Mr A Y Chudary

Woolton Manor Care Home

Inspection report

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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

This inspection was carried out on 06 and 12 September 2016. The first day of the inspection was unannounced.

Woolton Manor is registered to provide accommodation for persons who require nursing or personal care and treatment of disease, disorder or injury for up to 66 people. At the time of our inspection there were 58 people living at the home. 33 people were receiving personal care and 25 were receiving nursing care, another two other people who lived at the home had been admitted to hospital.

The home does not have 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. The previous registered manager left the home in February 2016. A new manager was appointed in April 2016 but has not applied to register with CQC as the manager. The name of a previous registered manager appears on this report as their application to de-register as manager of this home is currently being processed.

During the inspection we spoke individually with 10 of the people living at the home and with four of their relatives. We also held a meeting which was attended by a further four people who lived at the home and three of their relatives. We visited six people who were being looked after in their bedrooms but we were not able to communicate with them in a meaningful way.

We spoke individually with 14 members of staff and held a meeting with a further 4 members of staff one of whom we had spoken with individually, these staff held different roles within the home. In addition we spoke with two visiting health professionals.

We examined a variety of records relating to people living at the home and the staff team. We also looked at systems for checking the quality and safety of the service.

People felt safe living at the home. Staff had received training in safeguarding adults and knew how to report any concerns that they had. However safeguarding concerns were not always dealt with in line with local authority procedures.

The views of people using the service had not always been obtained and / or acted upon to improve the quality of the service they received.

People said they had always received their medication and were given pain relief when they needed it. Support was provided to people with their personal care but not always in the way they would prefer. People told us they did not have the opportunity to have a bath or shower as often as they would like.

People received the support they needed with their healthcare and had their legal rights protected where they lacked capacity to consent to treatment. Their care needs were assessed and clear guidance was in place for staff to meet the person's needs.

A choice of meals was always available and people had plenty to eat and drink but did not always enjoy the food provided.

A number of changes had recently occurred in the home including a high turnover of staff and a lack of activities. People living there felt this had impacted on their quality of life.

People liked the regular staff team and were satisfied with the care they provided. Sufficient staff worked at the home but a high staff turnover and use of agency staff had impacted on the experiences of people living there and staff working there who felt that at times there were insufficient staff available who knew people's care needs well.

Robust procedures were in place for recruiting new staff.

Staff had received training in recent months and felt that this was sufficient to meet their needs. However training records were incomplete and it was not possible to establish whether staff had undertaken more specialist training related to their role.. A process for supervision of staff had been put into place but was not yet embedded. Some staff felt unsupported whilst working at the home and that staff morale was low. Other members of staff felt supported and welcomed some of the changes being introduced.

It was unclear who managed the home when the manager was absent and we found that people living there, their relatives and staff had different opinions as to who was in charge of the home on a daily basis in the manager's absence.

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 concerns were not always managed in line with local authority procedures.

People generally received their medication on time and as prescribed.

Sufficient staff worked at the home but a high staff turnover had impacted on the experiences of people living there.

Robust procedures were in place for recruiting new staff.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always receive the support and supervision they needed to carry out their role effectively.

People were provided with a choice of meals and plenty to eat and drink but did not always enjoy the food provided.

People received the support they needed with their healthcare and had their legal rights protected where they lacked capacity to consent to treatment.

Is the service caring?

Requires Improvement

The service was not always caring.

People's view of the service had not been obtained and acted upon.

People liked the regular staff team and were satisfied with the care they received.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People received support with their personal care but not always in a way they would prefer.

A lack of activities at the home had impacted on the quality of life for people living at the home.

Peoples care needs were assessed and clear guidance was in place for staff to meet the person's needs.

Is the service well-led?

Requires Improvement

The service was not always well led.

The home did not have a registered manager or clear management structure in place.

Systems and process had been introduced to check the quality of the service. These were not fully effective at identifying and making improvements to the service.

Woolton Manor 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.

The inspection was carried out on 06 and 12 September 2016. The first day of the inspection was unannounced and carried out by two Adult Social Care (ASC) inspectors. The second day of the inspection was carried out by one ASC inspector.

Prior to our visit we looked at any information we had received about the home including any contact from people using the service or their relatives and any information sent to us by the home.

During the inspection we looked around the premises and spoke with fourteen of the people living at Woolton Manor and with seven of their relatives. We also spoke with two visiting health care professionals and seventeen members of staff who held different roles within the home.

We spent time observing the day to day care and support provided to people and visited people who were being cared for in their bedroom. We looked at a range of records including medication records, care records for six of the people living there, recruitment records for four members of staff and training records for all staff. We also looked at records relating to health and safety and quality assurance.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe living at Woolton Manor and said that if they had any concerns they would feel comfortable raising them with staff.

The home's records showed that seven referrals had been made to the local authority for potential safeguarding concerns. However we looked at records for one safeguarding referral and found that the home had not managed this correctly. Records and management of this issue did not demonstrate good practice in the governance of safeguarding issues.

This is breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the home did not effectively operate a system for assessing, monitoring and mitigating risks to the health, safety and welfare of service users.

Records showed that safeguarding training had been provided for 31 staff in 2016. Staff we spoke with had an understanding of safeguarding vulnerable adults and told us they would report any concerns to senior staff. They were also aware that they could report concerns directly to the local authority.

People told us that they usually received their medication on time and always received pain relief if they requested it. One person told us, "She comes around with the tablets twice a day. She's very good." Another person told us that they were always involved in discussions about their medication. We observed them discussing their medication with a senior member of staff who listened to their point of view and offered to arrange a GP review for them.

Medication was stored in a locked room on both units. We saw that these were clean and tidy although the room on the nursing unit was very narrow providing little space to move around.
Temperatures of drug fridges had been recorded and were within recommended limits. Room temperatures on the residential unit were also recorded as within recommended limits. However on the nursing unit these recorded as slightly higher than the recommended below 25 degrees. The room had an air cooling unit but this did not appear to be effective and the provider told us he would look into replacing it.

We checked a sample of controlled drugs and found that these were correct and had been recorded appropriately in the controlled drugs register. We also checked a sample of medication stocks with medication records and found these tallied

The second day of our inspection was the first day of the new monthly medication cycle. We saw that people were still being given their morning medication after 11am on the nursing unit and after 11.45am on the residential unit. We were told that this was unusual as arrangements were usually in place for night staff to set up the new cycle. The appointed manager told us that she would take action to ensure this did not recur.

There had been a high turnover of staff at the home in recent months. Of the three nurses working at the

home during our inspection two had only worked there for a month. Wherever possible shifts had been covered by agency staff who were generally but not always staff who had been to the home before. People living there told us, "I don't like the agency staff; they don't speak good English and trying to communicate with them is very hard," and "Agency can be difficult there's not the same rapport."

Rotas showed that six nurses who were working at the home in May 2016 were no longer employed there on a regular basis. The appointed manager told us that they were activity recruiting both care staff and nurses with a registered nurse due to commence work shorty at the home.

People living at the home said that at times they did not think there had been enough staff particularly when staff were not familiar with the home. Their comments included, "You can wait ten minutes or more for the toilet if they are busy," and "The girls are rushed off their feet at times." A relative said "They can be short staffed. It can be busy."

Staff had differing opinions with some staff telling us they through there were sufficient staff to meet people's needs and others saying they thought more staff, particularly permanent staff were needed. They told us, "We have been short staffed. There's a lot of pressure all the time trying to meet (people's) needs. They try to bring agency in," and "I think we need more. There are so many people in bed it can take time."

During the morning there were two nurses and five care staff on duty on the nursing unit. During the afternoon and evening there was one nurse and five care staff, and at night one nurse and three care staff. Staff rotas showed that these numbers were maintained with regular use of both bank and agency staff. On the residential unit there were two seniors, with either five or six care staff during the day and three staff at night. In addition the home employed administrators, kitchen and laundry staff and cleaning and maintenance staff.

During our inspection we observed that staff were busy but able to meet people's needs and find time to spend with people.

We looked at recruitment files for four members of staff who had recently commenced working at the home. These contained proof of the person's identification and notes of their interview. Prior to them commencing work at the home a series of check had been carried out on them including obtaining references and a Disclosure and Barring Service check. Where the reference did not contain a formal company stamp verbal confirmation had been obtained to check their authenticity. Checks had also been carried out to ensure nurses were registered with the Nursing and Midwifery council (NMC). Records had been obtained from agencies supplying staff to confirm staff training, qualifications and eligibility to work in the UK. These checks helped to ensure staff were suitable to work with people who may be vulnerable.

We looked at accident records and found the recording on these had improved with the introduction of a new form in August 2016. A monthly report of accidents and incidents had also been introduced which looked at the times, dates and names of people involved so that any emerging patterns could be noted and addressed.

We toured communal areas of the home and several bedrooms and found the building clean, tidy and adequately maintained. We were informed that bedrooms were redecorated as they became vacant and we saw that carpets were being replaced in communal areas. Doors were fitted with door-guards which automatically closed when the fire alarm sounded, radiators had guards fitted and window openings were restricted. Fire evacuation equipment was available and personal emergency evacuation plans (PEEPs) were in place.

Certificates had been obtained and checks carried out to monitor the safety of the premises. This included lifts, fire equipment, the electrical system and small electrical appliances. Weekly tests of the fire system, emergency lighting system, call bells and pressure mats had been carried out. Water temperatures were recorded monthly and unused taps were flushed weekly. The gas safety certificate had expired in July 2016; however we were informed that new gas boilers had just been installed and the gas certificate would be renewed when these were commissioned.

Gloves and aprons were available for staff to use when providing personal care and there were appropriate handwashing facilities throughout the home.

Requires Improvement

Is the service effective?

Our findings

People living at Woolton Manor told us they liked the regular staff team and had confidence in their abilities. Their comments included "On the whole very good. There is a nucleus of very good staff," and "The regular carers are always nice."

Staff told us that they had received training to help them carry out their role effectively. A member of staff explained "We are always doing courses to keep us up to date."

Training was provided by an external company and we were shown the training matrix for 2016. This showed that training had been delivered to staff in safeguarding adults, moving and handling, fire safety and health and safety. We also saw that some staff had attended external training in infection control. We saw training certificates for kitchen staff that showed they had completed more specialist training including food hygiene, healthier food and special diets. However training that staff had undertaken in 2015 and in previous years had not been carried forward to the current training matrix which meant that it was not possible to form an overall picture of the skills and knowledge of the staff team. We asked for, but were not shown a training plan for the home.

A matrix had been put together to record the dates staff received one to one supervision in 2016. Supervision provides staff with an opportunity to discuss their role, how they are performing and any training or support needs they may have. The matrix we were given showed that only one member of staff had received supervision in 2016. Records showed that staff meetings had taken place with the last being in August 2016. Some of the staff we spoke with told us that they did not find the meetings helpful as they did not feel listened to. We looked at the record of the meeting which showed staff were provided with information in a variety of areas including staff breaks, keeping the home tidy and the sickness policy. However they did not record any input from the staff team.

These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because staff had not received the training, support, supervision and appraisal necessary to carry out the duties they are employed to perform.

People living at the home had differing opinions on the quality of the food provided. Some of the positive comments we received included, "It's good, surprisingly good," "It's all right there is plenty of it," and "It went down, but now it's a lot better." Other people told us, "I am not impressed with the food. There's nothing wrong with the food itself, it's not imaginative," and "it's bland."

Everyone we spoke with told us that they were offered plenty of food and drinks and could have an alternative to the main meals if they wanted. One person who had particular dietary needs told us, "It's good, they do accommodate."

Some of the people living at the home and their relatives told us that people had to wait longer than they would like in a morning for a cup of tea or breakfast. One person said "Everyone is up early but comes to the

breakfast room between 9 and 10. Can it not be possible to get a cuppa before?" Several other people agreed with this and told us that they had to wait some time before getting a hot drink once they had woken.

The day's menus were written on a whiteboard in the dining rooms, however the boards looked as though they had been used many times and would not clean properly so the writing was not very clear, particularly for people who had eyesight difficulties.

The lunchtime meal on the first day of our inspection was soup and sandwiches with chicken and mushroom pie for tea. On the second day of our inspection the main lunchtime meal was scampi, chips and peas with meatballs, mash and vegetables for tea. Puddings were available at both meals. Some of the people we spoke with told us that they found the meals too heavy particularly as breakfast and lunch meals were close together. We spoke to the chef who explained there were no set menus currently being used at the home. Menus were planned on a daily basis.

We saw that care staff were given a list with the day's menu and alternatives which were always available, such as omelettes, jacket potatoes and sandwiches. They then asked people living at the home what they would like to eat that day.

We were told that a food committee had been set up to discuss meals and the things people would like to eat however this had since disbanded. Given the comments we received about meals and mealtimes a forum for obtaining people's views on meals would be beneficial.

People told us they received the support they needed with their healthcare. One person explained, "You see the doctor and such like. You tell them if it's serious and they get the doctor." Another person who was spending the day in bed told us that they had agreed this with the staff team in order to benefit their health.

A visiting health professional told us "As soon as anything is untoward they let us know. They follow care plans. Often ring us for advice." A second visiting professional confirmed this and told us staff were always able to provide the information they requested.

Care records confirmed that people's health was monitored, for example we saw regular records of people's weight and observations. Care records contained risk assessments and plans for falls, bedrails, moving and handling, continence, pressure care and nutrition. Input from health professionals was also recorded and showed that staff had followed the advice given.

People being looked after in bed were provided with adjustable beds with integral bedrails and pressure relieving mattresses. They had charts to record food and fluid intake and care interventions. We did not see any instructions for care staff on the charts, for example about how often people should be repositioned and what the mattress setting should be. Although staff we spoke with knew this information including it on the charts for individuals would ensure the information was easily accessible.

At this inspection we checked whether the service was working within the principles of the MCA, and whether any conditions or authorisations to deprive a person of their liberty were being met. We found that they were.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Records confirmed that where people lacked the capacity to agree to living at the care home then an application for a DoLS had been made to the relevant authorities.

Woolton Manor is a large Victorian building, set in its own wooded grounds in the Woolton area of Liverpool. Bedroom accommodation is over three floors with all of the communal areas on the ground floor. There are separate lounge and dining rooms on the residential unit with a large lounge /dining room for the nursing unit. A sheltered and secure garden is accessible from the main corridor and the residential lounge and provides seating areas for people to use. Car parking is available to the front and side of the home.

Some of the bedrooms provide en-suite facilities and there are a number of bathrooms and toilets located around the home that people can use. Bedrooms vary in size to meet people's needs and choices. For example we saw some people had space for a microwave and fridge and additional seating if they required it.

All communal areas of the home are accessible via ramps or lifts and corridors provide sufficient space for people using a wheelchair to get around easily. Adaptations are provided for people to use shower, bathing and toilet facilities and all bedrooms are equipped with call bells.

Requires Improvement

Is the service caring?

Our findings

People living at Woolton Manor told us that they liked living there and that staff were kind to them their comments included, "It's marvellous." "They are lovely. I am very happy. They think the world of you," and "By and large it's very good. They try hard."

We spoke with two visitors and they told us they were very happy with the care their relative received. They told us that their relative always appeared clean and comfortable. One of the visitors said "I would be quite happy to come here if I needed looking after." A second relative described staff as, "Caring." A letter from a family received in August 2016 read "We would like to thank all of the residential staff for the excellent care and love they gave to our Mum. She certainly had a great quality of life which without doubt extended her years."

A visiting health professional told us "The regular carers are always nice."

However people living at the home and their relatives also said that they had found some of the recent changes unsettling particularly with regards to the number of staff changes and use of agency staff. They also told us that the recent lack of activities had impacted on their life in a negative way.

During the two days of our inspection we observed that staff spoke respectfully to people and that they knew people well. We saw staff spending time reassuring people and listening to them as well as meeting their care needs. During the inspection we observed that a member of staff was based in both lounges so that they could check people were safe and respond quickly to their needs.

We asked several of the people living at the home who made decisions about their care and their daily lifestyle and received differing opinions. Some people said they made their own decisions telling us, "They know what you want. "We decided when to go to bed." However three people said "I am told," when we asked who decided what time they went to bed.

Meetings had been held with relatives in May and July 2016 to provide a forum for them to discuss their views of how the home operates. We were told that these meetings were also for people living at the home. The minutes of both meetings showed nobody living there had attended and only a few relatives had done so. However when we had a meeting attended by some of the people living at the home they told us that nobody had formally asked them their opinion of the service they received either individually or as part of a meeting. People did tell us that they knew the provider and he regularly chatted with them.

People's had been able to personalise their bedrooms to suit their lifestyle. For example people had added soft furnishings and seating whilst other people had added a desk and kitchen equipment.

Not all bedrooms had numbers on and only a few had the name of the person. Due to the size and layout of the building this could prove difficult for people living at the home, their visitors and new staff to find their way around easily and locate a particular bedroom.

Requires Improvement

Is the service responsive?

Our findings

People living at the home told us that they did receive the support they needed with their personal care. However they also told us that they would like the opportunity to have more than one bath or shower each week. Their comments included, "I have a shower when I am told, about once a week," "I would like more; it's less than once a week," and I get a good wash down every day but I couldn't ask for a shower because there's not enough staff. One carer used to give me a shower but she's left." A relative told us "I have had to mention to staff that (relative name) hasn't had one." We asked a member of staff about this and they explained, "Yes one bath or shower a week. If they want more we see if we can fit them in."

We looked at records held for people receiving nursing care which recorded whether people had been offered this support and / or had refused. The records indicated that one week ten people had not received / been offered either a bath or shower and another week 12 people had not received / been offered this support. They did record that people had received support to have a wash. This showed us that people were not being fully consulted about their care and their wishes were not always taken into account.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because the home did not seek and act on feedback from relevant persons for the purpose of evaluating and improving the service.

The home had employed an activity co-ordinator who had recently left. People living at the home and their relatives told us that there was now little to occupy them and they missed the activities that had previously taken place. Their comments included, "Every day it filled in an hour. Now there is nothing." "There was always something going on." "It's very boring, nothing to look forward to," and "I miss the shopping they did for me. For over a month I have had nobody." During the two days of our inspection we did not see any organised activities or occupation for people taking place other than a visiting hairdresser. The provider told us that a new activities coordinator had been appointed and was due to commenced working at the home shortly.

We looked at a care file for one person who had recently moved into the home. Prior to them moving in a member of staff had visited them in hospital and carried out an assessment of their needs. They had also filed information received from the hospital. This meant that staff were aware of the person's needs before they came to live at the home and could commence the process of putting a care plan together to support them effectively. We saw similar pre-admission assessments had been carried out for other people whose care files we looked at.

Individual care files were in place for all of the people living at the home. These contained information about the support the person needed with their health and personal care along with information about the person, their lifestyle and choices. The majority of plans we looked at had been updated within the past month. Where plans had not been updated records showed that the person's care needs had not changed. Daily records of the support and care offered to people and any discussions with other professionals were comprehensive and gave a clear picture of the support and care provided to the person.

Staff we spoke with knew people well as individuals and were able to explain the different support needs the person had and how they met these.

Throughout the two days of our inspection we saw staff meeting people needs and altering their communication methods to suit the person they were talking with.

We looked at the care of one person who was receiving end of life care. We saw that they had been made comfortable in bed and staff were aware of the care the person needed and how to provide this. This was backed up with information recorded within the care plans. Clear records had been kept of discussions with the person's' family and GP so that everybody knew the steps to follow as the person became frailer.

People living at the home told us that they would feel comfortable raising complaints with staff or asking their relatives to do so on their behalf. One person explained, "You can talk to them." Relatives also told us they would feel comfortable raising a concern if they needed to do so.

The home's complaints procedure was displayed in the entrance area. It advised people to speak with 'the person in charge' if they wished to make a complaint but it was not clear how they would know who the person in charge was. There were no names or contact details for either the manager or the provider. The complaints procedure gave details of CQC but did not reference any other statutory bodies for example the local authority or ombudsman.

Records showed that ten complaints had been received by the home in 2016 and that these had been investigated and responded to.

Requires Improvement

Is the service well-led?

Our findings

A new manager had been appointed to work at the home in April 2016 but had been away for a month returning shortly before the second day of our inspection. She had not yet applied to CQC to become registered as the manager of the home and informed us that she would do this as soon as possible. A previous registered manager was still registered for the home and has since applied to have their registration removed.

Lines of accountability and management within the home were unclear. Staff, relatives and people living there had differing opinions of who had been in charge of the home in the manager's absence. The provider visited the home frequently and was known to the people living there, staff and relatives. However the lack of a clear management structure in the home meant that in the absence of the manager it was not clear who was overseeing the running of the home.

The provider had appointed consultants to provide support and advice to the home and they were working with the manager to introduce a number of changes. Staff had different opinions of the changes introduced and the support provided by the management. Their comments included, "You don't feel valued. Your opinion does not matter," and "Staff morale is low." Other staff told us that they welcomed the changes taking place and found the new manager supportive. One relative commented "The new manager's door is always closed, not approachable," Whilst another relative told us they thought changes being made at the home were beneficial. Two people living at the home said they did not know the new manager. One person said "I knew [name of previous manager], then [name of deputy manager], she left and [name of senior nurse], she left."

A number of systems and audits had been introduced to the home to check the quality of the service and make improvements. A programme for auditing had been put together covering audits and check that should be carried out daily, weekly or monthly. We saw records of these audits and found that they had not yet become fully imbedded within the home, possibly due to the lack of a clear management structure in the manager's absence.

A member of staff had responsibility for undertaking a daily walk around of the home. We saw records that showed this had been carried out regularly although not on a daily basis. Areas identified as requiring improvements such as cleanliness, repairs or hazards had been noted and addressed as part of this daily auditing. The paperwork for this was time-consuming and did not easily lend itself to checking improvements requiring a longer time frame had been carried out.

Some weekly audits of people's medication and care plans had been undertaken. In July 2016 an audit of the home had been carried out including, medication, care plans equipment, the environment, and staff training. Following these and visits from infection control an action plan had been put together and shared with senior staff. The manager explained that she intended to check all actions had been met. We saw a copy of this plan which listed the date for completion of a number of actions as 'ASAP' (as soon as possible). This makes it difficult to establish whether improvements are being carried out in a timely manner,

We considered that the quality assurance systems introduced to the home are at an early stage and not yet effective. The systems had not noted some of the areas for improvement that we noted during this inspection. For example the effect on people of a lack of activities, people's opinions on meal times and the opportunity to have a more frequent bath or shower. Similarly although audits had identified a lack of staff supervision this had not yet been addressed.
These are breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is because systems and processes were ineffective at assessing monitoring and improving the quality and safety of the service people had received and seeking and acting on feedback from relevant persons.

A weekly report was prepared for the consultants which included information on accidents and incidents, things affecting people's health such as weight changes or pressure ulcers and complaints. This helps to quickly identify any concerns or patterns that emerge so that they can be addressed.

Desks had been built on the main corridor for both the nursing and residential units. At the time of our inspection the desk for the nursing unit was operational. We were advised that this was to enable staff to have more of a presence nearer to people living at the home. We observed that a phone, computer and records were located at this desk. As a main corridor the area is busy with people living at and visiting the home and staff frequently walking past. We discussed with the provider and senior staff the need to ensure information remained confidential including phone calls and information brought up on the computer.

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 17 HSCA RA Regulations 2014 Good governance The home did not seek and act on feedback from relevant persons for the purpose of evaluating and improving the service. Systems and processes were ineffective at assessing monitoring and improving the quality and safety of the service people had received and seeking and acting on feedback from relevant persons

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing This is because staff had not received the training, support, supervision and appraisal necessary to carry out the duties they are employed to perform.