Community Health Services Limited

# Catherine Court

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |
| Is the service safe? | **Requires Improvement** |
| Is the service well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

About the service
Catherine Court is a nursing home providing personal and nursing care to 35 people aged 65 and over at the time of the inspection. The service can support up to 60 people.

Catherine Court accommodates people across two floors with each floor having their own communal sitting, dining and small kitchen areas. People's bedrooms have en-suite facilities and each floor has a communal larger shower.

People's experience of using this service and what we found
People told us they were happy with their care. They commented "I am happy here; it feels like home to me. The girls are wonderful, friendly, lovely people." and "I am happy, they treat you natural, it is brilliant, the staff are very kind."

Relatives found it difficult to comment on the care provided due to the restrictions on visiting imposed over the year, due to the Covid-19 pandemic. However, they felt their family member received safe care and they were generally happy with the care provided. They commented "Staff are fantastic, brilliant and doing a very difficult job. The home has had three outbreaks of the virus and everyone has recovered...that must say something of their skills."

Relatives believed there had been a high turnover of staff at the service and this impacted on continuity of care. A relative commented "Last year when Covid-19 struck staff left and the home had to replace them...turn over has been very high as it's a difficult job. Agency staff have been used a great deal, both during the day and night, so very little continuity.'

Whilst relatives had received some communication from the provider and the service during the pandemic, they felt communication with the service had been poor. They confirmed the interim manager had recently held a zoom meeting with relatives to update them on changes within the service, including arrangements for visiting.

We received mixed feedback on the quality of food and activities provided. This was shared with the provider to follow up and address.

We found risks to people were identified but not always managed and some practices around infection control needed to improve to mitigate the risks of cross infection.

Aspects of the service were audited and had picked up some of the issues we identified. Other issues in relation to working to infection control guidance had not been picked up and some records relating to people's care and the running of the service were not suitably maintained and accurate.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; however, people's records did not always support this practice

Systems were in place to safeguard people from abuse. However, processes needed to improve to promote learning from accidents, incidents, safeguarding and complaints to ensure trends were picked up and addressed to safeguard people and prevent reoccurrence.

Safe medicine practices were promoted, and sufficient staff were provided to meet people's needs. Staff were safely recruited, and systems were in place to ensure staff were suitably inducted and trained for their roles. The interim manager was reviewing staff inductions, training and supervisions to ensure gaps in knowledge were addressed and staff were supported.

The registered manager had recently left, and an interim manager was managing the service. until a new manager was appointed. The interim manager was committed to improving the service, communication, developing staff and supporting the team in their roles to provide positive outcomes for people. Staff were complimentary of the interim manager and told us he was accessible, approachable, encouraging and supportive. They felt listened to and felt issues raised would be addressed.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 22 November 2018)

Why we inspected
The inspection was prompted in part due to trends in notifications around poor moving and handling practices, increase in safeguardings and concerns about the service, which included concerns around people's nutritional needs not being met. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from the previous comprehensive inspection for those key questions were used in calculating the overall rating at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Catherine Court on our website at www.cqc.org.uk.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards

of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

## 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.

Details are in our safe findings below.

**Is the service well-led?**

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

# Catherine Court

**Detailed findings**

## Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors and a pharmacist. Two Experts by Experience supported the inspection by making calls to people who used the service and their family members after the inspection.

An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Catherine Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. However, the registered manager had resigned prior to the inspection. An operations support manager was managing the service as an interim manager and they planned to become registered with the Commission until a suitable replacement manager had been appointed.

Notice of inspection
This inspection was announced by phone on arrival, before the inspectors entered the service.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with the interim manager, deputy manager, a registered nurse, two care staff, housekeeping staff member, laundry staff member, governance manager, regional director, provider clinical support manager and provider clinical governance lead.

We 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.

We reviewed a range of records which included three care plans, daily observation records for three other people, accident report, infection control, maintenance and ten medicine administration records.

After the inspection
We spoke with four people who used the service and three relatives. We set up telephone interviews with the service and spoke with a registered nurse, a team leader, three care staff and a housekeeping staff member. We sought feedback from professionals involved with the service. We reviewed a variety of records relating to the management of the service, including policies, procedures, audits and complaints. We reviewed six care plans and five staff files remotely and continued to seek clarification from the provider to validate evidence found.

Requires Improvement

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● Systems were in place to manage accident and incidents. However, procedures were not routinely followed, and action taken to mitigate risks following an accident. In records viewed, we saw a person had a recent fall. The person was checked over and an accident report was completed which indicated their care plan and falls risk assessment was updated. However, neither had been updated and therefore no measures were put in place to mitigate the falls risk.

● Risks to people were identified, however management plans were not always in place to mitigate risks. A person's risk assessment identified them as 'a high' risk of malnutrition. The service had contacted the GP who had prescribed an oral nutrition milk protein supplement. The person did not like milk and hence almost always refused the supplement. The risk assessment did not include strategies such as fortification of food, small/frequent snacks to preserve the person's weight as a result of their refusal to take the supplement. Instead generic statements were used such as "ensure a varied diet..." which was not specific to mitigate the risk.

● For other people their nutritional risks were not mitigated. A person's fluid target was 1000 millilitres over 24 hours, but the records viewed showed in the seven days prior to the inspection this had not been achieved. Another person's fluid charts showed their fluid target was not achieved in records dating back to January 2021 and currently. The governance manager told us that the organisational policy is that people not reaching the daily fluid intake target for a period of three consecutive days should be referred to the GP for review. The GP record for individuals did not indicate this had happened.

● Risks associated with pressure damage were not mitigated. People who were considered a high risk of pressure area damage had repositioning charts in place. The records viewed indicated the frequency of the turns during the day and at night. The charts viewed showed gaps in recording of up to four hours during the day instead of two hours as outlined on the person's chart. Daily welfare check records were also in place which were better completed but did not demonstrate that the person was repositioned at these checks.

● The service supported people with behaviours that challenged. Whilst this was identified there was limited detail as to how the behaviours that challenged presented and how staff were to manage and deescalate situations to mitigate risks. For example, a person's care plan indicated the person could display some challenging behaviour and aggression at times. It indicated there may be specific triggers and staff were to observe and record. However, there was no indication of triggers and the action was if the person becomes challenging or aggressive then staff are to leave them for 15 minutes. There was no detail as to the level of observation of the person during this time to mitigate risks to them and others and there was no further guidance as to what to do next if the challenging behaviours continued. Another person was on as required medicine for agitation. The medicine record showed the "as required" medicine was administered on five occasions in March, whilst the person's one to one records and daily records did not indicate the person was

agitated and no justification was provided for using the sedative. The interim manager completed an investigation and confirmed the "as required" medicine was administered as prescribed, but acknowledged the records did not always reflect that. They agreed to provide training and updates to staff on the use and recording of "as required" medicines.
● Some people required thickeners in their drinks to mitigate the risk of choking. We observed a staff member picked up a thickener left on the side and used it in a person's drink without checking the name or the instructions on the container. We found the name on the container did not match the name of the person whose drink it was. This had the potential for a person's drink not to be made up to the required consistency and put them at risk of choking.

Risks to people were not always mitigated. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately after the inspection to outline improvements to risk management.

● Risks associated with medical conditions such as diabetes, epilepsy, use of anti-coagulant medicines and choking were identified and managed.
● Health and safety checks took place and equipment such as the lift, fire equipment, gas, electricity and hoists were serviced. People had personal emergency evacuation plans (PEEPs) in place and regular fire drills took place. A full health and safety audit of the premises was scheduled to take place later in March.
● The interim manager had commenced a review of the environment and furnishings to ensure the service remained suitably maintained.

Learning lessons when things go wrong
● The notifications from the service to the Commission showed recurrent themes in relation to moving and handling, pressure area care and medicine errors. There was no evidence these were audited and reviewed to promote lessons learnt. The outcome of a safeguarding incident was for reflective coaching and group workshops to be facilitated. The interim manager told us they had a sign in sheet for the workshop but no other records to indicate it had taken place and what it entailed to promote learning. The actions from a local authority safeguarding report dated 20 October 2020 was for staff to be reminded of moving and handling manoeuvres and to adhere to people's moving and handling assessments. The team meeting minutes were not available to indicate if this was communicated with staff. Staff could not recall if the workshop had taken place or if a team meeting was held to address moving and handling concerns.

Records were not available to show that action was taken to address trends in accident, incidents and safeguarding to prevent reoccurrence. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that medicines related incidents were investigated properly with appropriate action plans and there were adequate processes in place to ensure staff learned from these incidents to prevent them occurring again.
● The service had a choking incident in 2020, which was still under review by the Commission to assess if it meets the threshold for a specific incident. The provider's learning from that was to have specialist diets such as puree diets individually prepared and labelled by the chef prior to them being served by staff. During the inspection we saw individualised plated meals were provided which were appropriately labelled. Staff serving the meals had a list of who required specialist diets to ensure individuals were provided with the meal they required.

Preventing and controlling infection

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Signage was not prominent on the first floor to indicate the outbreak status at that time. The laundry on the first floor did not have adequate signage and traffic flow (using a 'clean' and 'dirty' entrance) was not detected. The dirty laundry trolley had clean boxes of masks, gloves and a roll of disposable gowns stored on top which posed a risk of cross- contamination. Existing government guidance was available which explained how to manage people's clothing and other linen. This was pointed out to the management team and required further action after the inspection to prevent any cross-contamination. We observed the maintenance person, deputy manager and other provider support staff were wearing long sleeve tops. This breached the guidance of 'bare below the 'elbow'.

● We were assured that the provider was using PPE effectively and safely. However, during the inspection on three occasions we prompted a staff member to wear their mask correctly to ensure it covered their nose. We noted the interim manager reminded an office staff member to put a mask on.

It is recommended the provider works to best practice and relevant guidance in relation to infection control.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

Using medicines safely

At our last inspection we recommended the provider refers to national guidance in relation to the management of medicines. The provider had made improvements.

● People told us they got the support required with their medicines. They commented "I get my medication regularly." and "Medication given regularly, they always get the doctor if necessary."
● Medicines were safely managed. There were known systems for ordering, administering and monitoring medicines. Staff were trained and deemed competent before they administered medicines. Medicines were safely secured and records were mostly appropriate.
● The provider had introduced a new system to monitor and audit people's medicines on a regular basis, and we found improvements had been made as a result of this. For example, a dual audit by the manager and clinical lead were carried out periodically to ensure medicines were up to date and appropriate for people.
● People received their medicines as prescribed, including Controlled Drugs and those on covert

administration. We looked at 10 medicine administration records (MAR) charts and found no unexplained omitted doses in the recording of medicines administered, which provided a level of assurance that people were receiving their medicines safely, consistently and as prescribed. For the MAR viewed on site, protocols were in place for "as required medicines". However, as outlined under risk management the records viewed remotely showed an "as required tranquiliser" was administered not in line with the protocol. The interim manager agreed to follow this up and address. It.

● There were separate charts for people who had medicines such as transdermal pain relief patches, ointments and creams prescribed to them, and these were mostly filled in appropriately by nurses. We found one instance where a patch for pain relief was applied to a resident but had not been signed by the person applying that patch. This was rectified by the end of the inspection.

Systems and processes to safeguard people from the risk of abuse

● Systems were in place to safeguard people. Safeguarding policies and procedures were in place and accessible to staff. The notifications received by the Commission showed a delay in a serious incident assessed as safeguarding been reported to us. The interim manager was aware of their responsibilities to report and act on any safeguarding concerns.

● Some staff could not recall being trained in safeguarding, but all staff spoken with were aware of their responsibilities to report poor care and practice. The training records showed 92% completion of safeguarding training by staff

● People told us they felt safe. A person commented "Yes they look after me okay, I have not been here long, very kind, yes very safe, staff are very good." and "I feel very safe here, everybody is as one."

● Relatives believed their family member received safe care. A relative commented "Yes I believe [family members name] does get safe care ...I only get feedback if there are any incidents. Before Covid -19 I was visiting three days a week and could observe the level of care provided." and 'Yes as far as I know... [family member] is hoisted out of bed into a special chair."

Staffing and recruitment

● People told us there was enough staff available to support them. People commented "Yes there is enough staff I think, the staff have been brilliant." "I think there are enough staff, nearly all of them are kind, I would like to be able to go out". Relatives felt unable to comment on the staffing levels but felt there had been a high turnover of staff which impacted on continuity of care for individuals. A relative commented "Last year when covid struck staff left and the home had to replace them...turn over has been very high as it's a difficult job. Agency staff have been used a great deal, both during the day and night, so very little continuity."

● The rota showed sufficient staff were deployed to manage people's needs on most occasions. However, the home relied on agency staff, mainly registered nurses to cover shortfalls in the rota which impacted on continuity of care and consistent management oversight of the units.

● The management team acknowledged that significant staffing pressures existed during the pandemic, local outbreak and at the time of our inspection. Although planned nursing hours were not reduced, some shifts had been difficult to fill due to lack of available registered nurses.

● Strategies used to ensure adequate staff deployment included the use of multiple external agency workers, the management team working in a clinical capacity and other staff (such as activities coordinators) working to support care workers.

● Observation of staff showed they responded to people's requests promptly. People on the first floor remained in their bedrooms and staff accordingly anticipated these people's needs by regularly checking on them behind their closed doors. Call bells were answered promptly by staff.

● Systems were in place to ensure staff were suitably inducted and trained for their role. We received mixed feedback on the quality of inductions, training and support provided. The interim manager was reviewing staff inductions and training to ensure gaps in knowledge were addressed and that care certificate training

was signed off and completed. They had commenced supervision of staff and had a schedule in place for other senior staff to commence formal supervisions of staff.

● Staff were suitably recruited. They completed an application form, were interviewed and pre employment checks were carried out. These included references from previous employers, a medical questionnaire and disclosure and barring checks. The provider confirmed staff files included a recent photograph, although this was not included on staff files viewed remotely.

Requires Improvement

# Is the service well-led?

## Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider had a quality governance policy in place and audits of aspects of care and practice took place. For example, monthly care plans, medicines, staff files, kitchen and housekeeping audits were completed. Alongside this the provider carried out an annual review of the service. The annual review dated December 2020 had identified shortfalls in the service and a service improvement plan was in place. Whilst improvements were underway there was a delay by the provider in taking timely action to address the failings in the service.
- Evidence showed some lack of oversight in the assessment and monitoring of certain infection prevention and control measures. An infection control audit conducted by the service in March 2021 did not identify unsatisfactory measures or practices in relation to the laundry room, management of laundry and some staff practice of wearing long sleeved tops which was not in line with guidance.
- People's care records were not always contemporaneous, accurate or complete. The service had identified risks associated with falls, moving and handling, malnutrition and pressure area damage. Some records viewed were contradictory. For example, a person's care plan on mobility indicated they were a medium risk of falls and required the assistance of one staff member, whilst the mobility risk assessment indicated the person was a high risk of falls and required the assistance of two staff. Another person's moving and handling assessment indicated they required two staff to offer physical and emotional support to stand. Whilst the moving and handling care plan stated the person mobilised independently and a physiotherapist review that took place in February indicated they required the assistance of one staff member.
- Other records relating to the running of the service were not completed. We found that the medicine fridge temperature had not been recorded for three days (between 6 March to 8 March 2021) in the ground floor treatment room. Although the current temperature at the time of inspection was 4ºC and we were assured that the safety of the refrigerated medicines had been maintained, there was a potential risk that the temperature could have deviated from its recommended range during this time period.
- Handover records were in use which outlined the staff on duty and allocation of tasks. The handover records on the ground floor for the day of the inspection were not completed and previous handover records viewed were incomplete as some did not indicate the date, shift or staff on duty.
- The service had a series of maintenance records in place. The records were not easily accessible with duplication of information across different folders and systems. There were gaps in recording of some health and safety checks and other health and safety record checks were not accurate. For example, the monthly

visual check of fire equipment indicated the service did not have a fire blanket to check which was not the case.
● There was a lack of oversight with regards to mental capacity assessments. Decision specific mental capacity assessments were in place for people who required it, in relation to some aspects of their care. On the first floor we saw mental capacity assessments and best interest decisions were recorded for the administration of the Covid-19 vaccinations. However, for people on the ground floor relative consent had been obtained but mental capacity assessments and best interest decisions were not completed for people who were deemed not to have capacity in relation to Covid -19 testing and the Covid -19 vaccination, which had already been administered.

Records were not suitably maintained, and the provider did not have the oversight to ensure the quality and safety of the service provided. This is a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection and made immediate improvements, as well as confirming their commitment to working through the service improvement plan to fully improve the service.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● Staff told us they were clear of their roles. However, the regular use of agency nurses particularly on the ground floor unit meant there was a lack of management oversight of shifts. This resulted in records relating to people's care not been in place or kept up to date to mitigate risks to people.
●There was confusion about the service's infection prevention and control lead and staff were not aware who it was either. We were told the deputy manager undertook this role. However, when we asked them, they were unaware they were the lead. A different staff member was identified as the infection control lead on the clinical review meeting minutes of the 5 March 2021 and after the inspection the interim manager confirmed this had since been updated with a different staff member.
● Prior to the inspection the registered manager had resigned. An operations support manager had taken on the role as an interim manager until a new manager was appointed. The interim manager was clear on the areas that needed improving within the service to mitigate risks and meet regulations.
● Staff described the interim manager as "Approachable, accessible, listens and acts, open door policy, brilliant, encouraging and supportive". Staff commented [Interim manager's name] is brilliant, very encouraging, gives praise, which is appreciated, nice fella. He discusses my future, and has offered to steer me, really supportive." and "Supportive staff, I think we are a good team, we work well together."
● A person commented "The Manager is temporary, yes he came to introduce himself, nice bloke."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider had a duty of candour policy to support staff in meeting the regulation. It indicated people and their relatives were to be provided with a written explanation and apology following a safety incident.
● We requested to see duty of candour letters for notifications we had received which indicated the duty of candour was applied. The interim manager advised they had complied with the duty of candour through direct communication with the next of kin which is documented on people's care records and as noted on the notification forms. However, a written explanation and apology is required following a safety incident as indicated in the providers own policy and the duty of candour regulation. The interim manager evidenced they had worked to the duty of candour regulation and the providers policy in response to a recent incident which occurred after the inspection. They agreed to address this with staff involved in completing

notifications to ensure compliance with the regulation.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Systems were in place to get feedback from people who used the service, relatives and staff. The last survey was completed in August 2019. The provider recognised a survey was due and we were told this was underway.

● The service had kept families informed of Covid -19 outbreaks at the service and how this impacted on the visiting arrangements. When the service was not in outbreak status family visits took place in line with government guidance on visits to care homes.

● Relatives had received some communication from the provider and the service during the pandemic. However, they felt communication with the service had been poor. They commented "No to be quite honest the home do not communicate at all, I have had three emails from them in a year. There has been no personal information concerning my family member at all. I got more information from the newsletter from the Chief Executive Officer of Care UK." and I have only had a zoom meeting with the interim manager...no one else has communicated to me during this period.'

● On the day of the inspection the interim manager had arranged a virtual family meeting to update relatives on the management changes in the home, their Covid-19 outbreak status and plans to commence visiting in line with revised government guidance. The interim manager confirmed family meetings would take place regularly and the next one was scheduled for April.

● The provider had systems in place to promote good communication within the team such as weekly clinical meetings and staff meetings. The meeting minutes provided showed the meetings were not taking place at the frequency required by the provider and this was being addressed.

● Staff told us the communication had improved since the interim manager had taken over the management of the home. Some staff indicated communication between staff members still needed improving but they felt confident the interim manager would promote that. A staff member commented "[interim managers name] communicates more with staff, formally and informally and I feel able to talk to him" and "[interim managers name] has already brought about lots of changes and communication is definitely better and it feels like we are working more like a team."

Continuous learning and improving care and Working in partnership with others

● Evidence showed good working with health and social care professionals.

● The service determined, together with other agencies, when an onsite presence was required to review people or perform other actions. At other times, virtual consultations and meetings occurred to exchange information and provide updates.

● The service had a nominated external professional at a primary care setting that they could approach to gain advice and support about managing the outbreak and other questions related to the pandemic.

● There was good evidence of registered nurses on the first-floor liaising with people's diabetes specialist nurses. Evidence showed frequent consultation between the nursing staff to ensure people's diabetes was managed. This was especially important as the nursing team noted variation in people's blood sugar levels if they were infected with Covid-19.

● Evidence showed good partnership working to ensure all people in the service were offered and accepted their first dose of the Covid-19 vaccine. The service had worked with the GP practice to ensure eligible people were provided with recommended protection.

● A professional involved with the service confirmed they received appropriate referrals from the service. They told us 'Staff seek advice, which is appropriate and encouraged, the service facilitates assessments and recommendations are taken on board and implemented appropriately.'

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<br><br>Risks to people were not managed which meant safe care and treatment was not provided. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>There was a lack of management oversight which resulted in records not been suitably maintained and auditing was not effective in addressing shortfalls in the service in a timely manner. |