs and preferences was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The main care plans were compiled in a manner intended to support personalised care and contained a pen picture of each person. These original plans were well written and comprehensive and detailed individual likes and dislikes, as well as cultural and religious needs. Personal care preferences and needs were recorded as were risks to people's safety, monitoring of healthcare needs and end of life planning including advanced care plans. Where possible people or their representatives had agreed and signed the care plans. A relative told us that a pre-admission assessment had been carried out while their relative was still in hospital and the family were fully involved in the process.

We also observed examples of good care practices, such as staff checking pressure care mattresses were set correctly and encouraging people to drink. Staff told us that as care workers they had a role in recording people's care preferences. If a person had limited communication the care staff would speak with the person's family to find out

Requires improvement

# Is the service responsive?

about how best to provide care and support. If changes to a person's care plan were needed, they would inform the nurse on duty who would assess or refer the person to a specialist if appropriate. For example, if a person was not eating or drinking the nurse might refer to a speech and language therapist.

There was a programme of activities in place with at least two activities being provided each day. This included quizzes, board games, cookery, gardening, a hairdresser attending and art. There were also special themed days or evenings chosen by people who used the service with meals such as Italian food being served. We saw ball games, a quiz and a number of one to one sessions being carried out with the activities person. There had been a garden party in March, a 'Bake Off' competition in June and a fete in August. A member of staff told us there was currently only one activities coordinator, as one had left the service and their post was being advertised. They said "What she does is really good and she also does one to one activities with people. Care workers will also do activities if they find the time".

Although there was a varied programme of activities in place we could not see records of how often people being cared for in their rooms received mental stimulation and one to one sessions. The activities coordinator carried out what they described as a 'check in' with each person every day, however apart from that and when staff were attending them we noted that people spent long periods on their own. This could mean that some people were at risk of social isolation. We discussed this with the activities coordinator and the manager. They told us that recruitment was currently underway to employ a further activities person and there were volunteers who came and read to people and spent time with them. The manager said that recording of these visits would now be put into place.

There was a complaints procedure in place and copies were displayed around the home and formed part of the 'resident's handbook'. The complaints record log showed that any complaints and concerns received were recorded, investigated and the outcome fed back to the complainant in a timely manner and within the organisation's published timescales. Relatives told us they were aware of how to make a complaint. Their comments included "We have never had to make a formal complaint as any small concern you might have is listened to and put right very quickly. We feel quite comfortable going to the office or speaking to a manager or nurse".

Good

# Is the service well-led?

## Our findings

The home had been without a registered manager since January 2015. The previous registered manager had been promoted and an interim manager had taken over the daily running of the home. A senior member of staff told us there had been difficulties under the interim management and "Things got in a muddle and quite behind". The interim manager had since left the service and the service was currently being overseen by the previous manager. Another of the organisation's managers, who was present during the inspection, confirmed they were applying to be the registered manager for Hawthorne Court.

The manager promoted an open and transparent culture in the home. Records showed there were regular staff meetings, nurse meetings and a recorded, structured handover was carried out between each shift. A member of staff told us "(Service manager) is brilliant, a good manager. She is always walking around and points things out. She has 'surgery' days, when she keeps the door open. You can go in and speak with her". They said staff could raise any issues at staff meetings and the service manager "Will try to resolve them on the spot or will take them forward to the next meeting". Another member of staff confirmed they had "Regular staff meetings where we can put our point across". Staff were aware of the values and aims of the organisation and demonstrated how they applied these to their work.

The minutes of a staff meeting held on 21 August 2015 showed the manager had raised discussions and reminders with staff about updating support plans and directing and working with agency staff, so that people who used the service would benefit. The manager had also thanked staff for providing people with good basic care and reminded them that 'everything can be an activity for the resident if everyone works in a person centred way'. The manager had recommended that staff watch a television series on care for people living with dementia.

There were also separate meetings for people who used the service and for family and friends. Minutes of these meetings showed this gave people an opportunity to feed back on the care that was being provided and to make suggestions for the future. We saw this included the decoration of the environment, staffing issues, care issues, menu planning and the choice of activities. A relative told us "When they have meetings, they listen to what you have to say and try to make changes to suit each individual person".

Annual questionnaires were sent out to people who used the service and other stakeholders such as families and professionals involved with the home. We saw that returns were collated and an action plan for improvement based on the outcomes put in place. As a result of the last survey, a meeting had been arranged between the manager and person using the service. This had resulted in positive changes being made for the person in respect of their diet, the times they received their meals and to their personal environment.

Action was taken to drive improvements when this was required. The manager carried out audits of the quality and safety of the service and kept records of these. In addition, a service manager for the organisation carried out bi-monthly checks that were also recorded. The manager maintained a record of actions taken in relation to audits, incidents, and feedback from people using the service or others acting on their behalf. A copy of the report was sent to the service manager and provider. The service had systems in place to report, investigate and learn from incidents and accidents. Records showed that investigations were undertaken following incidents and that appropriate actions were taken in response. For example, in the event of a pattern of falls being identified, the provider's internal local governance team would contact the manager to check what action was being taken to reduce the risks of similar accidents happening again.

An external health and social care professional told us the service delivered good quality care and worked in partnership with them. They said the service was proactive, effective and responsive in communicating with them and taking on board any suggestions they made.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where legal requirements 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<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care<br><br>How the regulation was not being met: The provider had failed to maintain and review care and treatment plans and provide staff with up to date information relating to changes in people's needs and preferences. Regulation 9 (3) (b). |