Runwood Homes Limited

St Michaels Court

Inspection report

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Date of inspection visit:
22 March 2022
29 March 2022

Date of publication:
20 May 2022

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
St Michael's Court is a nursing home providing personal and nursing care to up to 86 people. The service provides support to older and younger people, some of whom may be living with dementia, a physical disability or sensory impairment. At the time of our inspection there were 38 people using the service.

The care home accommodates people across three separate floors, each of which has its own facilities, for example, dining room and lounges.

People's experience of using this service and what we found
Medicines management required improvement. There was poor medicines administration practice seen and poor guidance in the records on how people would like to take their medication.

There was a lack of staff training with staff not receiving all required training. There were also no competency assessments to check staff's understanding or spot checks to review care delivery.

There were times when the service appeared to be short of staff so the care provided was task-focussed more than person centred. People spoken with acknowledged at times there could be a shortness of staff in the mornings and around meals times, which could mean a wait.

The management oversight of the service needed improving and audits developed to monitor the quality of care and environmental issues to drive improvements.

People had choice about what they would like to eat and had enough. There were concerns people were not consistently being offered sufficient fluids.

Most staff were clear about escalating safeguarding concerns. People felt safe living in the service. They said, "Yes, I'm happy. I do feel safe. It's because I don't have to worry about anything." They were complimentary about the choice of food and its availability.

People said they received their medication on time and there was not a long wait for pain relief. People said staff noticed if they were not feeling well and contacted the GP. They said they had visits from a chiropodist, physiotherapist as well as the hairdresser.

People spoken with said they felt the home was clean and staff wore appropriate personal protective equipment (PPE) when providing care to them and during the pandemic.

The manager was new and responded to our inspection in a positive way and was open about the shortfalls. There had been a lack of reporting of incidents to Safeguarding and CQC. However, since the new manager has been in post this has been addressed and these are now being completed appropriately and in a timely

manner.

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; the policies and systems in the service supported this practice.

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

Rating at last inspection and update
The last rating for this service was Good (report published on 12 May 2021).

Why we inspected
We received concerns in relation to the management of medicines and care of people who lived in the service, staffing, and environmental safety issues. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

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.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from Good to Requires Improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective 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 St Michael's Court on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, staffing support and training and governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

St Michaels 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 Health and Social Care Act 2008.

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
On 22 March 2022, the site visit was completed by three inspectors and one medicine's inspector. On 29 March 2022 one inspector attended the service.

An Expert by Experience spoke with people who used the service and spoke with relatives, by telephone. 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
St Michael's Court is a 'care home'. People in care homes receive accommodation and nursing and personal care as a single package under one contractual agreement dependent on their registration with us. St Michael's Court is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
The service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post. However, there was a manager

covering the role who had not registered with the Care Quality Commission.

Notice of inspection
The first day of the inspection was unannounced. The second day of the inspection was announced. Inspection activity was completed on 19 April 2022, when final feedback was provided.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority.

We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

We used all this information to plan our inspection.

During the inspection
We spoke with two relatives, one person who used the service and observed care provided in the communal areas and staff giving people their medicines. We spoke with nine members of staff including the manager, registered nurse, carer, domestic, chef, and maintenance staff.

We reviewed a range of records. This included one person's care records and 17 medication records. We looked at three staff files in relation to recruitment and a variety of records relating to maintenance.

After the inspection
We spoke with six relatives, five people who used the service and six members of staff including two registered nurses. We also received feedback from five health care professionals who visited the service regularly.

We reviewed further records after the inspection, including 13 care records, and a variety of records relating to management of the service, including policies and procedures.

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 our last inspection we rated this key question Good. At this inspection the rating has changed 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.

Using medicines safely

● The manager had not ensured regular competency assessment of staff administering medication. We observed staff did not always follow safe and hygienic administration procedures. We identified one person who did not receive their morning medicines because the member of staff said they had become distracted by an incident they needed to attend to and then omitted to return to give the person their medicines at the scheduled time.

● Information about how individual people preferred or needed to have their medicines given to them was not accurate. Staff did not always know who could, if needed, have their medicines given to them concealed in food or drink (covertly) because they were unable to consent to taking their medicines and who would otherwise refuse them.

● Medicines prescribed on a required basis (PRN), did not always have instructions for staff to inform them when to give the medicines and how to monitor its affect. We noted that one person prescribed a potentially sedative medicine on a PRN basis was given it regularly three times each day and not on an occasional basis. Additional records did not always justify its use each time and there was a lack of records showing the prescriber had been contacted to review this medicine for this person.

● Oral medicines were stored securely, however, topical medicines stored in people's rooms were not being kept safely to prevent the risk of access and accidental harm. There were gaps in medicine refrigerator records so medicines requiring refrigeration may not have been stored within their correct temperature range potentially affecting their effectiveness.

● Records showed there were control measures in place for medicine stock levels and people received their oral medicines, however, we noted there were some gaps in records for the application of people's topical medicines.

● For a person prescribed medicated skin patches records showed the application of the patches to the person's body had not been varied to avoid the potential for irritant skin reactions.

● Regular checks of medicines intended to be carried out monthly had not been completed since September 2021. Controlled drug checks had also not been completed weekly in line with the service's policy.

Systems and audits were not in place to ensure medicines were administered safely and staff did not have regular checks on their practice. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider responded immediately during and after the inspection. They completed audits, staff competency checks, reinforced correct practice and reviewed PRN protocols. Immediate action was taken

to contact the prescriber of the sedative medication to review it.

Assessing risk, safety monitoring and management
● Information about risks and safety was not always comprehensive or up to date. Safety concerns were not consistently identified or addressed quickly enough.
● People who lived in the service were put at risk as items such as prescribed creams and denture tablets were not kept secure in lockable cabinets and were accessible. This risked potential accidental ingestion.
● During the inspection staff were witnessed not following a person's positive behaviour support plan and not giving the reassurance this detailed. The person was in their bedroom, being ignored which lead them to becoming distressed.
● Regular environmental checks were taking place. However, a number of concerns were not identified during checks. This included rooms and cupboards left unlocked allowing people to access products which may cause harm and enabling them to leave the building.

Environmental risk to people have not always been identified and actions have not always been taken which could put people's safety at risk. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider responded after the inspection completing a review of all bedroom cabinets to ensure they held appropriate items and to ensure the locks were used on them.

Staffing and recruitment
● People did not always receive person-centred care which meet their needs. This was because there was not consistently enough staff, so care was task-focussed rather than flexible to meet people's individual needs.
● Mixed feedback was received from staff and people who lived in the service, so we could not be assured about staffing levels. We observed medication being given late due to staff being distracted by an incident and forgetting to give this on their return.
● One person said, "Short staffed many, many mornings. [Staff are] rushed off their feet. Looking after 2-3 people at the same time. It's at different parts of the day. First thing in the morning and before meals. Cups of tea are not that regular and there can be longer waits for the toilet." Other people also identified times when staffing levels were short, including weekends.
● Staff spoken to acknowledged there were times when they were short of staff, some of which was due to unexpected absences. However, they said most of the time management sorted out cover.
● Concerns were raised with the manager regarding the dependency tool, which was used to identify levels of staff needed to meet people's needs, not taking into consideration aspects such as layout and size of building. The manager was looking at using a different dependency tool. They also had plans to move the people who lived in the service around so those with similar needs were in the same areas and re-arrange staffing levels to better meet people's needs.

People were not consistently receiving high-quality, timely care due to levels of staffing. This was a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Recruitment systems were in place to make sure the right staff were recruited. However, a Disclosing and Barring Service (DBS) checks was found with convictions which had not been risk assessed, potentially placing people at risk of harm. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

● Checks on nurse's registration to the Nursing and Midwifery Council (NMC) were undertaken for all nurses working in the service. A profile of a nurse working from an agency was seen. The NMC registration on the record had expired so had their DBS check. However, the manager requested an update profile for this person from the agency which was received.

Systems and processes to safeguard people from the risk of abuse
● Safeguarding policies and procedures were not fully embedded, and the service was not always fully engaged with local safeguarding systems.
● Daily meetings took place where incidents were discussed, including those which needed safeguarding referrals being made.
● Staff had an understanding of safeguarding practice and said they had received training. They felt confident in raising anything they were concerned about and knew who to report it to.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● 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 have also signposted the provider to resources to develop their approach.

Visiting in care homes
● Visits to people who live in the service have followed Government guidance. Essential care givers have been able to visit even when there has been a COVID-19 outbreak.
● Guidance and risk assessments were in place for visits outside of the care home and into the service.

Learning lessons when things go wrong
● Openness and transparency about safety was encouraged. Staff were supported when they raised concerns. There were systems in place, but they were not fully implemented or effective.
● Since the last inspection not all incidents had been reported to the local safeguarding team or to the Care Quality Commission (CQC). There was no harm identified to people as a result. The new manager had addressed this and was ensuring appropriate referrals were now being made.
● Examples of lessons learnt forms were seen for recent concerns raised with the local safeguarding team, where actions were identified. However, not all safeguardings were recorded within the recording logs for review.
● Staff spoken with said lessons learnt were taken to the daily meetings so actions could be taken forward in all departments of the service.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Care and support did not always reflect current evidence-based guidance, standards and best practice. Care assessments did not consider the full range of people's diverse needs.
- Care plans and risk assessments for the people who lived in the service were not always up to date, lacked information or had conflicting information which risked people receiving inappropriate care. For example, one person's records said their food should be a level 3 soft diet and in another part of their record said it was level 6 soft and bite size. The levels refer to descriptions in the International Dysphagia Diet Standardisation Initiative.
- During the inspection we observed one person not sat upright when being supported to have a drink as recommended in their care records. This put them at risk of choking.
- People did not appear to be weighed as their care records stated. For example, care records stated to weigh weekly, but records showed monthly. For those who refused or were unable to be weighed no alternative measures were put in place. This could mean changes in people's weight would not be picked up promptly for action to be taken, for example, changing diet or seeking health care professional's advice.

Care records were not all up to date and accurate to people's needs and staff did not always follow guidance within them. This put people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The manager had identified issues within the care plans and had appointed care plan champions who had been given protected time to update care plans and risk assessments, so they meet the needs of the people and were to the required standard.
- Some of the care plans which had been reviewed were person-centred in the way they were written and easy to understand.
- People spoke highly of staff and told us they were kind and caring. They said they were treated with respect and kindness by staff who were patient and respected their dignity. One person said, "[staff member] has given me confidence when having a shower. [Staff member] is a perfect gentleman." People said they have a choice whether they want male or female carers and felt staff were well trained when providing care and using equipment, for example, being lifted by a hoist.

Staff support: induction, training, skills and experience

- The service understood staff needed training and development, but this was not always up to date.
- The training matrix did not cover all required training to meet people's needs especially for clinical

training and training identified within policies. For example, care certificate, safeguarding, epilepsy, medication, wound care, enteral feeds, venepuncture, customer care, handling concerns and complaints, fire prevention, learning disability and mental health training were not covered on the matrix. The manager showed details of forthcoming training he has booked for medication and stated one of his focusses is on improving the training of existing staff.

● The service had failed to regularly assess the competency of staff in areas such as infection prevention and control and medicines administration and management.

● We had concerns about the clinical oversight of the nursing staff in their practice, training and management, due to the current management structure. The manager did not have a clinical background or qualification. At the time of inspection the post of deputy manager and clinical lead were being recruited to.

● Staff supervision had not been taking place for a significant period of time. However, the manager had started to implement a schedule for supervisions of staff. He was also starting to manage staff absence by meeting with staff when they returned to work following sickness.

Staff were not up to date with training and having their competency checked for areas needed to provide safe care to people. Staff had not been provided with regular supervision. This put people at risk of harm. This was a breach of regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A member of staff who had started recently and was new to care said they had started their induction on days to complete training and shadow staff before moving onto nights. They felt they had all the training they needed to do their job.

● The provider responded during and after the inspection showing details of training booked, completing staff competencies and sharing schedule of supervision, providing evidence of supervisions which had taken place.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

● The service monitored people's health, care and support needs, but did not consistently act on issues identified. People may not have the best possible health outcomes and there was a risk their health could deteriorate.

● People were given poor oral health care. There were oral health assessments in place but not all of them were completed. There was no record of referrals to dentists. The record of daily support with oral health had gaps which indicated people were not being supported to clean their teeth every day. Toothbrushes seen in bathrooms were old, worn and had bristles frayed or there was no toothbrush. Without proper regular care and dental attention people could be suffering from pain, or could have difficulties eating, which would impact on their health.

● People's care records stated referrals needed to be made to health care professionals. The records did not always state whether these referrals had been made, if they had, what date this was done and the outcome. People could, therefore, have a delay in receiving care they required.

Systems did not ensure there were records of whether referrals to health care professionals had been made and the outcome. This put people at risk of not receiving appropriate care. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A health care professional said the referrals for guidance were appropriate and the staff seemed to follow guidance given for care of people. Another said the staff sometimes appeared unclear which service pathway to use and they tried to guide them. They felt the knowledge and skills of staff could be variable

and put some of the issues down to the high turnover of managers who all tried to do their best.
● The manager responded after the inspection and said they had reviewed people's toothbrushes, implemented an assessment form and have organised for a dental service to visit the home regularly to provide dental care.

Supporting people to eat and drink enough to maintain a balanced diet
● People did not consistently receive enough to drink which risked dehydration. During the inspection we saw people were not regularly supported to drink. Records showed people were not consistently offered the amount of fluid they were assessed as required, especially at weekends.
● People said, "water is always available. Tea doesn't always turn up, not every day." Another said, "I could do with a bit more to drink." It was important people had sufficient drinks, so they did not become dehydrated.
● People could exercise choice and had access to sufficient food throughout the day and they could eat where they liked to. One person said, "Every day you get choice of food at lunch and later on in the day." Another person said, "I like all the food. You get a choice of food. I get enough to eat, and I choose where I have my meals."

People were not consistently being offered enough fluids to meet their targets. This put them at risk of dehydration. This was a breach of regulation 14(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● People had access to outside space and a number of communal areas to use. The home had three floors with long turning corridors, which could make observation of people difficult.
● The manager said they had plans to change the floors so each had a specific purpose, for example, nursing, residential and dementia care, to make better use of staff time and ensure staff had the right skills and experience to meet the needs of the people they were caring for.
● The floor which would be dedicated to dementia care, was not decorated in a dementia friendly way. Consideration should be given to this in line with latest guidance.

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● People who lacked capacity had mental capacity assessments in their records. However, they did not

state who had been involved with the assessment or best interest decision, only said family and/or GP, without names.

● People who required DoLS authorisations had these applied for or approved. However, the DoLS care plans did not always reflect the conditions relating to the authorisations and how these were being meet. For example, one person who had medication given covertly had conditions saying this should be reviewed monthly, but this was not happening.

● Staff were observed to ask for consent before entering people's rooms and before supporting them. People and their relatives said staff always knocked before entering rooms.

We recommend the provider undertakes a review of all people to ensure appropriate DoLs applications have been made and where authorised to ensure conditions are reflected within the care plans and have been actioned, where appropriate.

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 our last inspection we rated this key question Good. At this inspection the rating has changed 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Governance and performance management were not always reliable and effective. Systems were not regularly reviewed. Risks were not always identified and managed.
- Audits had not been completed in line with the provider's audit matrix. Audits completed were not robust enough to pick up all issues and address them, which could put people at risk of not receiving the correct care or being kept safe.
- Following the last CQC inspection, the provider did not pick up failings in the service, which lead to the quality of care provided to people to deteriorate. These were identified when the local authority undertook a monitoring visit. They have been working with the local authority to address the shortfalls.
- The provider has been completing monthly assessments of the service. The previous months were viewed which identified issues and actions to be taken. However, some of these issues were picked up during this inspection, which were still outstanding. For example, not all audits being completed, medication issues and supervision of staff.

Due to lack of systems and processes to effectively monitor the quality of service provision the service people were placed at risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The manager undertook daily walks around the home which looked at the general home management. Actions were identified and taken to the daily meetings with the senior staff from each department for discussion and taking forward.

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

- The manager had been in post since January 2022. His initial vision was to put a clear staffing structure into the service and create an open-door policy and become more transparent. He wanted to engage with staff and develop good working relationships where they felt valued.
- Staff said they felt supported by the manager and he was approachable. They said the new manager had resolved issues when they had raised a problem or when issues had been identified at meetings. Although some staff were more sceptical due to the number of managers the service had and how each one had made changes when they started.
- People who used the service and their relatives felt overall it was well managed and the manager listened

to them. One person said, "Yes, a well-managed home. They've just changed managers. Yes, I go to resident's meetings. Yes, management listens."

Continuous learning and improving care; 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 manager responded to our inspection in an open and transparent way and looked to address shortfalls identified and had plans in place for improvements within the service. The manager understood his responsibilities under duty of candour.

● However, systems were not clear on how complaints were managed and monitored, for example, there was no formal or informal complaints log to capture this information and manage responses. Some complaints were dealt with under different systems, for example safeguarding referrals. It was, therefore, difficult to identify if all lessons learnt were being identified to improve the service and if duty of candour was being fully implemented.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● Staff meetings had recently started to take place, which staff said they found useful and productive. A survey had been sent around staff to gain their feedback with the closing date after the inspection.

● People who lived in the service said they had attended resident's meetings/surgeries and felt they were listened to. The surgeries were held weekly and were informal general discussions. The monthly meetings had an agenda and were more formal.

● Mealtime experience audits took place regularly to gain feedback and monitor support provided.

● The manager and staff gave examples where they had worked with other agencies to promote people's care needs.

● Relationships were being developed with local charity which was based next to the service. They had been invited to a resident's meetings to talk about what they provide. The plans were for people to attend art and craft sessions there.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care records were not all up to date and accurate to people's needs and staff did not always follow guidance within them. This put people at risk of harm. Environmental checks were not finding concerns which could put people's safety at risk. Systems and audits were not in place to ensure medicines were administered safely and staff did not have regular checks on their practice. Systems did not ensure there were records of whether referrals to health care professionals had been made and the outcome. This put people at risk of not receiving appropriate care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People were not consistently being offered enough fluids to meet their targets. This put them at risk of dehydration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Due to lack of systems and processes to effectively monitor the quality of service

provision the service people were placed at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing People were not consistently receiving high-quality, timely care due to levels of staffing. Staff were not up to date with training and having their competency checked for areas needed to provide safe care to people. Staff had not been provided with regular supervision. This put people at risk of harm.