Look Ahead Care and Support Limited

Felstead Street

Inspection report

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Date of inspection visit:
29 March 2016
30 March 2016

Date of publication:
12 July 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Felstead Street on 29 and 30 March 2016, the inspection was unannounced. Our last inspection took place on 24 July 2013 and we found that the provider was meeting all of the regulations that we checked.

Felstead Street provides accommodation and care for 24 people with mental health needs. Look Ahead provide the support and an independent landlord owns the property. The building was divided into two separate services. On the ground floor the service provides long-term care for up to 16 people. The first floor provides rehabilitative support for up to eight people to help them prepare for independent living. The first floor was named the Felstead Street Independent Project (FSIP). This floor was overseen by Look Ahead and the community mental health team provided life skills workshops to help people learn independent living skills in the community.

At the time of the inspection there were 24 people living in the service. All the bedrooms had en suite bathrooms in addition to shared bathrooms. There was a large garden and comfortable lounge areas.

The service had a registered manager. 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.

All of the people we spoke to told us they felt safe in the service, however, there were not suitable numbers of staff employed to meet the needs of the people who used the service. This had an impact on the quality of care being provided.

Staff had a good understanding of the safeguarding procedures and followed protection plans to minimise the risk of harm to people. Staff had a good working relationship with the community policing team. Thorough recruitment checks were completed to assess the suitability of the staff employed.

Accidents and incidents were monitored closely through the use of an internal IT system. Prevention measures had been put in place to minimise future re-occurrences of incidents.

Regular testing and servicing of equipment was carried out. The building required repairs and these were reported to the property owner within the appropriate timescales.

People's medicines were managed safely. Staff were knowledgeable regarding the administration, storage and disposal of medicines.

People told us they liked the food, however safe food hygiene practices were not always followed and maintained.

Menus reflected the diverse cultural needs and preferences of the people who used the service. People were supported to learn cooking skills before moving into their own homes in the community.

Staff had received sufficient training and were assisted with their ongoing learning and development needs. Training was reflective of the needs of the people who used the service.

Where people had been deprived of their liberty for their own safety the provider had taken appropriate steps to apply for authorisation from the local authority and to notify the Care Quality Commission (CQC). Where people did not have the capacity to make decisions for themselves, the provider had followed a best interests process in line with the Mental Capacity Act 2005 (MCA). Staff had completed training in these areas. People's health care needs were regularly assessed and reviewed.

People told us staff were caring. Important relationships were encouraged and fostered between people; their relatives and friends. People who used the service were informed of their rights and responsibilities of living in the service. Staff encouraged people to take part in the activities that were important to them. People told us they felt motivated to do well.

People's cultural identity was recognised and valued. Community meetings were held to keep people informed of changes to the service, and obtain their feedback on how their care should be delivered. Staff supported people to develop independent living skills.

People were able to voice their concerns if they were unhappy with any aspect of the service. Complaints had been responded to appropriately when they were raised. There were good systems in place to monitor the quality of services provided.

We found two breaches of regulation relating to the safe care and treatment of people and staffing. You can see what action we asked the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Aspects of the service were not safe.

People's care and support needs were not always met due to low staffing levels.

The provider had good systems in place to protect people from harm. Staff encouraged people to take positive risks. People told us they felt safe and enjoyed living in the service.

Safe and effective recruitment practices were followed to ensure that all staff were fit, able and qualified to do their jobs.

People were supported to take their medicines safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported to maintain a well-balanced diet, however good food hygiene practices were not always followed.

Staff told us their learning and development needs were met and felt well supported to undertake their roles.

The service was meeting the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). People were able to make choices and decisions about their lives.

People had good access to healthcare services.

Is the service caring?

Good

The service was caring.

People told us staff were considerate; caring and their privacy was respected.

Positive relationships were developed and maintained with people and their relatives. People were encouraged to follow their aspirations and interests.

Advocacy support was offered to people to assist them to have their voice heard.

People's cultural and religious needs were valued and celebrated.

Is the service responsive?

Good

The service was responsive.

People were helped to make informed decisions about the type of care and support they received.

The provider held 'customer celebration awards', to celebrate the personal achievements of people.

People understood how to raise complaints. Concerns were actioned and responded to in line with the providers complaints procedures.

Is the service well-led?

Good

The service was well led.

People and staff were made to feel valued and that they contributed to overall running of the service.

Staff told us they were supported by the registered manager.

Records and systems were regularly audited and staff had good working partnerships with other agencies.

Feedback forms were sent to people and their relatives to ask for their ideas and suggestions on how they could improve service delivery.

Felstead Street

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.

We visited Felstead Street on 29 and 30 March 2016 to undertake an inspection of the service. The inspection was unannounced. The inspection team consisted of one inspector and a specialist advisor who is a registered mental nurse.

We checked information that the Care Quality Commission (CQC) held about the service which included a Provider Information Return (PIR), the previous inspection report and notifications sent to CQC by the provider before the inspection. The PIR is a form that asks the provider to give some key information about the service, including what the service does well and any improvements they plan to make. The notifications provide us with information about changes to the service and any significant concerns reported by the provider.

We spoke with eight people who used the service, one relative and three health and social care professionals who were working in the service on the day of our inspection. We spent time observing the care people received, listened to a staff handover and attended a group cooking workshop. Before our inspection we contacted the community mental health team (CMHT) and spoke to one health and social care professional to gather information regarding the service.

We spoke with four care workers, the operations manager and the registered manager. We looked at the records in relation to eight people's care including their medicines records. We also looked at five staff recruitment and training records, minutes of meetings with staff, quality assurance audits, staff rotas and a selection of the provider's policies and procedures.

Requires Improvement

Is the service safe?

Our findings

People's care and support needs were not always met because there was not always a suitable number of staff available to meet people's needs and ensure the effective operation of the service. The rota showed that at times low staffing levels had an impact on the service running efficiently.

The rota showed there was not enough staff on duty during the day. Three staff members worked the early shift and two staff members worked the late shift. Additionally two staff were required to work during the night. We observed that the registered manager seemed rushed when responding to people's requests in the service. For example, staff were required to work in the reception area to allow people and visitors access in and out of the building. The registered manager was on duty in the reception area; one staff member was supporting a person in the community and another was supporting a person with their personal care needs. The registered manager then left the reception area when a person requested they needed assistance as the person had lost the key to their room. A relative then came to the reception area asking to be let out of the building and appeared frustrated when they were unable to leave, as there were no staff available to assist. During this time, the office phone was ringing and the registered manager returned to let the visitor out of the building and answer the phones. There was a deputy manager also on duty but they were also supporting people with their individual needs.

We viewed a family feedback questionnaire that highlighted a concern from a relative who had waited outside the service for 10-20 minutes before they were able to access the building. There was a written apology letter to the relative that explained that this was because staff would have been supporting people in another area of the building after five o'clock in the afternoon.

We spoke to a staff member who told us, "It is stressful at times, especially during these last few months of staff shortages" and another said, "We could do with more staff." We were told staffing levels were problematic due to three staff members leaving the service and a change in the organisation's management structure. Staff reported feeling pressurised with their workloads and this had an impact on them being unable able to attend training courses. In the residents' meeting it was recorded that staff were unable to attend the quality group due to staff shortages.

Daily records for one person showed support was provided by staff for daily life skills such as activities, dietary and health needs. However we saw written records in the care file that a key worker had been unable to attend monthly key work sessions with the person they supported from September to November 2015 due to their increased workload. A key worker is a staff member who monitors the progress and support needs of the people they are assigned to. This ensures there is continuity of care for people who require support. We also looked at written records that explained that people's activities had been reduced because of staff shortages and would resume in April 2016. This meant that people did not always have assistance from staff to ensure their care and support needs were being met.

We found that there was no behaviour management training given to staff when repeated incidents had occurred in the service. For example, staff recognised the incidents could be managed more effectively if

there was additional staff to support them. The staff we spoke with told us they knew how to report incidents when they happened in the service. There were several incident forms that had been completed following concerns were a person's behaviour had become challenging for the service. The police had been called to assist staff to address the person's behaviour. We saw the registered manager had worked with the community mental health team to put a behaviour management plan in place to prevent further incidents occurring.

It was evident from the minutes of the staff team meetings that there was always a discussion following these incidents to address the impact on other people's well-being who lived in the service. However staff not been offered behaviour management training to ensure that they had the skills to manage incidents effectively.

The above issues relate to a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulation 2014.

The registered manager explained that the care co-ordinator who supported the person was in the process of organising a meeting with partner agencies to address the incidents. Following our inspection the registered manger sent us information to inform us she has arranged for staff to attend training called 'dealing with difficult situations and people'.

The operations manager of the service explained that the service was in the process of a staff restructure that would be completed during April 2016. Staff were informed of this in the team meetings. The operations manager told us that the restructure would include the recruitment of additional staff to address staffing levels.

All of the people we spoke with told us they felt safe and supported in the service .One person told us, "The staff and residents are friendly, I feel safe here and do not have any worries", and another said, "I like here, I enjoy it."

People's risk assessments showed us that staff were made aware of the therapeutic benefit to people of positive risk taking. For example, the registered manager explained they would be encouraging more people to take part in 'travel training'. The training would support people to travel independently without staff assistance. In turn, this would lead to increasing people's self-confidence; self-esteem and daily life skills in the community.

Staff we talked to told us that if safeguarding concerns arose they would not hesitate in bringing this to the attention of other staff or the registered manager. There was clear guidance for staff to follow on how to protect people from harm, there was a record of events and the preventative actions taken. Staff had a good relationship with the mental health police liaison officer, who had worked to assist staff in the event of any reported concerns. This showed us the provider worked in partnership to minimise harm to people who used the service. Staff were familiar with the whistleblowing policy and staff explained that they would follow the provider's procedures.

The provider had a staff recruitment procedure in place. This made clear that staff were only to be employed subject to various checks including references, proof of identification and criminal records checks. Criminal records checks were carried out on all the staff and the provider had systems in place to verify whether staff were suitable to work with the people using the service. We found proof of identification in the form of passports, and references were checked for all staff.

We saw people's medicines were managed safely. There was a clear protocol in place regarding the management and recording of medicines. We looked at medicines administration recording (MAR) charts and found medicines were clearly documented. There were clear written records of medicines to show when and why medicines were given to people. Some people were able to take their own medicines and there was a good management plan in place for staff to monitor this. One new member of staff told us about some of the side effects of the medicines and how this could affect people's emotions or behaviour. This meant that people were supported with medicines by staff that had a good understanding of people's health needs.

When requesting PRN (as needed) medicines staff administered these only when deemed, appropriate to help people with physical health matters or emotional distress. There were PRN guidelines in place for staff to follow. We looked at documents that showed us the staff had developed a good working partnership with the community pharmacist linked to the service. We were informed that new staff members were not allowed to administer medicines until they had attended the organisations medicines management training. This was followed by new staff shadowing an experienced staff member. Before staff were allowed to assist people with their medicines, they were assessed by the registered manager to ensure their competency in the role. Medicines were stored in a secured lockable cabinet. At the time of the inspection, there were no controlled drugs on site.

There was a call bell in each person's room that was connected to the main office to help people alert the staff if they felt unsafe. When people moved into the service, we found they had completed a fire safety induction. Fire action notices were placed on the back of people's doors to inform them of the assembly points outside the building and what to do in the event of a fire emergency. Servicing of fire and electrical equipment was routinely carried out.

The communal areas on the ground floor of the building required repairs to be carried out. The manager told us the repair work was reported to the property owner of the service. We looked at the maintenance records and saw that the proprietor was planning repair works to the building. People were informed about daily activities and which staff would be working on a particular day by viewing the noticeboards in communal areas. The noticeboards were updated with information such as the visitors' policy and house rules to keep people informed of their rights and responsibilities while using the service. There was CCTV on site and out of hours numbers were available for staff to contact the management in the event of any emergencies.

Requires Improvement

Is the service effective?

Our findings

People were not always supported to follow good food hygiene practices. We examined the communal kitchen on the first floor of the home. We looked in the fridges and found items of food tem such as milk and vegetables were out of date and needed to be discarded. Meats and salads were left uncovered and not labelled with the date of opening. Meats were not stored separately from other foods in the fridge. The fridge and microwave needed to be cleaned. If food is not cooked, stored and handled correctly, people can become ill with food poisoning and infections from cross contamination. Therefore the provider was not protecting people from avoidable harm related to food hygiene practices.

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

We spoke to the registered manager who told us it was joint responsibility of staff and people who lived in the home to keep the fridge clean and dispose of perishable foods. We viewed the kitchen monitoring chart where staff had recorded they had checked and cleaned the fridge daily. We found the monitoring chart had not been completed for one week by staff. The registered manager acted on this immediately and had a member of staff clean the fridge, microwave and discard of the items. We looked at staff training records and saw they had completed up to date training in food safety and nutrition and food hygiene.

We examined the kitchen on the ground floor and found this to be clean, food items were stored appropriately and labelled. Food hygiene notices were displayed in the kitchen on the ground and first floor.

People told us that they had access to food and drinks throughout the day and were able to choose what they wanted to eat. One person told us "The food is nice, different." We looked at the menus and saw they reflected the diverse cultural needs and preferences of the people who used the service. A person commented how they cooked jollof rice because he/she preferred it. Snacks and drinks were made available to people between meals and for those who ate 'little and often'.

Staff reported people were encouraged to eat a well-balanced diet. We attended the lunch cookery session with the people who lived on the first floor. Two health professions from the CMHT held the session. We were told the workshop was held weekly to promote healthy living, good nutrition and support people to cook healthy dishes. We saw the people who attended were fully engaged in preparing a healthy Quorn dish with vegetables. We observed that the cooking workshop was an opportunity for people to socialise and build good relationships with each other. One health care professional told us people chose the foods they would like to cook in the residents meetings, and then were given money to purchase the food for the session. The workshop also showed people how they could eat healthily on a low budget and learn cooking skills for when they moved into their own homes. .

People in the home told us they were well cared for and supported by staff, "This place is more supportive than other places that I have stayed before."

All the staff we talked to demonstrated an understanding of their job roles and the philosophy of the organisation they explained was to help people to reach their full potential. Staff reported they aided people's recovery by using a person centred approach. The main goal was to help people resettle into accommodation where they required less support or to be able to live independently in their own homes.

There were suitably qualified and competent staff working in the service. Staff understood that learning was on-going and told us they were supported by the registered manager. Staff were offered professional development training to increase their knowledge and skills and to enhance the quality of their work.

In the staff files we looked at, we saw staff had completed the organisation's induction training. One member of staff told us, "Look Ahead is very good with supporting staff in careers progression, lots of training is available." They had completed a diploma in Health Care (Mental Health) and were looking forward to further support from the organisation to progress to a higher level qualification.

Staff training records showed staff had participated in first aid, fire awareness, infection control, health and safety and insight into mental health. We also saw staff were booked on to training that reflected some of the challenges people with mental health needs faced in their daily lives, such as dual diagnosis and hoarding.

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 saw records to show that where people had been deprived of their liberty applications had been made to the local authority and best interests meetings had taken place in line with the MCA framework. Staff had completed MCA and DoLS training. We found in care records that staff had been involved in discussions during people's Care Programme Approach (CPA) meetings to give their opinions regarding people's capacity. This was evidenced when discussing concerns with staff regarding a person's behaviour that required frequent intervention from the emergency services. CPA meetings are used to ensure that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs.

People were involved in making decisions about their care and support. For example, we saw capacity assessments had been carried out regarding the management of people's finances. The registered manager also told us a person's relative was in the process of seeking lasting power of attorney for his/her finances. One staff member said, "We support our customers to protect their rights and help them to be socially inclusive."

People were supported to maintain good health and had their healthcare needs regularly reviewed. A relative told us, "I know my [family member] will improve, she/he is on the way to a good recovery, and would like to stay here." Care files showed people had attended regular appointments with GPs, psychiatrists, dentists and opticians. We found that where people had diabetes there were diabetic management plans in place that were being followed. Staff were knowledgeable about the physical health

needs of the people they supported. People were weighed monthly and this was written in people's care records. Staff discussed with us the healthy life styles workshops to assist people with weight management issues such as walking and swimming to increase their levels of activity. There was a good working relationship with health care professionals and the staff readily sought help and guidance when required.

Good

Is the service caring?

Our findings

People told us staff were kind, considerate and caring. One person said, "I like the staff they are caring, they knock on my door, and I can have my family visit me here."

We observed staff interactions with people and saw they were approachable, professional, and sincere. They all appeared to have mutual respect for each other and acted in a professional manner at all times. This included the staff that were not actually working directly with people, such as the cleaners.

Staff told us that they knew the people they worked with very well and each person's individual needs. For example, before we spoke to people a member of staff told us about the person's background and what the person's moods or emotions may be like at that particular time. In all the files we looked at we found people had completed a personal profile of what they were like on a 'good' and 'bad day'. In the profiles, the written comments included, 'I don't like to be rushed', 'I like a cup of tea', and another person commented, 'I sleep a lot'.

We saw that people were encouraged to express their views and were involved in making decisions about their care. In one care file we saw the person's care plan was co-produced, which showed people planned support services together with staff. One person completed their own notes from a meeting he/she attended. We noted that staff had written in a care plan about the activities they supported a person with and had written the word 'offered'. This showed us that the person had been given the opportunity to choose the type of support they received.

People were encouraged to maintain positive relationships with family, friends and staff. We saw in one care profile there was a picture of a person's relative and he/she was encouraged to call the relative and plan a visit to their home. Another person commented that he/she would like to visit their relative who lives abroad. The service felt homely and welcoming with pleasant surroundings and there was evidence of personal décor in people's rooms. One person happily invited us to see their room and there were photographs of friends and relatives displayed. We saw records to show people had been encouraged to tidy their rooms, and put books on their shelves. People were offered advocacy support when needed which meant their views and wishes were genuinely considered when decisions were being made about their lives.

Staff sought to develop trusting relationships with the people they supported. One staff member offered to take a person to lunch and another offered to become a befriender. This meant that there was a reduced risk of social isolation that had a positive effect on people's wellbeing.
We observed one member of staff discussing a trip to the shoe shop with a person to pick up his/her shoes which were ready for collection. The person requested to be escorted by a staff member who was of the same gender. This was readily agreed. There was a good rapport and interaction between people and the staff team. On two separate occasions, we saw a person acknowledged two staff members who had been away for a few days and welcomed them back.

People were treated with respect and dignity, for example, although the staff had keys for the individual

bedrooms we observed that staff never let themselves in. They always knocked on the door and waited until they were invited in. People were offered support in private areas of the service when it was considered appropriate.

Good

Is the service responsive?

Our findings

People told us they were supported to achieve their own personal goals, aspirations and wishes. One person told us, "The staff help and support us with different activities", and another commented, "Seeing others getting on well gives us the incentive to get on too."

Care plans were written in a way that people understood and were signed by the people who used the service. This showed us that people agreed to the support and care they would receive. We saw in care files people had talked to staff about 'things that are important to me'. Some of the discussions included people's preferences on their appearance and interests. For example, 'How I like my hair' and 'I enjoy reading psychology'.

The staff held monthly meetings to discuss how well people had worked towards achieving their personal goals. For example, in two people's care files we saw how staff had helped them to get a job interview, play football, clean their rooms, cut their hair and bake a cake. We spoke to a health professional who was visiting the service. He/she reported they had seen a great change in a person's behaviour; because the person was 'proud' that they could do their own laundry and had reached other personal goals. Staff held 'customer celebration awards', to celebrate the personal achievements of people in the service. This made people feel valued.

People's needs were both physically and emotionally assessed and agreed in individual care plans. There was evidence of social inclusion. A number of people were engaged in trips to the library, computer classes, voluntary work, the gym, visiting local cafés and restaurants; others were engaged in other community activities to increase their skills and employability.

A music therapy class took place in the communal room and we observed people singing and clapping along to the music. We noted a person whose behaviour was challenging to the service was involved in the class and enjoyed being part of the event. One staff member said, "We persevere with the difficult to engage customers, we never impose on them, we give them time out and gently and gradually encourage them to attend to their activities of daily living."

People's individual diverse needs both culturally and spiritually were being met. Staff supported people to meet their religious and cultural needs by celebrating festivals, attending places of worship of their choice and engaging with their communities. We saw in one person's support plan that his/her cultural identity was important to them. Records showed that the person had attended an art group, festival and a mental health forum that was specific to their culture. Another person had travelled abroad and had donated a picture to the building from their travels, which was nicely displayed in the communal hallway. This showed us that people's cultural identity was recognised and valued.

There was evidence in care records that staff were quick to identify and respond to people's changing needs. One new staff member told us about an experienced staff member of the team who observed a change in a person's behaviours and intervened immediately when they saw there could be conflict.

We saw staff had completed training on motivational interviewing, equality and diversity and customer relationships. Motivational interviewing is a guide to inform staff on how to engage people to clarify their strengths and aspirations and to help people make their own decisions.

People told us they knew how to make a complaint. Weekly community meetings were held to give them the opportunity to talk about any issues, complaints or suggestions they may have. The registered manager had completed training on complaints and incident reporting. There was a written record of complaints and we noted they had been actioned and responded to in a timely manner.

Good

Is the service well-led?

Our findings

People and staff told us they were happy with the way the service was run, despite the low staff numbers. One member of staff said, "The people and staff are close, staff are brilliant."

There was evidence of strong leadership, delegation and support by the registered manager who had completed a health and social care qualification to support her in her role. There was a good team spirit and the staff reported that they felt supported by the registered manager. Staff told us they were involved in the decision making about the service and had an opportunity to discuss any concerns at team meetings or during supervision.

The service had a duty of candour procedure that read 'We must make sure we are open and honest with customers when something goes wrong with their care and support'. We saw in written records and from speaking with people that the staff team followed this procedure while working with people in the service.

Regular feedback forms were sent to people and their relatives to give their ideas and suggestions on how the provider could improve the service. One of the forms was called, 'Tell us how we are doing'. The questionnaire was based on the questions the Care Quality Commission (CQC) ask people to make sure health and social care services provide people with safe, effective, compassionate, high-quality care. We saw that 19 people responded to the questionnaire. The results were mainly positive. One person wrote, 'Felstead is a place of change, positivity and security' and another person had written 'Staff understand me'.

People using the service and staff were made to feel valued and that they contributed to the overall running of the service. We saw there were customer nomination forms and one person had nominated a member of staff because they helped them with walking and cooking. The person had written the staff member was 'kind, caring and helpful'.

There was a good working relationship between the Look Ahead staff and the CMHT. From our discussions with the staff, they told us they had a good working relationship with health care professionals. Staff had formed a good social network in the community, and worked with partner agencies including GPs, the community pharmacist and the police.

The organisations internal audit team carried out regular compliance checks to ensure the staff continually strived to work towards improvement. The registered manager had completed audits on medicines, staff files, the environment and people's finances. After the inspection, the registered manager sent us information to show staff had been booked onto further training in light of the learning from the incidents that were reported. This included 'dealing with stress in the workplace' and a 'customer relationship workshop'.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: The provider did not ensure that care was always provided in a safe way for service users as they had not done all that was reasonably practicable to mitigate risks to service users. Regulation 12 (1)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing How the regulation was not being met: The provider did not deploy sufficient numbers of suitably qualified and competent staff in the service. Regulation 18 (1)