

Little Sisters of the Poor

St Joseph's Home - Bristol

Inspection report

St Joseph's Home
66 Cotham Hill
Bristol
BS6 6JT

Tel: 01179733815

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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?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

We undertook an unannounced inspection of St Joseph's Home - Bristol on 6 September 2016. When the service was last inspected in April 2014 no breaches of the legal requirements were identified.

St Joseph's Home – Bristol provides accommodation and nursing care for up to 42 older people. At the time of our inspection there were 39 people living at the home.

A registered manager was in post at the time 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 persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the home is run.

The home was not consistently safe as robust recruitment procedures had not been followed. This meant that staff had begun work without the full range of checks being completed or documented. Medicines were not always administered or stored safely, as recording omissions were identified. Risk assessments identified potential risks to people. However, these were not consistently accurate or detailed enough to be able to inform staff of how to reduce the risks to people.

Staffing levels were safe. Staff were supported through an induction process, regular supervision, training and meetings. Training needs were identified for staff and planned accordingly. Care was not always effective as care plans did not always provide accurate or detailed enough information in regards to people's nutrition and hydration needs.

People and relatives told us that staff were kind and caring. We observed positive interactions and relationships between staff and people living at the home. The home supported people to maintain their independence and respected their privacy. People's needs were fully assessed to ensure the home was able to meet them.

The registered manager was aware of their responsibilities in regards to the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to assess if the deprivation of liberty for a person when they lack the capacity to consent to care or treatment or need protecting from harm is required. The registered manager kept clear records of the steps taken in the DoLS process. Staff were aware how the Mental Capacity Act 2005 was relevant to their role and applied the guiding principles through choice and enablement. Staff were not always confident in their knowledge of DoLS. We have made a recommendation about staff knowledge and understanding of the Deprivation of Liberty Safeguards.

The home was not always well-led. There were quality assurance systems in place. However, these did not always highlight areas that may need improvement. Feedback was sought from people and relatives through surveys. However, further investigation or changes as a result were not always completed. People were given the opportunity to feedback and make suggestions through regular meetings and we saw

changes made as a result. The home had established positive community links and held events which were inclusive to the wider community. Volunteers were encouraged at the home and supported the home in the activities it provided to people.

We found three 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 this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The home was not always safe.

Safe recruitment procedures were not always followed.

Medicines were not always administered or stored safely.

Risk assessments were in place but did not always give clear guidance on how to manage risks.

Staff knew how to identify and report safeguarding concerns.

Is the service effective?

Requires Improvement ●

The home was not always effective.

Care records lacked guidance in supporting people effectively with nutrition and hydration needs.

The home was meeting the requirements of the Deprivation of Liberty Safeguards. People's rights were being upheld in line with the Mental Capacity Act 2005.

Staff were supported through effective induction, supervision and regular training.

Is the service caring?

Good ●

The home was caring.

People and relatives commented on the high quality of care and support.

We observed positive relationships with people living at the home. Staff spoke to people with kindness and respect.

People were supported to remain independent.

People's visitors were welcomed and involved with the home.

Is the service responsive?

Good ●

The home was responsive.

People were offered a variety of activities. People were involved in deciding the activities on offer.

Meetings were held to gain people's views and opinions.

Complaints and concerns were responded to.

Is the service well-led?

The home was not consistently well-led.

Systems in place to monitor the quality of care and support did not always show effective action had been taken.

Surveys gained feedback from people. However, further analysis was not always completed.

The home had clear values which staff were aware of.

The home had developed positive links with the local community.

Communication systems were in place for staff through meetings and handovers.

Requires Improvement 

St Joseph's Home - Bristol

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.

The inspection was carried out by one inspector, a specialist nurse advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give key information about the home, what the home does well and improvements they plan to make. We reviewed the PIR and other information we had about the home including statutory notifications. Notifications are information that the service is legally required to send us.

Some people at the home were not always able to tell us about their experiences. We used a number of different methods such as undertaking observations to help us understand people's experiences of the home. As part of our observations we used the Short Observational Tool for Inspection (SOFI). SOFI is a way of observing care to help us understand the needs of people who could not talk with us.

During the inspection we spoke with 12 people living at the home, the registered manager and eight staff members. We spoke with two relatives of people that lived at the home and one volunteer. We looked at five people's care and support records and five staff files. We also looked at records relating to the management of the service such as incident and accident records, meeting minutes, recruitment and training records, policies, audits and complaints.

Is the service safe?

Our findings

People were not always kept safe as safe recruitment procedures were not always followed. We reviewed five staff files. We found that four out of the five files did not contain two satisfactory written references as described in the provider's policy. Some files we viewed only contained one reference and one contained no references at all. We found three files where people had previously worked with vulnerable adults and these references had not been sought or followed up. When people have worked previously in health and social care or with children or vulnerable adults it is a regulatory requirement that satisfactory evidence of their conduct in this role is sought. The checklist at the front of the recruitment files had been marked that the references section on all files as being completed. If robust recruitment procedures are not followed it can put people at risk of being cared for by people who are not suitable for the role.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

It was not possible to tell if medicines were administered safely or as prescribed because documentation was not always fully completed. We found instances when people's Medicine Administration Records (MAR charts) had not been signed or a reason for not giving a medicines recorded. For example, one person's MAR chart had not been signed for five medicines on 2 and 3 September 2016. In addition, we noted gaps on 26 August 2016 and 31 August 2016. Another person's chart had also not been signed on 31 August 2016, 1 September 2016, 2 September 2016 and 3 September 2016 for five different medicines.

Topical medicine administration charts had also not been consistently signed to indicate they had been applied as prescribed. In addition, body charts that were in place to inform staff where to apply the creams and lotions were unclear; for example, the whole of the body map for one person was shaded in. It is good practise to shade the area of the body where the cream should be applied, but staff had documented below the body map that the cream should only be applied to the shoulder areas. Some recording issues had been identified during the medicines audit by senior staff and had been discussed with those relevant people in their supervision. However, this had not fully addressed the omissions in recording due to the quantity of gaps we viewed.

Medicines were not always stored safely. Medicines were stored securely and temperatures of storage areas were monitored and in range. However, bottles and tubes had not always been labelled with the date they had been opened. For example, we saw one bottle of pain relief medicine that had not been dated when opened. Other bottles had been marked as "Found opened on 29 August 2016." Not marking bottles of medicines when they had been opened meant there was a risk that the medicine could expire and staff would not be aware. For example, we looked at one tube of topical cream which had a dispensing label of 27 October 2015. The tube had been opened, but there was no date to indicate when it had first been opened. Therefore it may have expired.

We noted that when a medicine to be given when required had been prescribed. There was no guidance available for staff on factors or triggers that may lead to a person requiring an additional medicine, such as

pain relief. This meant that staff could not be sure when this medicine should have been given and what the intended outcome should have been.

Individual risk assessments identified potential risks to people for example in nutrition, falls and mobility. However, not all of the assessments that we looked at had been completed in full, and the care plans associated with the identified risk, did not contain enough guidance for staff on how to reduce the risks. In addition to this, some of the care plans contained information that staff said was not an up to date reflection of the person's needs. For example, in one person's plan, a falls risk assessment had been completed and reviewed monthly. The person had been assessed as being at moderate risk of falling. However, there was no falls prevention plan in place. The same person had a moving and handling risk assessment that had not been completed in full because their weight had not been noted in the assessment. Although the care plan listed the hoist and sling information for staff to use when assisting the person to move, when we discussed the person's care with staff, they said the person was weight bearing and did not require hoisting

We saw some examples of person centred care planning in relation to nutritional risk and the risks of choking, although this was not consistent. For example, in one person's care plan staff had documented that they preferred their food to be cut up into small pieces and that they liked to eat their meals with a teaspoon. But, this level of detail was not seen across all the care records we viewed. We looked at the plan for one person who was diabetic and being fed via percutaneous endoscopic gastrostomy (PEG) (feeding via a tube into the stomach). Their liquid feeding regime was in the care plan and was detailed. However, the plan also stated they were able to have three teaspoons of oral liquid per day and three teaspoons of ice cream per day. When we discussed their care with staff, staff said the person no longer received anything orally which meant the plan was not accurate and did not reflect the person's current needs. In addition, the plan also informed staff the person could "Have meals suited to her needs which she can choose daily from the menu." This was inaccurate and meant there was a risk that staff who were unfamiliar with the person might inadvertently provide food which the person could not have

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

Staffing levels were safe. We reviewed the staffing rotas from the previous eight weeks and the number of staff was consistent with the planned staffing levels. The home had a policy to try and not use agency staff to ensure continuity of care. However, there had been a high turnover of staff in the last 12 months and as new staff were recruited agency staff had been used to maintain safe staffing levels. One member of staff said, "Staffing levels are pretty good." The home prided itself on having high staffing levels to ensure staff had quality time to care for people. People told us that staffing levels were good during the day but that at night they sometimes had to wait for assistance. One person in regards to staffing at night said, "People answer the bell when they can. They may take a while but it is because they are busy with someone else." The registered manager was conducting an audit of response times to call bells during the night to clarify if sufficient night staffing was in place.

The provider had policies and procedures in place for safeguarding adults. This contained guidance on what staff should do in response to any concerns identified. From the training records we reviewed we saw staff received training in safeguarding adults. This was confirmed with staff. Staff said they knew how to recognise signs of abuse and how to report any concerns they might have. One staff member said, "I would report it to my line manager immediately." Another staff member said, "I would nip it in the bud and tell my manager straight away."

Accidents and incidents were recorded. Accident forms gave details of what had happened and actions taken at the time and afterwards. A monthly analysis was completed of any accidents and incidents to give an overview and to ensure actions taken had been effective. A quarterly health and safety meeting was held to discuss relevant matters. We reviewed the recent minutes and saw the accident and incident analyses were discussed to see if these related to any health and safety matters. We also saw that training and policies were discussed. For example, volunteers at the home were invited to attend the arranged mini bus training.

The home was maintained to a high standard. We reviewed records which showed that appropriate checking and testing of equipment and the environment had been conducted. This ensured equipment was maintained and safe for the intended purpose. This included safety testing of electrical equipment, the lift and transfer aids such as bath hoists. There were also certificates to show testing of fire safety equipment and gas servicing had been completed. Risk assessments were in place for the premises and grounds. These detailed how risks could be minimised in areas such as using the lift and accessing the gardens.

Staff had regular training in fire safety. Systems were in place to regularly test fire safety equipment such as emergency lighting, alarms and extinguishers. After a recent external assessment into fire safety in July 2016 a number of improvements were being made as recommended. However, we did note the last practice fire drill had been conducted in June 2015. The registered manager told us that when people joined the home the emergency procedures were shown to people. There were personal evacuation plans in place for people. We saw folders were available on each floor and contained information for staff on how to safely evacuate people during an emergency. These plans contained details of people's mobility and had all been reviewed six monthly.

Is the service effective?

Our findings

People did not consistently receive effective care because care records did not always contain enough guidance on how to support people around their nutrition and hydration needs. In addition, this information was not always accurate and up to date. Nutritional assessments had been completed which gave an indication of people's risks of being malnourished. The assessment tool being used did not provide clear guidance for staff on how to develop plans of care for people who had been assessed as at risk. For example, we looked at the plan for one person who in June 2015 had been assessed as "Normal status." By November 2015, their assessment showed they were "At risk of malnutrition." The assessment tool indicated at this stage people should be weighed monthly. However, they had not been weighed again until January 2016 and then were not weighed monthly, despite continuing to lose weight. The care plan informed staff the person "Had a poor appetite," but provided staff with no information on how to encourage the person to eat or the types of food that might tempt them to eat. There was also nothing documented to indicate if a referral to a dietician had been considered or whether staff should monitor the person's food intake as directed in the nutritional assessment tool. In another person's plan it was documented that the person was having their food and fluid intake monitored, but when we asked staff, they said the person had never been on a food or fluid chart.

We looked at the food and fluid charts for two people. The charts had been filled in, but there were gaps and it was not clear if people had been offered something to eat and drink and had refused or not. The charts did not have a documented target for fluid intake and although the total input had been documented within a 24 hour period, it was not clear if poor intake was being monitored or escalated. For example, one person's fluid chart showed that on 4 September 2016 they had drunk 400mls during the whole day. In the daily notes staff had documented, "Encouraged to drink enough" and "Slept most of the night, care given and fluids encouraged," but there was no reference to whether staff had noted the very low intake.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had access to healthcare services. We saw records that showed that people were seen by their GP, by a chiropodist and by district nurses. The system for referring people to the GP was robust and we saw a log book that showed when people were referred, the reasons why, the outcome and that people's relatives were informed.

New staff completed an induction. This was aligned with the Care Certificate for identified staff members as the home mostly recruited staff with a recognised care qualification. It involved an introduction to the organisation, mandatory training and shadowing experienced members of staff. Staff spoke positively about their induction. One staff member said, "I felt confident at the end of the process." Another staff member said the induction was, "Detailed."

We reviewed the staff training records and saw that staff received ongoing training in areas such as moving and handling, food hygiene and fire safety. A training plan was in place for the year which identified staff

training needs. For example, record keeping and care planning training had been arranged for September 2016. Training specific to the needs of people living at the home had been conducted for example in diabetes and percutaneous endoscopic gastrostomy (PEG) feeding. One person told us, "The staff are all well trained here."

Staff said they received regularly supervision and this was confirmed in the records we reviewed. Staff said they felt supported in their roles. One staff member said, "It is useful and supportive."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The provider had met their responsibilities with regard to the Deprivation of Liberty Safeguards (DoLS).

The registered manager was aware of their responsibilities in regards to the Deprivation of Liberty Safeguards (DoLS). Applications had been made for two people. Documentation recorded the steps taken in the process. The registered manager was aware of notifying the Commission as required when authorisations had been made.

Training records showed that staff had completed training in the Mental Capacity Act (MCA) 2005 and DoLS and staff we spoke with confirmed this. Staff understood the principles of the MCA and how this applied to their working practice. Staff told us how they always gain consent from people before giving care and offer choice. For example, we observed a member of staff ask a person if they would like to be supported into the garden. However, despite having training in the Deprivation of Liberty Safeguards staff we spoke with were not always confident in their knowledge and who within the home this may apply to.

We recommend that the home considers how to embed training to ensure staff are confident in their knowledge and understanding of the Deprivation of Liberty Safeguards.

Is the service caring?

Our findings

People were supported by staff who were caring and compassionate. We saw positive interactions between staff and people living at the home. Staff spoke kindly to people, used people's preferred names and there was a pleasant and friendly atmosphere throughout the home. One relative said, "I think this place is wonderful. The staff work so hard and are so good to the residents. They are kind and caring." One staff member said, "Our residents have such great histories and we are lucky to have such hard working, caring staff."

We observed that staff interacted well with people; they crouched down to people's level in order to make eye contact, and sat with people for periods of time talking or reading together. We observed a member of staff borrow a newspaper from one person to show another person because they had seen an article they thought the person would enjoy. One person told us, "It is marvellous. Nothing is too much trouble. The girls work so, so hard."

When we spoke with staff they said the quality of care was high. One member of staff said, "I love my job, we go the extra mile here." Another member of staff told us they had recently sat with one person who was nearing the end of their life because the family had asked them to, "Because we were her second family." Another staff member said, "It feels like a community here and I know that families appreciate what we do."

The home supported people to remain independent. For example, we observed one person using a mobility aid to walk with staff close by for assistance if needed. At a mealtime we saw that a dish of vegetables was placed on each table. People could then help themselves as they wished, rather than food being served for people. There were kitchenettes on each floor so people could prepare food for themselves and drinks whenever they wished. Staff told us that families often used these spaces so they could have a private meal with relatives.

Relatives told us that staff ensured people looked and dressed the way they wished to. One relative said, "They co-ordinate her outfits and put her broaches on." There were specific rooms designed so people could access hairdressers, beauticians, physiotherapist, chiropodist and complimentary therapies.

Staff were knowledgeable about maintaining confidentiality within their role. One member of staff described this as, "Can't talk to people outside the home. Being careful. It is their private life and I respect this." We observed people being treated with dignity and respect. People were spoken to politely. Staff listened to people's responses and acted accordingly. For example, a member of staff could see a person did not want the window open next to them. The member of staff asked if they wished for it to be closed and shut the window. The member of staff asked the person, "Is that better?" Staff told us they ensured people's privacy was maintained by always knocking on people's door before entering and we observed this taking place.

The home had received 15 compliments in the last 12 months. One compliment read, "May I please express my heartfelt appreciation of the wonderful kindness and care shown to [Person's name]." Another compliment read, "We really appreciate all your hard work and hospitality and are very grateful to you all."

Another person had said, "St Joseph's is a model home with so much to commend it."

Family and friends could visit whenever they wished. One staff member said, "Visitors come whenever they want." Relatives we spoke with said they visited regularly and were welcomed by staff. Relatives spoke of the community atmosphere of the home and how they were welcomed and involved.

Is the service responsive?

Our findings

People told us the home was responsive to their needs. We observed staff being attentive to the support people required, whilst encouraging people do things for themselves at their own pace. One person said of their care and support, "It is all I can wish for."

Care records contained a photograph of people, essential information and their life history. A full assessment of people's needs was conducted before people came to the home to ensure their needs would be met. We saw that the home had informed people who they had assessed if they could not satisfactorily meet their needs. Care records described people's personal preferences in relation to clothing, food and activities. Care plans were regularly reviewed.

It had been identified by the registered manager that care records required more detail into how people preferred their care and support to be delivered. Some care records we reviewed showed clear information for staff. For example, one person's plan described in detail their preferred night time routine, including "Likes the bedroom door open, lights off and bathroom light left on" and "Likes the window closed at night." However, other plans did not provide this level of detail. For example, in another person's plan it was documented, "Ensure continues to wear clean clothes daily," but did not detail the kind of clothes the person preferred to wear. The registered manager had arranged for care planning training for staff in September 2016 to address this.

People told us there was a variety of activities and outings on offer. One person said, "There is always lots going on, something for everyone." A staff member said, "People go out a lot." We saw that recent events had included a birds of prey show, bingo, musical entertainment, keep fit classes and craft sessions. Mass was held daily and afterwards there was coffee and cake for people to socialise in a communal room. The home had different rooms, with clear signs, open for people to enjoy different activities for example the library, the shop, arts and crafts room, the chapel and TV lounges. One member of staff said, "It is a lovely place here. People have their spiritual life and lots of socials. People are not isolated."

People told us there was a party to celebrate people's birthdays every month. One person told us, "The room is decorated with balloons and there is lots of party food, music and entertainment." The home was kept immaculately clean. The grounds were safe and an accessible garden was well maintained. People told us they enjoyed having afternoon tea in the garden when the weather was nice.

The home held regular residents meetings. We reviewed recent minutes and saw that information about the home and staff were communicated to people, events were promoted and people's opinions sought in regards to a variety of topics such as the food, trips out and fundraising. People told us they were given the minutes of the meeting and they were displayed in the lift and on noticeboards throughout the home. We saw that the newsletter was also displayed in the main kitchen. The chef told us how the comments and suggestions around food were incorporated into the menu and specific points taken on board. For example, 'request for coleslaw but finely chopped.' People told us they enjoyed the meetings and that their views were responded to. One person said, "The meetings, yes they seem to sort out most things."

The home had received one complaint in the last 12 months. The complaint had been fully investigated and this had been recorded. The registered manager had met with complainant to ensure they were satisfied with the outcome. We noted that this would be beneficial to record along with the agreed outcome. People told us they would be happy to raise a complaint should the need arise. One person said, "I've told Sister if I'm not happy and she's sorted it immediately." We saw that there was a comments and suggestions box in the library. People could anonymously make suggestions. We saw that comments were then passed to an appropriate member of staff to action.

Is the service well-led?

Our findings

The home was not always well-led as quality assessments were not consistently effective in identifying and achieving improvements needed. We saw that quality assessments were completed by a member of staff external to the home. This audited areas such as care records, medicines, health and safety and staffing. A report of the findings was then sent to the registered manager. We saw that the audits identified areas such as gaps in recording on MARs in April 2016 but it was not always clear what action had been taken to address these areas identified, which had also been found at this inspection. A night care plan had been suggested in December 2015, but it was not clear if this had been implemented.

A survey had been conducted in February 2016 for people, relatives and health professionals. Overall the results had been positive. Comments included, "Well run home," and "Care is first class." However, we did find that some comments that were less positive which may have benefited from further follow up had not been investigated. This may have helped identify areas which could be improved upon. There were no recorded actions or changes made from the results of the survey. The registered manager said this would be addressed in the next survey.

People and relatives said they could speak with the registered manager or any senior staff members if they had any concerns. We spoke to 8 members of staff. Staff commented that the home was well managed and people were well cared for. We spoke to two members of staff in detail about the registered manager. One staff member said the registered manager was, "Fine." However, both staff members said they found the registered manager, "Unapproachable." The registered manager said ways to address this would be considered. For example, by speaking with staff more often on an individual level.

The religious values of the organisation were an integral part of the home. Staff said there was a positive working culture that had seen recent improvements. Staff told us there had been a big turnover in staff which had been unsettling. However, now team work had improved and staff were working well together. One staff member said, "We are proud of what we do here."

An employee appreciation day had been arranged to celebrate employees' hard work and to recognise staff who had been long serving members of the team. We viewed a comment by a staff member that said, "A very big thank-you for my long service recognition."

The home had a visible community presence and had established good community links. For example, the local primary school would visit to sing to people. We saw posters displayed for an upcoming bring and buy sale being held at the home. The home was also welcoming visitors and showing them around the chapel as part of the Bristol Open Doors day. This was a local event where members of the public could visit places of interest, that are not usually open to the public. We saw that the home had let a local art group use their garden for drawing. The group had commented, "Thank-you so much for letting us come and draw in your beautiful garden."

The home had a large number of volunteers who supported the home and people. Volunteers assisted in the

activities and trips provided by the home. The home offered training to volunteers. We saw many volunteers had relatives who currently or in the past had lived at the home, this enabled relatives to feel involved and part of the home.

Staff attended a daily handover at the start of their shift. Important information was communicated to staff at this time both in a written and verbal format. Handovers had been addressed at a recent team meeting to discuss how improvements could be made to current system. Staff told us that it would be good to further improve the communication and teamwork between day and night staffing. One staff member said, "It needs to be cohesive."

The registered manager organised regular team meetings. We reviewed the minutes of recent meetings and saw that a comprehensive range of subjects were covered. For example, Information was communicated to staff about medicines, keyworking and the findings of a recent quality assurance visit. Discussions were staffing and the values of teamwork. Staff members told us that they found staff meetings informative and useful. One staff member said, "We can air our opinions and views."

The registered manager understood the legal obligations in relation to submitting notifications to the Commission and under what circumstances these were necessary. A notification is information about important events which affect people or the home. The registered manager had completed and returned the Provider Information Return (PIR) within the timeframe allocated and explained thoroughly what the home was doing well and the areas it planned to improve upon.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Regulation 12 (2) (b) (g) The provider had not always ensured that medicines were administered safely. Risk assessments lacked accurate information to reduce risks to people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Regulation 17 (2) (c) The provider had not always ensured that records were complete, accurate and informative of how to support people effectively with their nutrition and hydration needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed
Treatment of disease, disorder or injury	Regulation 19 (3) (a) The provider had not ensured that effective recruitment procedures were maintained.