Park Vista Care Homes Limited

Park Vista Care Home

Inspection report

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05 December 2017
06 December 2017

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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Park Vista Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Park Vista Care Home is registered to provide nursing and personal care and accommodation for up to 59 people. At the time of the inspection there 53 people living in the home.

The accommodation is split over three floors. People support needs varied over the three floors with the first floor being predominantly where people with nursing needs were accommodated.

This unannounced inspection took place over three days, 28 November, 5 and 6 December 2017.

At the previous inspection in January 2017 the home was rated as Good.

At the time of the inspection there was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were not always protected from harm. The procedure for reporting safeguarding incidents had not always been followed and the relevant agencies had not always been notified. Action had not always been taken to prevent a reoccurrence of safeguarding incidents. Information to reduce risks to people was not always recorded. People's risk assessments were not always updated after significant events.

Medication was administered by trained staff. However information about when medication should be administered was not always available and people did not always receive their medication in a timely manner.

Staff did not always receive supervisions and appraisals in line with the providers expectations.

People's personal information was not always kept private and secure.

Care plans did not always provide staff with the information that they required to meet people's individual care and support needs. The care provided was not always based on people's preferences.

The systems being used to assess, monitor and improve the service provided were not effective. This was because not all areas requiring improvement had been identified.

People were supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice

There were enough staff available to meet people's needs. The recruitment process was followed to ensure that only suitable people employed. The majority of staff received the training they required to meet people's needs Staff had not received supervisions and appraisals at the frequency determined by the registered provider.

Staff were kind and compassionate when working with people. People's privacy and dignity were upheld. Visitors were made to feel welcome to the home
Staff monitored people's health and welfare needs and acted on issues identified.

People told us that they were provided with a choice of food and drink that they enjoyed. When needed, people received the support they needed from staff to eat and drink. Staff supported people to maintain their interests and their links with the local community to promote social inclusion.

People and their relatives had been asked their views on the quality of the service and what improvements could be made so that they were involved in the running of the home.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Health and Social Care Act 2008 (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the 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 service was not always safe.

Safeguarding procedures had not always been followed when people had been potentially harmed.

Risk assessments did not always include information for staff about how to reduce risks to people they supported.

Medication was administered by trained staff. Information was not always available about when medication should be administered.

Is the service effective?

Requires Improvement

The service was not always effective.

Not all staff received training, supervision or appraisals as outlined by the registered provider.

Staff were acting in accordance with the Mental Capacity Act 2005 including the Deprivation of Liberty Safeguards. People's rights were being promoted and/ or protected.

People had access to a range of healthcare services to support them with maintaining their health and wellbeing.

Is the service caring?

Requires Improvement

The service was not always caring.

People's information was not always kept confidential.

Members of staff were kind and caring and knew people well.

Relationships with families and friends were promoted.

People's rights to privacy and dignity were valued.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care and support needs were not always planned for and evaluated.

People were encouraged to take part in activities and events that they enjoyed.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The systems for assessing, monitoring, and identifying areas for improvement were not always effective.

Notifications were not always submitted to the Commission as required by the law.

People and staff were involved in, and able to make comments in relation to the running of the service.

Park Vista Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

This inspection took place on 28 November, 5 and 6 December 2017 and was unannounced. We had planned only to carry out a shorter "focussed" inspection. However due to our findings on the first day we choose to change the inspection type into a full comprehensive inspection. The inspection was carried out by one inspection manager, two inspectors 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 our inspection we reviewed the information we held about the service. We reviewed notifications the registered provider had sent us since our previous inspection. A notification is important information about particular events that occur at the service that the provider is required by law to tell us about. The local safeguarding team and GP surgery provided information about their contact with the home.

During our inspection we spoke with five people who lived at the service, six relatives, the providers representative, the registered manager, the deputy manager, 3 registered nurses, 1 senior carer, 4 care assistants, daily activities coordinator, the chef, a kitchen assistant and 4 housekeeping staff. We looked at the care records for five people and records that related to health and safety and quality monitoring. We looked at medication administration records (MARs). We observed how people were cared for in the communal areas. 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. This helped us understand the care provided to people who had limited communication skills.

Requires Improvement

Is the service safe?

Our findings

Prior to our inspection we were notified by the local safeguarding team of concerns that they had about the lack of appropriate reporting of safeguarding issues by staff in the home. During the inspection we found that as well as the issues already identified by the safeguarding team there were other occasions when people have suffered potential harm which had not been reported. This had meant that the incidents had not always been investigated or the appropriate action taken to prevent a reoccurrence.

Although the registered manager and deputy manager were aware of incidents that had taken place, they had not ensured that the appropriate action had always been taken to report it, investigate it or prevent it from happening again. The provider's representative told us that they expected staff to complete incident forms and pass them onto them so that they could report them to the local safeguarding team. However we found that this process had not always been followed. Following this feedback, the representative of the registered provider took immediate action to ensure that all safeguarding concerns identified were reported.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had completed safeguarding training and were able to tell us about the different kinds of abuse that could take place and the signs and symptoms they would look out for. Staff also confirmed that safeguarding issues and possible scenarios were discussed during supervisions to check their knowledge.

Risk assessments had not always been completed to ensure that staff had the information they needed to reduce risks to people. For example, one person's care plan stated that they had a pressure sore. We requested to see the risk assessment for the person's tissue viability. The registered manager confirmed that a risk assessment was not in place..

One person had recently moved into the home and on admission it was noted that they had a pressure sore. Their admission assessment stated that their skin integrity was "high risk". However there was no guidance about how staff could reduce the risk of further pressure areas developing. Their wound management chart stated that their pressure sore should be redressed every three days. However there was no record of the pressure sore being checked or redressed for the previous five days. The nurse working at the time of the inspection stated that she was planning to check the pressure area that day. The nurse said that she didn't know why it hadn't been checked as frequently as required.. There was a repositioning chart in place for the person. However the chart did not state how often the person should be repositioned. The gaps between recordings of repositioning varied from one hour to 16 hours. The registered manager stated that the person should be repositioned at least every two hours. Staff told us it was not clear whose responsibility it was to check that the person was being repositioned.

Staff were aware of the process to follow if anyone suffered an accident. However we noted that this process had not always been followed. This was because investigations had not always been undertaken following

accidents. This meant that actions to prevent a reoccurrence had not always been considered. For example, two people had experienced physical altercations with each other. Appropriate action had not been taken to prevent this from happening again. There was a log of accidents and incidents each month so any patterns or trends could be identified and action taken as necessary to prevent a reoccurrence. Staff confirmed that trends from accident analysis were discussed during the recent team meeting.

The registered provider had failed to assess all risks and to have sufficient guidance for staff to follow to show how risks were mitigated when managing health conditions and health and safety.

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

On the first day of the inspection we identified that although there was a protocol in place for one person who required medication to be administered on a "when needed" basis it did not contain all of the relevant information. The medication was prescribed for treating anxiety. There was no information regarding when the medication should be administered, the amount to be administered and the maximum dosage to be administered over a 24 hour period

One person had a protocol in place for paracetamol. However paracetamol was not detailed on the persons medication administration record and there was not any in stock in the home for the person. The deputy manager was not aware if the person was currently prescribed paracetamol

We looked at a protocol for a third person who was prescribed, "When required" medication and found that the guidance was not clear about when it should be administered.

There was not clear guidance about where and how often creams should be applied. A nurse on duty told us one person's cream was prescribed to be applied twice daily but this was not recorded on the person's medication administration record.

One person's medication administration records had two different surnames for them. The person was prescribed antibiotics. Although these had been administered, records had not been fully completed.

Feedback provided from healthcare professionals was that prescribed medications had not always been administered in a timely manner. There had been a three day delay in administering antibiotics to one person and a 24 hour delay for one person who was prescribed medication as they were near the end of their life to make them comfortable. One person should have received a 3 monthly injection in August however the GP noticed in November that that this had not been administered since May.

Not all staff had signed the staff signature list so that they could be identified from the medication administration charts if needed.

Although medication audits were being carried out in the home each month they had not highlighted any of the issues we identified during the inspection.

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

The registered manager stated that they were not aware how the staffing levels had been decided. They explained that when people's needs had changed and they had requested extra staffing this has been

authorised by the registered provider.

During the inspection we saw that there was a sufficient number of staff working to meet people's needs in a timely manner. However people's feedback about how long they had to wait for staff assistance was mixed. One person said, "I have to wait to go to the toilet, often I have an accident before they get to me'. Another person told us, "It used to be alright but now they're short staffed all the time'." Another person told us, "They say 'ring the bell' but by the time they come it's too late. The response at night is better, there's three of them on." The GP had requested for one person to have an x-ray and was given the reason of not enough staff available when they had enquired why it had not been arranged in a timely manner.

Staff told us and records confirmed that when they had been recruited they had completed an application form and had attended an interview. The records showed that references had been sought and a criminal records check had been undertaken before they were employed. This showed that appropriate checks had been carried out and staff were assessed as suitable to work in the service.

Each person had a personal emergency evacuation plan (PEEP) in place, so that could be safely evacuated from the building in the case of an emergency. There was a fire risk assessment in place and regular checks were completed on fire equipment. Staff completed regular health and safety checks of the equipment including hoists to ensure they were in good working order to keep people safe.

There was an infection control lead for the home. Infection control policies and procedures were in place and regular infection control audits were carried out. Staff completed infection control training and were aware of their responsibilities. Staff were seen to use personal protective equipment such as gloves appropriately on the day of the inspection.

Requires Improvement

Is the service effective?

Our findings

Not all staff had received one to one supervision or appraisals at the frequency determined by the provider's policy. The provider's representative stated that only 5 staff had received an appraisal in the past 12 months. The policy stated that staff should receive supervision every two months. We found that this was not the case. There were 48 people working at the service and at the time of our inspection only 16 supervisions had been completed in the last 12 months. The representative of the registered provider stated that they would be putting measures in place to ensure all staff received an annual appraisal and regular supervision.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We requested information about staff training during the inspection. However the information was not clear so we requested further information from the registered provider. The representative of the registered provider stated that 85% of the current staff at Park Vista had completed their mandatory training and that some staff had also received extra training in other areas such as the use of the syringe driver. The registered provider had their own induction which all new staff were expected to complete within a certain time frame. The registered provider had recognised that the training was not always achieved in their expected time frame. The representative of the registered provider stated that they were reviewing the content of their induction package to ensure that it included the same information as the Care Certificate (a nationally recognised qualification).

There were pre admission forms and assessments in place for staff to complete before people were admitted to the home. This meant that people's needs had been assessed before moving into the home. However the quality of the assessments and level of information recorded varied. There was a new resident admission protocol which stated that it must be completed on admission. However these had not always been completed.

The registered provider employed a member of staff to liaise with organisations and stakeholders when people moved into the home. The member of staff was available to liaise with the person wanting to move into the home, relatives and other social and healthcare professionals. This role aimed to ensure a coordinated and timely move between services.

The chef told us about one person who had a soft diet. The persons care plan also stated that they required a soft diet. When we asked staff why the person had a soft diet they told us that the person was living with dementia and was not chewing their food and pocketing food in their mouth. However no referral had been made for an eating and drinking assessment to see if this was the correct course of action to take. The registered manager stated that they thought the person must have had an assessment but they could not find any evidence of this taking place.

We observed lunch time and saw that people received the assistance they required with eating and drinking.

People could have a choice of meals each day. People told us, "I like the lunch and tea choices", "the room and food are very good." Another person told us, "The options are OK most of the time but the chef will make something different for you." The chef ensured that they met with people when they moved into the home to ask what their likes and dislikes were and any special requests for food or drink were met. The chef was very passionate about his role and the large part that food and drink played in people's lives and the need to provide a balanced diet. Where people were restricted to pureed foods these were prepared in a mould of the food so that they resembled the pre pureed food. Fortified milkshakes were prepared daily for people who needed to increase their calorie intake. Any dietary needs such as a diabetic diet were catered for. We saw that drinks and snacks were offered throughout the day.

People confirmed and records showed that they had been referred to healthcare professionals when needed. Records showed that people had been referred to the GP, district nurses and other healthcare professionals as required.

The staff had worked with relatives of the home to raise money to purchase a garden room so that people could enjoy the garden all year round. There were various communal spaces for people to use throughout the home and more private spaces to meet family and friends if people didn't want to use their bedroom.

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 found that where applicable capacity assessments had been completed. The assessments showed that the staff member completing the assessments with people had tried to make the information accessible to them. When best interest decisions had been made these had been recorded. When needed, DoLS applications had been submitted to the local authority. Staff were aware of the requirements of the MCA and the relevant codes of practice. This meant that people were only having decisions made on their behalf or their liberty restricted after following the correct procedures.

Requires Improvement

Is the service caring?

Our findings

People told us they thought that the staff were mostly caring. One person told us, "The staff are great, I have a good relationship with them.' People and their family members told us that communication could be improved within the home. This was discussed at the relatives meeting and with us directly. For example, people told us that when they moved into Park Vista they were not informed of the facilities available or who to discuss their queries with. One person told us that they were not aware that they could have their meals in the dining room as they had always been served them in their bedroom. Another person told us that they didn't know how long they were staying in the home for or what the plans for improving their mobility were. The registered manager stated that they were aware that issues regarding communication had been raised by people using the service and their relatives and that communication would be improved. The representation of the registered provider told us that they were putting together a new welcome to the home pack so that people had the basic information they needed and contact details so they could ask any questions.

People's personal information about them was not always kept private and secure. We saw that care plans were left on a desk and others were in an unlocked cupboard and that people's weights were displayed on a notice board in a communal area on the ground floor.

The registered manager gave us examples about how the staff were caring. One person had expressed regret for losing touch with their family and the staff had contacted the police, missing persons and other organisations to track down their relatives. The person had received a letter from a relative and arrangements were being made for them all to meet.

We observed staff taking time to explain procedures to people. For example, we saw a nurse ask someone if they could take their blood pressure, explained what they were doing and discussed the results with them. They reassured the person by making a joke with them which made the person laugh.

Each day there was a "Resident of the day." Staff told us that the person was the focus of the day for example, their care plans were checked with them to make sure they were still accurate. They were also asked if there was anything they would like to do or anywhere they would like to go so that it could be arranged if possible.

People told us that they could have visitors at any time and they were always made to feel welcome.

We saw that staff referred to people by their preferred names. Staff knew people well and were able to tell us how people liked to have their needs met and what their preferences were. Staff had a friendly rapport with people they were working with and when they entered a room acknowledge the people in there and checked on their welfare. People confirmed that staff normally knocked on their bedroom doors before entering. Staff told us they treated people with dignity and promoted their privacy and ensured that any personal care was always carried out with doors and curtains closed.

There was a keyworker system in place. A keyworker is a named member of staff that was responsible for making sure people's needs were met. However people and their relatives told us that they were not always informed if their keyworker changed. One relative told us, "We don't know about a key worker. When we arrived we were just shown to her room and (the staff) left." Another relative told us, "I don't know who to go to, no one has told me about a keyworker or contact."

People had been provided with information about advocates when they needed it. Advocates are people who are independent of the service and who support people to make and communicate their wishes.

Requires Improvement

Is the service responsive?

Our findings

People care plans were not always a true reflection of what support people needed. For example, one person was known to regularly exhibit behaviour that was challenging when they were being assisted with personal care. One member of care staff told us about the signs to expect before it happened and how distracting the person in different ways helped them to remain calm. However the person's care plan did not include the information that the person could display behaviour that was challenging or how staff should support them with it. The staff member also told us that the person seemed to prefer male carers. However their care plan stated that they had no preference.

Care plans were not always person centred and sometimes showed a lack of understanding of people's needs. For example, one person's care plan stated, "[Name] has dementia. Sometimes he gets very emotional for no reason." This showed a lack of insight into how the dementia affected the person and the reasons for how they may be feeling.

Care plans did not always give consistent information. For example, one person's care plan stated that they needed the assistance of two members of staff with personal care. Further on it stated that they only needed the assistance of one member of staff with personal care. The quality of the care plans also varied. For example, one person who was diabetic had detailed information about how their diabetes was managed and how staff should support them. However another person's care plan for their diabetes stated that if there were "Signs of a diabetic issue to ring the GP or 111 straight away." The care plan was not personalised and did not provide information about what signs and symptoms staff needed to be aware of.

Some people who had moved into the home recently didn't have a care plan in place. We observed one person walking down the corridor with a member of staff holding their arm. The person was complaining about walking and was out of breath. Another member of staff came along and asked why they were walking and not using their wheelchair. The first member of staff did not respond so the second member of staff went and got the person's wheelchair for them. The second member of staff told us afterwards that the person was not supposed to walk long distances. We asked to see the person's care plan. Although the person had moved in to the home 10 days previously there was no care plan in place for them. The registered manager confirmed that there was no care plan in place and arranged for it to be written that day.

The records showed that not all care plans were being followed. For one person their records stated that they needed two members of staff to assist them to stand. However we saw that one member of staff helped the person. The member of staff stated that she always helped the person on her own. The person told us that they had been told it should be two members of staff to help them but sometimes it was only one.

Most staff that we spoke with knew people well and were able to tell us about their individual needs. However, this information was not reflected in their records. The lack of detailed records posed a risk to people as new or agency staff may not have the knowledge to care for people in line with their personalised needs. The registered provider had failed to maintain accurate, complete and contemporaneous record in respect of each service user.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although not all care plans were accurate and provided enough detail, staff received verbal daily handovers from senior staff. Staff told us these handovers helped them to keep up to date with any changes in people's support.

The registered manager stated that there was a complaints procedure available. The complaints procedure was displayed near the registered manager's office. The records showed that complaints had been investigated in live with the complaints procedure.

One member of staff was employed as an activities coordinator. Their role was to organise and provide activities on both an individual and group basis. The activity plans for November and December 2017 showed a full and varied programme of events took place including visits from local schools and churches. The activity coordinator told us that she received plenty of help from friends and relatives of residents when she organises local trips and needs people to help. One person told us, "There's plenty of activities if I want to do them". One relative told us, "The activity co-ordinator is very effective." The registered manager told us they had arranged for the children from a local nursery to visit people in the home which people had really enjoyed.

The registered manager stated that they discussed people's end of life wishes with them at the appropriate time. One person had stated that they would like to be baptised before they passed away and this had been organised. The registered manager stated that relatives and friends were welcome to stay in the home when supporting people at the end of their life. Staff also spent time with relatives and friends explaining what to expect. Staff also stated that if someone didn't have any friends or family who were able to be with them then extra staffing was provided if the person wanted to have someone with them. The registered manager stated that it was their aim to make people's passing peaceful, comfortable and pain free.

Requires Improvement

Is the service well-led?

Our findings

The inspection took three days to complete as it was very difficult at times to get the information requested in a timely manner. A number of the records we needed to look at were not available in the home and had to be brought over from the providers head office.

There was not always an open and transparent culture in the home. It was difficult to know from the records if care was always being provided as expected and not recorded or if the records were correct and care was not being provided as expected. For example, we looked at two repositioning charts and found large gaps between entries. When we asked for one person's repositioning chart we found a staff member filling it in before bringing it to us. We also saw evidence that staff were requested to retrospectively complete medication administration records when there had been an omission for signing. Records should be made contemporaneously to ensure they are a true and accurate record of the care provided. When we discussed a safeguarding incident with one member of the management team they were not open and transparent with us about the fact that it had occurred previously in the home between the same two people.

In some areas of the service there was a lack of accountability for completing tasks and checking that they had been done. For example, repositioning charts should be completed by the staff member assisting the person to reposition. No one could tell us whose responsibility it was to check the charts to ensure that people were being repositioned as expected or if not take appropriate action. Supervisions and appraisals were delegated by the registered manager to the heads of departments but registered manager had not identified that they were not being carried out as expected. Medication had been prescribed for five people but not provided in a timely manner. This had not been identified until healthcare professionals returned to see the same people. On the second day of the inspection we were told by the registered manager that they had requested the deputy manager to update a medication administration protocol. However when we asked to see the protocol it had not been updated. The deputy manager stated that they had requested one of the nurses to update the protocol.

Although there were many internal audits in place they had failed to identify the issues found during the inspection. For example although a monthly medication audit was being carried out it had not identified the lack of PRN protocols. The provider stated that they would be looking at the effectiveness of the audits and changing them where necessary.

Processes were in place to ensure documents were completed correctly however these were not always being followed. For example, the provider stated that all care plans were supposed to be signed off by the registered manager seven days after completion. However this process had not been followed to ensure that the care plans were completed to the expected quality and gave staff the information they required to meet people's needs.

The systems in place to check the quality of the care being provided were not effective. Records were not accurate and up to date.

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

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. The registered manager was aware that they needed to inform CQC of important events. However these notifications had not always been made. The provider had identified that some of the notifications had not been sent but not all of them.

Notifications as required had not been sent to the Commission. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

There was a registered manager in place at the time of the inspection. They were not in the home for the first day of the inspection. The registered manager stated that her values were about, "Placing the resident in the driving seat." Reviews recently received by an independent organisation included positive comments about the management of the home. These included, "The general manager is very compassionate and supportive" and "The manager is always available at short notice." One relative told us "There's no them and us"(when asked if the registered manager was approachable) The registered manager stated that one of the challenges of the service was to move away from doing things in a certain way just because it had always been done that way. They stated that they wanted to provide an individualised service and "Not a one size fits all" approach.

Satisfaction surveys had been sent to people living in the home in the home in October 2017 and a report complied of the findings. 47% of the people said they were either extremely satisfied or very satisfied. Residents and relatives meetings were being held in the home. The meetings gave people the opportunity to discuss what was going well, what could be improved and what activities they would like to be provided.

Staff were aware of the whistleblowing policy and told us that they would raise any concerns they had about any issues within the home. The whistleblowing policy was displayed on the staff notice board.

Daily meetings took place between the heads of departments. A range of information was shared during these meetings,. Regular staff meetings were held and staff confirmed that they could raise any issues they wanted to. Staff also told us that the meetings were used to reflect on practice and make suggestions for improvements.

The registered manager or deputy manager completed monthly health and safety checks throughout the home.

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 18 Registration Regulations 2009 Notifications of other incidents Notifications as required had not been sent to the Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of people was not always appropriate, met their individual needs and reflected their preferences. People's care plans were not person centred.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Not all risks to people had been assessed and where possible reduced.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment There was a failure to establish and operate effective systems to report and investigate all incidents of harm, investigate it and prevent a reoccurrence.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to check the quality of the care being provided were not effective. Records were not accurate and up to date.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Not all staff had received appropriate training, supervision and appraisals.