Runwood Homes Limited

Rowena House

Inspection report

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Doncaster
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 26 and 27 January 2016 and was unannounced on the first day. This was the first inspection of the service following the Care Quality Commission registration in September 2015. The service was previously registered under another provider.

The service has a registered manager who has been registered with the Care Quality Commission since September 2013. 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.

Rowena House is a care home situated in Conisborough, Doncaster which is registered to accommodate up to 34 people. The service is provided by Runwood Homes Limited. At the time of this inspection there were 21 people living at the home. Accommodation is provided on both the ground and first floor. The service has several communal and dining areas and easily accessible secure gardens. The home is close to local amenities of shops and healthcare facilities.

Medication was not always administered as required by the prescriber. Gaps in the medication records meant some medications may have been missed. Some medication protocols were inaccurate which meant people may not have received 'as and when required' properly. Medication was stored correctly and returned to the chemist if they were no longer required. You can see what action we told the provider to take at the back of the full version of the report.

The requirements of the Mental Capacity Act 2005 were in place to protect people who may not have the capacity to make decisions for themselves. The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including balancing autonomy and protection in relation to consent or refusal of care or treatment.

People's physical health was monitored as required. This included the monitoring of people's health conditions and symptoms so appropriate referrals to health professionals could be made.

There was a recruitment system in place that helped the employer make safer recruitment decisions when employing new staff. We found staff had received a structured induction and essential training at the beginning of their employment. This had been followed by regular refresher training to update their knowledge and skills. Staff knew how to recognise and respond to abuse correctly. They had a clear understanding of the procedures in place to safeguard vulnerable people from abuse.

There were sufficient staff with the right skills and competencies to meet the assessed needs of people living in the home. Staff told us they felt supported by the manager and provider, formal supervisions were taking

place and appraisals were planned for later in the year.

Staff were aware of people's nutritional needs and made sure they supported people to have a healthy diet, with choices of a good variety of food and drink. People we spoke with told us they enjoyed the meals and there was always something on the menu they liked.

People were able to access some activities although there was no dedicated activity co-ordinator. People told us they had enjoyed baking and having entertainment from outside the home. They also liked involvement from the local community. Some people told us they would like more activities as sometimes there was not sufficient happening.

There was a strong and visible person centred culture in the service. (Person centred means that care is tailored to meet the needs and aspirations of each individual.) We found the service had a friendly relaxed atmosphere which felt homely. Staff approached people in a kind and caring way which encouraged people to express how and when they needed support. Everyone we spoke with told us that they felt that the staff knew them and their likes and dislikes.

Staff told us they felt supported and they could raise any concerns with the registered manager and felt that they were listened to. People told us they were aware of the complaints procedure and said staff would assist them if they needed to use it. We noted from the records that two formal complaints had been received since the transfer of services in September 2015.

There were systems in place to monitor and improve the quality of the service provided. However, we were unable to see how effective they were embedded as audits were relatively new following their registration in September 2015. We saw copies of reports produced by the registered manager and the provider. The reports included any actions required and these were checked each month to determine progress. The regional care director carried out monitoring visits and an action plan had been developed which the registered manager was working towards. The action plan related to objectives set by Runwood Homes Limited

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 required some improvement to make it safe.

Medication was not always administered as required by the prescriber. Gaps in the medication records meant some medications may have been missed.

Staff knew how to recognise and respond to abuse correctly. They had a clear understanding of the homes procedures in place to safeguard vulnerable people from abuse.

People's health was monitored and reviewed as required. This included appropriate referrals to health professionals. Individual risks had also been assessed and identified as part of the support and care planning process.

There were enough qualified, skilled and experienced staff to meet people's needs. We saw when people needed support or assistance from staff there was always a member of staff available to give this support.

Is the service effective?

Good

The service was effective.

Each member of staff had a programme of training and was trained to care and support people who used the service safely and to a good standard.

The staff we spoke with during our inspection understood the importance of the Mental Capacity Act in protecting people and the importance of involving people in making decisions. We also found the service to be meeting the requirements of the Deprivation of Liberty Safeguards.

People's nutritional needs were met. The food we saw, provided variety and choice and ensured a well-balanced diet for people living in the home. We observed people being given choices of what to eat and what time to eat.

Is the service caring?

Good

The service was caring.

Staff had an excellent approach to their work. People and their relatives were complimentary about the care provided. People told us that staff were very caring and respected their privacy and dignity.

Staff were motivated and passionate about the care they provided. They spoke with pride about the service and the focus on promoting people's wellbeing.

People were supported to maintain important relationships. Relatives told us there were no restrictions in place when visiting the service and they were always made to feel welcome.

Is the service responsive?

Good

The service was responsive.

People had their care and support needs kept under review. Staff responded quickly when people's needs changed, which ensured their individual needs were met.

People had access to some activities although this was an area which could be improved to be more person centred.

People's concerns and complaints were investigated, responded to promptly and used to improve the quality of the service.

Is the service well-led?

Good

The service was well led.

The registered manager had developed a strong and visible person centred culture in the service. There was a strong emphasis on promoting and sustaining the improvements already made at the service. Staff told us that the management team were knowledgeable which gave them confidence in the staff team and led by example.

The registered manager continually strived to improve the service and their own practice. Systems were in place but not fully embedded to monitor the quality of the service people received.

Systems were in place for recording and managing complaints, safeguarding concerns and incidents and accidents. Documentation showed that management took steps to learn from such events and put measures in place which meant they

were less likely to happen again.

Rowena House

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection team consisted of an adult social care inspector and took place on 26 and 27 January 2016 and was unannounced on the first day. At the time of our inspection there were 21 people using the service. We spoke with the registered manager and the deputy manager. We also spoke with three care workers, a general assistants and the cook. The regional care director was also present during the inspection and received feedback following the visit.

We also spoke with seven people who used the service and three visiting relatives. This helped us evaluate the quality of interactions that took place between people living in the home and the staff who supported them.

We spent time observing care throughout the service. We also 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.

Prior to the inspection we gathered information from a number of sources. We looked at the information received about the service from notifications sent to the Care Quality Commission by the manager. We spoke with the local council quality assurance officer who also undertakes periodic visits to the home, and a visiting district nurse. We also spoke with the pharmacist who visits the home periodically to undertake training and audits of medication.

Prior to our visit we had received a provider information return (PIR) from the provider which helped us which helped us to prepare for the inspection. 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 looked at documentation relating to people who used the service, staff and the management of the

service. We looked at three people's written records, including the plans of their care and we looked at Deprivation of Liberty Safeguarding applications which had been submitted to the local council supervisory body. We also looked at the systems used to manage people's medication, including the storage and records kept. We looked at the quality assurance systems to check if they were robust and identified areas for improvement.

Requires Improvement

Is the service safe?

Our findings

We spent time observing how staff related to people who used the service. People living on Rosewood unit were living well with a dementia type illness. It was clear from our observations that staff understood how to keep people safe in the unit while helping them to move around the home unrestricted. People living on the Willow unit told us they felt safe in the home. One person said, "I have lived here for a while now and I can say I have always felt safe, staff are very good and spend time talking to us if we are upset about anything."

Medication was securely stored with additional storage for controlled drugs, which the Misuse of Drugs Act 1971 states should be stored with additional security. We checked the controlled drug (CD) book against the actual drugs stored in the cabinet. We found the checks undertaken by staff after administering controlled drugs ensured stocks were accurate. People's medication was stored in a secure cupboard in their individual bedrooms. We checked records belonging to four people who used the service and found errors in the records. Medication administration records (MAR) showed some gaps where medications had been administered but not signed for. This meant staff had not followed the provider's medication policy. Audits undertaken by the registered manager had identified this. However, the action expected by the manager had not been followed making the audit ineffective.

One person's inhaler described that it should be administered four times each day. However, the MAR showed it had only been administered twice a day for the duration of the MAR, which was three weeks into the four week cycle. This meant the person had not received their medication as prescribed. The deputy manager confirmed the inhaler had only been administered twice a day.

Another person was prescribed medication to help with anxiety. This was prescribed half a tablet three times a day. However, staff were having to physically cut the tablet. This meant staff was handling the medication and potentially not administering an accurate dose of the medication.

Another person was prescribed pain relief to be administered 'when required'. However, the MAR did not have an amount carried forward from the previous month. This made it difficult to audit the amount of medication administered. We spoke to the registered manager about this and she told us that staff were instructed to return any stock left over at the end of the cycle so there should not be any medication to carry over. This meant staff had not followed the provider's medication policy as medication had not been returned. We also noted the protocol for staff to follow stated the wrong type of medication used for pain relief for one person. The protocol was for paracetamol when the actual medication was co-codamol. This meant the person may be given the wrong medication or not receive any medication to control pain, due to the confusion on the protocol.

We were told that staff administering medicines regularly had their competence checked and this was confirmed by the registered manager. We saw evidence to support this.

The above was a breach of Regulation 12 (2) (f) (g) (h) safe care and treatment; of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent it from happening. People we spoke with told us they felt safe. One person said, "It's my home, I feel safe and staff look after us all." Another person said, "There is always someone you can ask for help, I feel safe when staff move me because they know what they are doing."

A safeguarding adult's policy was available and staff were required to read it as part of their induction. We looked at information we hold on the provider and found there were no ongoing safeguarding investigations. The manager told us that she was aware of when and what was required to be reported to the Care Quality Commission.

We spoke with staff about their understanding of protecting vulnerable adults from abuse. They told us they had undertaken safeguarding training and would know what to do if they witnessed bad practice or other incidents that they felt should be reported. They were aware of the local authorities safeguarding policies and procedures and would refer to them for guidance. They said they would report anything straight away to the nurse or the manager.

Staff had a good understanding about the whistle blowing procedures and felt that their identity would be kept safe when using the procedures. We saw staff had received training in this subject.

The registered manager told us that they had policies and procedures to manage risks. There were emergency plans in place to ensure people's safety in the event of a fire or other emergency at the home. Risks associated with personal care were well managed. We saw care records included risk assessments to manage risks of falling, risk of developing pressure sores and risks associated with nutrition and hydration.

Systems were in place to make sure that managers and staff learnt from events such as accidents and incidents, complaints and concerns. This reduced the risks to people and helped the service to continually improve. The registered manager told us that people were referred to the fall team if they became at risk from frequent falls. This demonstrated the service worked closely with other health professionals where a particular risk was identified.

The registered manager told us that staff had transferred from the previous provider. They told us that the service had employed a deputy manager recently and we looked at their induction programme which was being completed. We spoke with the deputy manager and told us they thought the recruitment process was robust and thorough. Most staff had worked for the previous provider for many years. We found the recruitment of staff was robust and thorough. We looked at six staff files which contained information about the applicant. There was clear evidence how staff had transferred from the previous provider.

The registered manager told us that staff were not allowed to commence employment until a Disclosure and Barring Service (DBS) check had been received. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. This helps to ensure only suitable people were employed by this service. The registered manager was fully aware of their accountability if a member of staff was not performing appropriately.

We looked at the number of staff that were on duty and checked the staff rosters to confirm the number were correct. The registered manager told us they used a dependency tool to assist with the calculation of staff needed to deliver care safely to people. The registered manager told us that the organisation calculates staffing ratios but she had flexibility to increase hours if required. People we spoke with told us they thought there were sufficient staff to assist them safely. We spent time observing staff and found people's needs were

attended to without delay. Buzzers were answered in a timely manner and staff spent time speaking to people in an unrushed attentive manner.

We checked around the home to see if it was clean and tidy. There were no obvious trip hazards and everywhere was very clean. We did not notice any unpleasant odours or badly stained furniture and bedding. People we spoke with told us that the home was always clean. Relative confirmed they always found the home very clean.

We saw staff followed good hand hygiene procedures and protective equipment such as aprons and gloves were available throughout the building. We spoke with the general assistant who was undertaking cleaning duties. She told us she was very keen to ensure cleaning was carried out to a high standard.

Good

Is the service effective?

Our findings

People were supported to have their assessed needs, preferences and choices met by staff that had the right skills and competencies. People who used the service and relatives we spoke with told us they thought the care staff were competent and well trained to meet their or their family member's individual needs. One relative said, "I've got no worries about the training they [care workers] get and how they do their job." One person we spoke with said, "I think the staff know what they are doing, they all seem very nice. They are always asking me if I am alright and offer help where needed."

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 to 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 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. Staff were aware of the Mental Capacity Act and the Deprivation of Liberty Safeguards. This legislation is used to protect people who might not be able to make informed decisions on their own. At the time of the inspection the registered manager told us they had made applications to the local council's supervisory body for everyone living at the home. We looked at a sample of the DoLS applications which gave information about the reasons for the application so that they could support people's needs in the least restrictive way. The applications which had been submitted were still awaiting decisions.

Staff had attended regular training to ensure they had the skills and competencies to meet the needs of people who used the service. The records we looked at confirmed staff had attended regular updates in essential topics such as safeguarding, first aid, fire, health and safety and moving and handling people. Most of the staff who worked at the home had also completed a nationally recognised qualification in care to levels two, and three. We saw that staff had completed training using on-line programmes and also attended face to face training in practical subjects such as moving and handling.

The registered manager was aware that all new staff employed would be registered to complete the 'Care Certificate' which replaced the 'Common Induction Standards' in April 2015. The 'Care Certificate' looks to improve the consistency and portability of the fundamental skills, knowledge, values and behaviours of staff, and to help raise the status and profile of staff working in care settings.

Systems to support and develop staff were in place. We saw evidence of supervisions that had taken place. These meetings gave staff the opportunity to discuss their own personal and professional development as

well as any concerns they may have. The registered manager told us that annual appraisals were planned for later in the year.

We spoke with staff about the support they received. They told us they had very good relationships with the manager and deputy and they felt supported in their roles. They told us they felt able to discuss any issues either work related or on a personal level without fear that information shared would be dealt with in confidence. Staff told us during the period leading up to the transfer to the new provider information was shared regularly. They said they trusted the manager to be transparent when discussing the move to Runwood Homes Limited. Staff told us that the new provider had excellent values and they shared those values to provide the best care possible for people who used the service.

Staff told us that they attended a handover at the start of each shift which informed them of any concerns in relation to people's health. One staff member said, "I find the handover essential as I only work part-time. The information we receive gives us an overview of the health and wellbeing of people we support."

We found the service worked well with other health care agencies to ensure they followed best practice guidance. The deputy manager gave us an example of working closely with the doctors and district nurses who visited people at the home regularly.

The provider had suitable arrangements in place that ensured people received nutrition and hydration that met their assessed needs. We looked at four people's care plans and found they contained detailed information on their dietary needs and the level of support they needed to ensure that they received a balanced diet. Risk assessments such as the Malnutrition Universal Screening Tool (MUST) had been used to identify specific risks associated with people's nutrition. These assessments were being reviewed on a regular basis. Where people were identified as at risk of malnutrition, referrals had been made to the dietician for specialist advice.

We joined a group of people eating their meals on Rosewood unit. We carried out a SOFI during lunch on the first day of this inspection. We noted the menu was not displayed which meant people living with dementia could not see information about the meal that was being served. We saw staff offered a choice of main course which was served from a heated trolley. We observed staff appropriately assisting people to eat their meal. The meal was unrushed and people were offered seconds. People we spoke with told us they had enjoyed their meal and the food provided was consistently good.

The provider displays posters which showed how they gave a great deal of emphasis on ensuring people enjoyed the mealtime experience. One staff member was identified each day to complete the 'dining experience' record. These were analysed by the manager to ensure staff were following the protocols expected of them.

The cook told us they received training specific to their role including food safety, healthy eating and food processing. They had a good knowledge of specialist diets. The cook had knowledge about the latest guidance from the Food Standards Agency. This was in relation to the 14 allergens. The Food Information Regulations, which came into force in December 2014, introduces a requirement that food businesses must provide information about the allergenic ingredients used in any food they provide. The cook told us they had been awarded a 'five star' rating by the local council who were responsible for monitoring the food and cleaning standards. This represents the highest standard that can be achieved.

We looked at the care records belonging to four people who used the service and there was clear evidence that people were consulted about how they wanted to receive their care. Consent was gained for things

related to their care. Relatives and people who we spoke with told us, "The staff asked us to help to complete information about [my relatives] likes and dislikes and also about people that were important to them." We saw evidence of this when we looked at the care records. 'My day' record was completed with information about their life history and things they liked to be involved in. This record is often used for people living with dementia.

Good

Is the service caring?

Our findings

We looked at four care and support plans in detail. People's needs were assessed and care and support was planned and delivered in line with their individual needs. People living at the home had their own detailed and descriptive plan of care. The care plans were written in an individual way, which included family information, how people liked to communicate, nutritional needs, likes, dislikes and what was important to them. The information covered all aspects of people's needs, included a profile of the person and clear guidance for staff on how to meet people's needs.

The SOFI observation we carried out showed us there were positive interactions between the people we observed and the staff supporting them. We saw people were discretely assisted to their rooms for personal care when required; staff acknowledged when people required assistance and responded appropriately. We noted that call bells used for assistance were answered in a timely manner and most people told us that they received assistance when needed.

People told us they were happy with the care they received. We saw staff had a warm rapport with the people they cared for. Our observations found staff were kind, compassionate and caring towards the people in their care. People were treated with respect and their dignity was maintained throughout.

All of the people, relatives and visitors we spoke with told us they, or their family members or friends, received good care. They were very complimentary about the majority of the care staff. Comments about the care staff included, "You couldn't wish for better carers – they're just wonderful." And "They work jolly hard and they have a laugh with you as well." And "I think these carers are fantastic. They'll do anything for you."

Relatives and visitors to the home told us that there were no restrictions to the times when they visited the home. One relative said, "My family visits regularly and it is always the same. Staff are kind and considerate. They always ask how I am and tell me how my relative is." Another relative said, "We are made to feel welcome. Everything is relaxed; staff could not be more polite."

A dignity board was displayed in the entrance with examples of how people should be treated. The registered manager told us that they planned to develop a dignity tree so that people can add quotes about what dignity means to them. We saw there were designated dignity champions. The champion's role included ensuring staff respected people and looked at different ways to promote dignity within the home. We observed that people were treated with respect and dignity was maintained. Staff ensured toilet and bathroom doors were closed when in use. Staff were also able to explain how they supported people with personal care in their own rooms with door and curtains closed to maintain privacy.

Good

Is the service responsive?

Our findings

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. The people we spoke with told us the standard of care they received was good. We looked at copies of four people's assessments and care plans. They gave a clear picture of people's needs. They were person-centred in the way that they were written. For example, they included such information as people's preferences about their likes and dislikes in relation to food and leisure activities, and the times they usually liked to go to bed and to get up. People we spoke with told us they had recently been involved in completing life history information. We saw an apprentice sat quietly with one person talking about the things they liked to do. For example going dancing and socialising with friends.

We found that people's care and treatment was regularly reviewed to ensure it was up to date. Most people we spoke with said they knew a care plan was written but did not show any interest in reading it. One person said, "They [staff] told me they alter it [care plan] to suit. I think they understand perfectly what my requirements are. Not just mine, everyone's." Relatives we spoke with told us they were able to discuss any concerns with the registered manager. One relative said, "I know that I can speak to the staff and the manager about my family member's care. They are approachable and deal with things very professionally."

We saw that many ladies had painted nails and stylish hair do's from a regular hairdresser. The registered manager told us that they did not have a dedicated activity co-ordinator, however one of the care team managers organised activities when they were on duty. We spoke with the regional care director about our concerns that there was little opportunity for people to take part in activities. They told us that staff on duty were responsible for organising activities while on duty.

People we spoke with told us that they enjoyed activities that did take place in the home. We were told that the registered manager had booked 'Zoology' which involved small animals being brought into the home for people to pet. A sponsored walk and pie and pea supper was also planned to raise money to help towards paying for outside entertainers. Two people told us they liked to go into Doncaster to do some shopping. They told us they used the handy bus which picked them up at the door and dropped them off in town. They said, "We liked to meet people we know and have a coffee."

A relative we spoke with told us that they thought there had been some improvements since the new providers had taken over. However they thought more activities would benefit people who lived at the home. They told us they had been involved in promoting the service. This included telling friends how good the care was at the home. She said, "I would recommend Rowena House to anyone looking for a care home."

The registered manager told us there was a comprehensive complaints' policy and procedure, this was explained to everyone who received a service. It was written in plain English and we saw these were displayed on the notice board in the entrance. The registered manager told us that they met regularly with staff and people who used the service to learn from any concerns raised to ensure they delivered a good quality service.

We looked at records in relation to two complaints that had been received. We found one complaint about trees in the grounds had not reached a conclusion and the registered manager told us she would follow-up on the complaint until concluded. We saw a good number of thank you cards had been received from relatives who wanted to express their views on the care of their family members. People we spoke with did not raise any complaints or concerns about the care and support they received. People told us that they would know what to do if they had any complaints or problems. One person said, "I haven't got any problems. I get everything I need."

Good

Is the service well-led?

Our findings

The service was well led by a manager who has been registered with the Care Quality Commission at this location since September 2015. However, she was previously registered at this location under the previous provider in 2013.

People we spoke with told us they knew who was the registered manager and said they were approachable and would deal with any concerns they might have. One person said, "I know that the manager makes sure we are all well looked after." Another person said, "We all get along very well and a lot of that is down to how the manager leads the service." Relatives confirmed to us that they were happy with how the service was led. One relative said, "We all went through a lot when we were waiting to hear about the future of the service, but the manager kept us all informed which helped a lot."

Staff told us that they had been supported through a very difficult time leading up to the transfer to the new provider. They said the manager and deputy manager played a big part in being there for staff, relatives and people who used the service. One relative told us in regard to any concerns over the transition, "Staff acted very professionally and they have made sure their concerns were not passed on to people who live here."

The values of this service were reinforced constantly through staff discussion, supervision and behaviour. The management team told us the ethos was to provide the very best care, support and environment to people to help them to live their lives to the full, supported by skilled and dedicated staff who understood the importance of achieving this. Staff told us they were proud to work at the home and wanted to provide the highest standard of care possible.

We saw the manager engaged with people who used the service, staff and relatives by holding regular meetings. We looked at the minutes of several meetings which covered areas for development and future events planned for the home.

We looked at a number of documents which confirmed the provider managed risks to people who used the service. For example we looked at accidents and incidents which were analysed by the registered manager. He had responsibility for ensuring action was taken to reduce the risk of accidents/incidents re-occurring.

The provider had effective quality assurance systems in place to seek the views of people who used the service, and their relatives. Surveys were returned to the registered manager who collated the outcomes. Any areas for improvement were discussed with staff and people who used the service to agree any actions which may need to be addressed.

The registered manager told us that quality monitoring systems were in place following the transition to the new provider. We checked a number of audits on all aspects of the service provided. These included administration of medicines, health and safety, infection control, care plans and the environmental standards of the building. We were unable to assess how effective these were as they are still being tested and were not fully embedded. We will look in more detail at these at our next inspection of the service.

The regional care manager supports the manager in developing action plans for the future of the service. He told us that the service was making progress and was pleased with the staff's response to change. We saw examples of monthly quality visits completed by him which were reviewed at each visit.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to record and administer medicines appropriately. Regulation 12 (2)(f)(g)