Care Quality Commission

Grace Care Service Limited

Ramping Cat Nursing Home

Inspection report

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Ratings

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

Overall summary

We inspected The Ramping Cat Nursing Home on the 1 September 2015. The Ramping Cat Nursing Home provides residential and nursing care for older people over the age of 65, a number of the people living at the home were living with dementia. The home offers a service for up to 39 people. At the time of our visit 31 people were using the service. This was an unannounced inspection.

We last inspected in June 2015 when we carried out a focused inspection to see if the provider had taken action following our December 2014 inspection. We found people did not always receive their medicines as prescribed. We issued the provider and registered manager with a warning notice, requiring they address our concerns by 31 July 2015. At this inspection we found improvements had been made, however we still had concerns around how people's medicines were stored and managed.

There was a registered manager in post on the day of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service did not always manage people's medicines safely. Protocols for the administration of 'as required' medicines were not available. These protocols provide guidance as to when it is appropriate to administer an 'as required' medicine to ensure people receive their medicines in a consistent manner.

The environment was not always safe. Some rooms which posed a danger to people, staff and visitors were not always secured. There was on-going building work and some wires in the building were loose and window restrictors were not always working or in place.

Staff received supervision however no staff were observed or had their competencies assessed. Staff told us they felt supported by the provider and manager. Not all staff had knowledge of the Mental Capacity Act or Deprivation of Liberty Safeguards.

People were cared for by supportive and compassionate staff. People told us they valued the staff and we observed many kind and caring interactions between staff and people.

People spoke positively about the support they received around their healthcare needs. People were supported with their dietary needs and spoke positively about the food they received.

People and their relatives told us they knew how to make complaints. People told us their concerns were acted on, however the registered manager and provider were unable to identify trends in people's complaints or concerns as there were no clear systems for documenting concerns.

People's care plans were not always current and accurate. Two people staying at the home did not have care plans in place. Staff however knew people well, and people spoke positively about the support they received.

People were not always involved in planning their care. People who wished to self administer their own medicines, were not supported to do so. Other people told us they were involved in their care, with one person telling us how they choose how staff assisted them.

The registered Manager had developed systems to monitor the quality of the service, however these were not always effective or consistently being used. People and their relatives views had been sought, however there was no evidence these views had been acted upon.

Some concerns raised following recent safeguarding concerns had not been acted upon or monitored by the registered Manager. Some concerns we reported to the registered manager during our inspection were not addressed. Additionally, staff were not aware of the culture within the home, and not all staff felt involved in making decisions within the service.

Staff protected people from the risks associated with their care. Staff had clear guidance to protect people from pressure area damage.

There were enough staff deployed by the provider to meet people's needs. People told us they felt safe in the home, staff had a good understanding of safeguarding and the service took appropriate action to deal with any concerns or allegations of abuse.

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

Requires improvement

The service was not always safe. People were not always protected from the risks of their environment.

People received their prescribed medicines, however staff did not always manage medicines effectively. The service had no 'as required' medicine protocols.

People told us they felt safe and staff had good knowledge of their responsibilities to report concerns. There were enough staff deployed to meet people's needs.

Is the service effective?

Requires improvement

The service was not always effective. Staff did not always have the training and support they needed to meet people's needs. Staff did not have knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards.

People were supported with their nutritional and healthcare needs. People spoke positively about the food and support they received.

Is the service caring?

Good

The service was caring. People spoke positively about the care they received from care staff. Care workers knew the people they cared for and what was important to them.

People were treated with dignity and kindness from care workers and were supported to make choices.

Care workers respected people and ensured that their dignity was respected during personal care.

Is the service responsive?

Requires improvement

The service was not always responsive. People's care plans were not always current and accurate.

People were not always involved in decisions regarding their care and their care was not always centred on their preferences.

People had access to a range of activities, and told us they enjoyed their lives in the home. People knew how to complain and felt action was taken.

Is the service well-led?

Requires improvement

The service was not well led. The registered manager had quality assurance systems, however these were not always effective or being consistently used.

Summary of findings

Concerns raised during our inspection, were not always acted on. The registered manager and provider had not taken steps to ensure building contractors within the home were of good character.

There was not a caring culture in the home. Staff were not aware of the provider's culture or aims or goals. Staff were not always supported to ensure the service ran well.

Ramping Cat 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 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 1 September 2015. This was an unannounced inspection. The inspection team consisted of five inspectors and a pharmacy inspector.

Before the visit we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. This enabled us to ensure we were addressing potential areas of concern. We spoke with local authority safeguarding and contracts teams.

We spoke with 10 of the 31 people who were living at Ramping Cat Nursing Home. We also spoke to two people's relatives and visitors. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with two registered nurses, four care workers, the home's chef and the registered manager. We looked around the home and observed the way staff interacted with people.

We looked at seven people's care records, and at a range of records about how the home was managed. We reviewed feedback from people who had used the service and their relatives.

Requires improvement

Is the service safe?

Our findings

At our last inspection in June 2015, we found people did not always receive their medicines as prescribed. Care and nursing staff did not always keep an accurate record of when people had been assisted with their prescribed medicines. These concerns were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We issued the registered manager and provider with a warning notice requiring they meet the relevant regulation by 31 July 2015. At this inspection, In September 2015, we found the provider had taken some action, however we still identified concerns.

Some people's Medicine Administration Records (MAR) charts did not have information recorded with regards to how much medicine had been brought into the home, therefore we could not check whether these people had received their medicines correctly. There were no omissions on people's MAR charts and where people had not received a medicine, a code or reason had been recorded, although there was widespread use of a code that was not recognised which sometimes made it difficult to interpret whether people had received their medicines correctly.

Medicines were stored in locked medicine trolleys within a locked treatment room; however cupboards containing medicines within the treatment room were not locked. We found one bottle of morphine in the cupboard which had expired and another where the label had faded so we could not identify whose medicines they were. Medicines requiring cold storage were kept within a refrigerator in the treatment room. The refrigerator was not being monitored to ensure it was working; the current temperature was within range at the time of our visit however the maximum refrigerator temperature reading was in excess of the manufacturers guidelines. Two bottles of antibiotic syrup which were supposed to be kept in the refrigerator had been stored in the cupboard, these medicines had expired and were no longer fit for use.

There was not always a photograph of people for identification purposes as part of their medicines records. People's allergies were not always recorded on MAR charts. These concerns put people at risk of receiving medicines which may have a negative impact on their wellbeing.

Protocols for the administration of 'as required' medicines were not available. These protocols provide guidance as to when it is appropriate to administer an 'as required' medicine and ensure that people receive their medicines in a consistent manner. The administration of topical medicines was being done by carers without appropriate training. We found one analgesic gel labelled for one patient being used for another and creams which were meant to be stored in locked cupboards or the refrigerator had been left in people's bedrooms.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected from the risks within the home. Wires were dangling from the ceiling which could be pulled by people, staff or visitors. Rooms on the first floor and ground floor of the home did not always have window restrictors in place or these restrictors were broken (these are devices which stop windows from opening fully to prevent the risk of someone falling). Three pieces of art work were being rested on handrails in the service. If people used this handrails there was a risk of the art work falling on them. Where builders were working within the home, we found paint left in communal areas away from the attention of staff. We raised concerns to the registered manager who asked for builders in the property to ensure all wires were tidied to prevent the risk of people being harmed.

Areas of the home which should be locked, such as the home's laundry, lift motor room and plant room, we were able to gain access to these areas throughout the inspection. These areas contained equipment which could pose a risk to people, staff and visitors. We discussed this concern with the registered manager, however no action was taken to secure these areas.

One person had previously absconded from the home via the laundry room. The provider and registered manager agreed to ensure this route was now secured and that a key pad would be kept on the front door to ensure people were kept safe. Neither of these actions had been followed, the front door was unlocked and open during the morning of our inspection and the laundry was accessible throughout the inspection. We discussed these concerns with the registered manager, who told us the person who absconded was no longer mobile. Care staff however told us, and we observed, that the person was mobile and they

Requires improvement

Is the service safe?

monitored where they were throughout the day. The registered manager had applied to deprive this person of their liberty as they did not have the capacity to identify risks if they left the service alone.

This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe in the home. Comments included: "I'm definitely safe here", "We have no concerns, we feel safe, we're happy here" and "I feel safe and secure here."

Staff had knowledge of types of abuse, signs of possible abuse which included neglect, and their responsibility to report any concerns promptly. Staff told us they would document concerns and report them to the registered manager, or the provider. One staff member said, "I would report any concerns to the manager." Another staff member added that, if they were unhappy with the manager's or provider's response they would speak to their recruitment agency, safeguarding or CQC. Staff told us they had received safeguarding training and were aware of the local authority safeguarding team and its role.

People had assessments where staff had identified risks in relation to their health and wellbeing. These included moving and handling, mobility, social isolation and nutrition and hydration. Risk assessments enabled people to stay safe. Each person's care plan contained clear information on the equipment and support they needed to assist them with their mobility. For example, staff ensured people's pressure relieving mattresses were set in accordance with their needs and preferences.

Where people were at the risk of falls staff ensured they were protected from harm. Staff ensured people were referred to local healthcare professionals to ensure the support they provided was safe and effective. One person was at risk of falling from bed, staff ensured the bed was set at it's lowest position and safety mats were available to prevent the person from injuring themselves if they fell from their bed.

Staff had good awareness of assisting people with safe moving and handling. Staff had the equipment they needed to safely move people. One staff member clearly identified another staff member was starting to attempt an unsafe moving and handling procedure. They intervened to ensure the person was protected from harm.

People told us there were enough staff to meet their needs. Comments included: "If I want them they're never too far away", "They come when you need them and there is always someone around" and "Staff spend time with me, I don't feel alone."

There was a calm atmosphere in the home on the day of our inspection. Staff were not rushed and had time to assist people in a calm and dignified way. Staff had time to spend talking to people throughout the day. Staff told us they had enough staff, one member of staff said, "We have enough staff here, we have time to assist people safely." The registered manager told us the amount of staff deployed would depend on people's needs. Staff rotas showed the numbers of staff required were on shift.

Records relating to the recruitment of new staff showed relevant checks had been completed before staff worked unsupervised at the home. These included employment references and disclosure and barring checks (criminal record checks) to ensure staff were of good character.

Requires improvement

Is the service effective?

Our findings

Staff did not always have the training they needed to meet people's needs and ensure their safety. Some staff we spoke with did not have awareness around the Mental Capacity Act 2005 (which provides the legal framework to assess people's capacity to make certain decisions, at a certain time), or first aid training. We discussed these concerns with the registered manager. They informed us all staff, apart from recent starters had received this training. They stated care staff did not have first aid training, as this was provided by nurses, however would seek to provide training.

One staff member tried to assist people with their mobility using unsafe moving and handling practices. On one occasion a staff member stopped them, however they assisted someone else using a practice which may put the person and staff at risk of injury. We discussed this concern with the registered manager, who informed us refresher training around moving and handling was booked for September 2015. We asked the registered manager if they observed care staff to ensure people were assisted with their mobility safely. The registered manager was unaware of any concerns and had not observed staff to ensure their practices were safe.

Following our concerns around the administration of people's medicines, all nursing staff had been retrained regarding medicine administration. The registered manager informed us that all nursing staff had been observed administering medicines, however there was no record of these observations. We asked the registered manager if nursing staff had had their competencies assessed around medicine administration. They informed us this had not happened, and was not needed as they had recently been retrained.

These concerns were a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Staff told us they had been supported by the registered manager and provider to develop professionally. Two care workers told us they were supported to complete their Qualifications Credit Framework (QCF) level 2 diploma in health and social care. Another care worker was currently taking QCF level 3 in health and social care.

Staff had access to supervision and appraisal (one to one meetings) from the manager. Staff supervision records showed staff were supported. Supervision records showed the registered manager used supervisions to understand staff concerns and make changes where necessary. People and their relatives spoke positively about the staff. One person told us, "They know what I like". Another person said, "They're good to me."

Staff offered people choice throughout the day, and sought people's consent. One staff supported one person with ensuring they were comfortable. The person was unable to talk, so the staff member used eye contact and paid close attention to the person's facial expressions. They asked the person closed questions and gave the person time to respond. The person smiled and received the support they wanted from the staff member.

The registered manager had identified one person who they believed were being deprived of their liberty. They had made Deprivation of Liberty Safeguards (DoLS) applications to the supervisory body. 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. These applications included the reason they have made the application, which referred to the individual person's safety.

People were supported to maintain good health through access to a range of health professionals. These professionals were involved in assessing, planning, implementing and evaluating people's care and treatment. These included GPs, psychiatrists, district nurses, community mental health nurses and speech and language therapists. For example, one person had support from occupational therapists to support their mobility needs and other aspects of their care.

People were supported by care workers with thickened fluids because they were at risk of choking. These people had been assessed as at risk, and speech and language therapist (SALT) guidance had been sought and followed. We observed staff prepare people's drinks in line with this guidance. Where care staff had concerns over people losing weight they contacted the person's GP. People were supported with dietary supplements and were given support and encouragement to meet their nutritional needs.

Requires improvement

Is the service effective?

People spoke positively about the food and drink they received in the home. Comments included: "The food is all right here", "I like the choice, I can't complain" and "I have enough to eat and drink, so I'm okay"

The atmosphere at lunch time was calm and pleasant. Staff talked to people in a respectful way. Staff asked if people wanted clothes protectors and respected people's wishes if they chose not to. People who needed assistance with their meals were supported by care staff who supported them to make choices. Staff assisted people as they provided them their meals, to ensure people had a good meal experience. Staff were organised in ensuring all people had their meals in a safe and dignified way.

One staff member was concerned someone did not like their choice of lunch, they talked to them and provided them with an alternative. The person told us the staff member they were not hungry, however would like a pudding. The staff member took two puddings over. The person asked if they could have both and the staff member respected this choice. The person told us, "Sometimes I just want a pudding."

The home's chef and staff were aware of people's dietary needs and preferences. The chef told us they had all the information they needed and were aware of people's individual needs. People's needs were also clearly recorded in their care plans.

Good

Is the service caring?

Our findings

People spoke positively about the care they received in the home. Comments included: “Can’t complain about the staff, they are polite and attentive. I think they need a medal. Very good nurses, pleasant and medical attention is good”, “Very nice staff” and "The staff are very caring. Can't complain."

One person told us how they were encouraged by staff to make decisions and spend time with other people. They told us, “I felt I could not mix with some people who were too unwell and they [staff] kindly started smaller lounges for a few like me. I do most of my things as I am able. They [staff] would come and make my bed. I have my breakfast in bed, it’s my choice. The staff are very nice and they understand me”.

One relative told us, “I think my Mother is well looked after, she always has biscuits and it’s so much better that the nursing staff are on site”. The provider has carried out a recent quality survey among the relatives; positive feedback has been received and the following comments were received “Staff are friendly” and “We’re very happy with everything”.

The atmosphere was calm and friendly with staff engaging with people in a respectful manner. We observed warm and friendly interactions. Staff offered people choices and respected people’s wishes. One person asked for a cup of tea and some biscuits. The care worker acted on this person's request. They provided a small selection of biscuits which the person enjoyed.

Staff took time to listen to people and responded to their questions. We observed one staff member take time to talk to a person who was quietly spoken. The staff member took time to speak with the person supporting them to make choices. They did this by asking them questions and ensuring the person made a choice they wanted.

People were encouraged to personalise their bedrooms. One person showed us their collection of stuffed animals. They told us why they were important to them. Staff also knew why the person had these items. One person spent time showing us their old cabinet which they brought with them and how staff had supported them to have a space they liked to spend time in.

We observed staff to be calm, helpful and sensitive when they assisted people. Staff worked and supported people at a relaxed pace. Staff knew what was important for each person, and respected their choices.. For example, one person was assisted to the lounge and the staff brought their talking clock and placed it next to them. Staff told us “I like working here, I have good support from the team”.

People were supported with their meals at a relaxed pace. Staff sat down to assist people with their meals if they required help and engaged them in conversation. Staff offered a choice including having two meal options and they assisted with cutting up the food if required.

People were treated with dignity and respect. We observed staff assisting people throughout the day. One person liked to spend most of their day in their room. Staff checked on this person by knocking on their door and introducing themselves. When staff assisted this person with personal care they ensured their room door and curtains were closed to ensure their dignity was protected. Their preferences were recorded in care plans and people told us their choices were always respected.

Requires improvement

Is the service responsive?

Our findings

People's care plans often included detailed information relating to their health needs. They were written with instructions for staff about how care should be delivered. However, these did not always accurately reflect people's needs. For example, one person's mobility needs had changed and these changes had not been accurately recorded. One care plan stated they were mobile, however another stated they were dependent of staff to mobilise. This person's care plan also stated they required bed rails, however staff told us the person did not need bed rails.

Two people were staying at the home for a period of respite. A pre-admission assessment had been completed for both people. These assessments contained information about their healthcare needs. We found that there were no care plans or risk assessments for these people. This meant there was no guidance for staff on these people's needs and the support they required. We discussed this concern with the registered manager who was unaware that care plans had not been written for either of these people.

People's care plans did not always contain information around their mental capacity or for specific decisions such as consent to care and accommodation. For example, one person's care review clearly showed they had capacity to make decisions regarding their care. They told us they were supported to make all decisions about their care. However, other people's care records contained limited information around their mental capacity and the support they required to make decisions.

People's care plans were not always personalised and did not always contain people's life histories, hobbies or interests. There was limited information of how people wished to spend their time in the home, what was important to them or how they wished to spend their day. The registered manager told us that the team were in a process of working with individuals and their families to ensure that a full life history was in place for the people living at the service.

Staff recorded complaints and concerns from people and their relatives on people's on-going care records. They did not always record these complaints in the services complaints book. This made it difficult to show if concerns had been responded to by the registered manager or provider or if people were happy with the outcome. The registered manager or provider may be unable to identify any trends in people's complaints and concerns as this information was not recorded consistently. This meant improvements to the service as trends may not be identified.

These concerns were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People told us they knew how to raise concerns to the registered manager. We saw the last complaint was recorded and responded to in accordance with the provider's complaints policy. One person said, "I raised a concern about the temperature of my room once, I was happy with the action staff took."

People told us they enjoyed their social life in the home. One person said, "I enjoy spending time with people, and the activities are good", "I like going out for walks in garden" and "We have a bit of fun. I like playing games with staff. We have a good laugh."

People enjoyed activities and interaction from staff throughout our inspection. People were supported to play games, which they enjoyed. In the afternoon the activity co-ordinator supported people to be engaged with arts and crafts. Staff encouraged people to be involved. People enjoyed talking amongst themselves and drawing. There was a lively and pleasant atmosphere whilst these activities were carried out.

People were supported to spend their days as they chose. One person told us how they liked to watch and sit with other people in the morning and then spend time in their own company in the afternoon. They said, "the staff assist me to spend time with people. In the afternoon I like to watch quizzes on TV in my room."

People and their relatives were able to express their interest in their or their relatives care. People told us they were able to make changes in their care, and that their relatives were involved if needed. One person and their relatives view were clearly recorded on the person's care records. One person said, "I like to involve my family too."

Requires improvement

Is the service well-led?

Our findings

When we last inspected the service in June 2015, the registered manager and provider had a system to monitor and manage incidents and report concerns or trends. However, incidents had occurred since we last inspected and there was little reflection of how this system had detected risks and the potential impact of these on people receiving a service.

A number of concerns had been made to the CQC since June 2015 when we last visited. There was an incident of a person leaving the building and getting onto the main road. At the time the registered manager had not been made aware of these concerns. Safeguarding asked the registered manager to investigate the concerns, and actions were set to ensure the home was secure to avoid further concerns. On the day of our inspection we found the routes which the person had used to leave the premise were unsecured. Staff told us and we observed that the person who had absconded was able to move and therefore could leave the premises unsupervised. This meant that action had not been taken in relation to these concerns.

Feedback sought following these incidents identified the service was not always open to seeking advice and there were concerns regarding the management of the service.

Concerns found on the day of this inspection were raised with the registered manager. These included the main door to the building being open when we arrived and throughout the day despite paperwork seen stating it should remain locked by a keypad. The registered manager told us she could see who was leaving and entering the building and the risk was managed. A person was wheeled outside the main door and the door was shut. When a staff member brought the person back in the door was left open again. We saw a workman and a visiting professional enter the building without having to ask for access.

We asked the registered manager about builders and decorators who were working in the home during our inspection. These workers were carrying out maintenance work in all areas of the service, including people's rooms, corridors and lounges. We asked the registered manager whether the workers had been security checked and if a risk assessment for working in areas with vulnerable adults had been carried out. The registered manager phoned the provider but was not able to provide any evidence of DBS checks or risk assessments. The Health and Safety Policy stated that risk assessments should be done for subcontractors.

Quality audits were not always being consistently carried out. The last audit of wheelchair maintenance was September 2014. There were also comments about problems with the flow of hot water in July 2015 but no note of actions taken to resolve this. Care plans had not always been reviewed effectively to ensure they reflected people's needs. Additionally some people did not have care assessments. When we discussed this with the registered manager, they were unaware of these concerns. There were no current audits to ensure people's care records were current or accurate.

Polices and procedures had not always been updated. A policy on the “Protection of a Resident” was due for review Jan 2013 but had not been done. The nursing home is referred to as Nightingale House in a Quality Assurance policy. Medicine policies had not been reviewed, and there were no policies around the self administration of medicines. Two people told us they administered their own medicine, however had not been given this option within the home. While they were not concerned by this, as there were no guidelines for staff to follow people were not supported to maintain their independence.

The provider and registered manager did not have an effective business continuity plan. For example the continuity plan provided to us contained no details of arrangements for alternative accommodation in the event of building damage and need for evacuation. We asked the registered manager who stated it would be updated when the building work had been completed.

People’s and relatives views were being sought, and the registered manager had collated these views, however they had not yet documented the actions they needed to take. Feedback stated there was a need for a deputy manager at the service, but this had not happened. We discussed this with the registered manager, who was aware of the need for support to manage the quality of the service.

Not all staff felt able to suggest improvements or felt communication was inadequate. Comments included “We let the manager know about things but it is rarely acted upon”. One staff member said team meetings were “Being told things we had done wrong”. We saw minutes of a team

Requires improvement

Is the service well-led?

meeting which were a list of things to put right and it did not reflect staff input to the meeting. This meant staff did not always receive feedback in a motivating way which would enable them to have a clear vision of what the service wanted to achieve and the values of why these changes were important to the organisation and the people they supported.

The registered manager had overall responsibility for managing the home. No lead areas for other staff were identified, and therefore all aspects of management were undertaken by one person. As a service that has grown, this meant the day to day running was a big responsibility.

Nursing staff had been given the responsibility to review people's care records, however the quality of care plans had not been monitored. Nurses, including those on night shifts were responsible for reviewing people's care records, this meant it was difficult for night nurses to review people's care needs with the person. Care staff were not involved in reviewing people's care needs, although they worked with people on a daily basis.

These concerns were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Staff did not effective systems in place to manage people's medicines. There were not 'as required' medicine protocols. People's medicines were not always secured appropriately. Regulation 12 (f)(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment How the regulation was not being met: The environment was not always safe and people were at the risk of undue harm. Regulation 15 1 (b)(d)(e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Staff did not always receive the training and supervision they needed to meet people's needs. Regulation 18 (2).

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The registered manager and provider did not always have effective systems to monitor the quality of the service people received. People's care records were not always current and accurate. Regulation 17 (1)(2)(a)(b)(c)(f)

The enforcement action we took:
We have issued a warning notice informing the provider they must make improvements by 31 December 2015.