Care Quality Commission

Nazareth Care Charitable Trust

Nazareth House - Birkenhead

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?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

We carried out this comprehensive inspection on 28 July 2015. Nazareth House Birkenhead is a care home registered to accommodate up to 51 people who require nursing or personal care. The service did not have a registered manager because the registered manager had resigned shortly before our visit. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People who lived at the home told us they felt safe. Policies and procedures were available for safeguarding vulnerable adults and for whistle-blowing, and nearly all of the staff had received training about safeguarding. Maintenance records showed equipment and services were checked regularly and kept in safe condition. The premises were clean and tidy with no unpleasant smells. Actions were being taken to address the findings of an infection control audit. People's medicines were managed safely and people told us they had their medicines at the right time.

Summary of findings

On the day we visited there were enough staff to meet people's needs and staff rotas showed that these numbers were maintained. However, a number of people told us they thought the staff were rushed and did not always have time to spend with them. Safe recruitment processes had been followed before new staff were employed, however records did not show us that new staff completed induction training or that they had been supported in their new employment. Training records showed that there was an annual programme of training and most staff were reasonably up to date with all of this training. Records indicated that most staff had an appraisal in 2014 but only a small number so far in 2015. Staff supervision meetings were very infrequent.

Some of the people living at the home had a diagnosis of dementia. Where people are living under constant supervision and are unable to decide if they wish to live at the home, consideration should be given to making a Deprivation of Liberty Safeguard (DoLS) application. This helps to make sure the person's best interests have been taken into account and their legal rights protected. Nobody living at Nazareth House had been assessed to see if a DoLS application should be made on their behalf.

People told us they got a menu to choose from every day. Most of the people we spoke with thought the food was good, hot and tasty. We looked at a sample of care plans and found that nutritional risk assessments were recorded and plans put in place where a risk was identified. People at high risk were weighed weekly. Records in people's care files showed us that people had received support to access a range of health professionals. This included podiatrists, dentists, GP, district nurses and attendance at medical appointments.

People we spoke with said the staff treated them with dignity and respect. Staff were aware of barriers to communication that may affect people and put measures into place to support them. We saw that people had been supported to take a pride in their appearance. People were able to receive pastoral support from the nuns who lived in a separate part of Nazareth House and the nuns were available to sit with people who were reaching the end of their life.

During our visit people told us they were happy with the care they received but they would like to have more to do. Before our visit we received information of concern regarding the care of people who were at risk of pressure damage and who had developed a pressure sore. Care staff we spoke with were aware of pressure care and that they should observe for skin breakdowns when assisting with personal care. Appropriate equipment was in use to prevent pressure damage and we saw that pressure care mattresses and cushions were working correctly and were on the correct setting. People at risk were repositioned every two hours, however we found that repositioning charts were not completed consistently. Pressure ulcer dressings were changed every two to three days as advised by the NHS wound care specialist nurse and as stated in detail in the care plans. We found that care plans were a little repetitive and generic rather than person-centred, however the pressure care plan was detailed and care plans contained some information about the choices people could make in their everyday lives.

We found that complaints we were aware of had not always been logged and there were no records to show how they had been addressed. The registered manager had recently left the home and the area manager was spending two to three days a week at the home with additional support being provided by another manager from within the organisation. The area manager had held meetings with staff on 2 July 2015 and 20 July 2015 and the organisation's chief executive officer had visited. From speaking with staff, visitors, and people who lived at the home, we considered that people's views had not always been listened to, and the monitoring audits carried out had not always identified and addressed improvements needed. The area manager had written a detailed action plan and was working with the local authority to ensure that this was implemented.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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.

Not all staff had received training about safeguarding.

There were enough staff to meet people's needs and safe recruitment practices had been followed when new staff were employed.

Regular health and safety checks were carried out.

Is the service effective?

Requires improvement

The service was not always effective.

Staff had not all received the training and support required to carry out their work. They had not received training about mental capacity and consent.

People who had a diagnosis of dementia had not been assessed to see if a Deprivation of Liberty Safeguard application should be made on their behalf.

People's health was monitored and people had access to medical professionals as needed.

Is the service caring?

Good

The service was caring.

People we spoke with said the staff treated them with dignity and respect.

Staff were aware of barriers to communication that may affect people and put measures into place to support them.

People were supported to take a pride in their appearance.

People were able to receive pastoral support from the nuns who lived in a separate part of Nazareth House and the nuns were available to sit with people who were reaching the end of their life.

Is the service responsive?

Requires improvement

The service was not always responsive.

People told us they were happy with the care they received.

Care plans contained some information about the choices people could make in their everyday lives, but were generic rather than person-centred. Pressure area care plans were detailed.

People told us they would like more activities

Complaints we were aware of had not always been logged and there were no records to show how they had been addressed.

Summary of findings

Is the service well-led?

The service was not always well-led.

The service did not have a registered manager.

Consultation with people who used the service and their families needed further development.

Some auditing tools were in use but there was scope for further development of quality assurance processes.

Requires improvement

Nazareth House - Birkenhead

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 on 28 July 2015 and was unannounced.

The inspection team consisted of three Adult Social Care inspectors, a specialist professional advisor (SPA), and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The SPA was a healthcare professional with experience in the nursing care of older people.

During the inspection we spoke with ten people who lived at the home, three visitors, the area manager, and seven members of the staff team. We looked at the care records of six people who used the service. We looked at staff records, health and safety records, medication, and management records.

Prior to the inspection we had been informed of concerns by Wirral Council and we had been contacted by a relative who also had concerns.

Requires improvement

Is the service safe?

Our findings

We asked people whether they felt safe living at Nazareth House. People who lived at the home told us they felt safe. One person said “I feel safe here, the staff help me a lot, if there was something wrong I would tell my daughter”. A relative said “I feel my Mum’s care is safe. The home is clean.” Another visitor said they did not think their relative was always kept safe.

Policies and procedures were available for safeguarding vulnerable adults and for whistle-blowing, however these were not easily accessible for staff as they were kept in the offices which were sometimes locked. Records showed that most staff had received training about safeguarding vulnerable adults, and had periodic refresher training, but the training records we looked at showed that two carers and four other members of staff had no date recorded for safeguarding training and another three staff had not updated their training since 2012. This meant that they may not be aware of how to respond appropriately to a potential abuse. Staff we spoke with had an understanding of safeguarding and told us that they would report any concerns they had to senior staff or to outside organisations. Staff also knew about the organisation’s whistle-blowing policy, which protects staff who report something they believe is wrong in the workplace.

The home’s maintenance person showed us the records he kept. These showed that weekly checks were carried out of wheelchairs and beds, including brakes and bed rails, and remedial action was taken where needed. Fire exits and call points were checked weekly, and fire extinguishers and emergency lights monthly. A full annual service of fire prevention equipment was done by external contractor. A fire drill for 15 day staff had been carried out on 20 May 2015 and for five night staff on 27 May 2015. We did not see any plans for the other staff to participate in a fire drill, to ensure that everyone working in the home would know how to respond to a fire emergency. We saw that regular water checks were carried out including flushing out of any outlets in empty rooms. Electrical installations were tested as satisfactory in October 2014 and portable appliance testing was done in December 2014. Moving and handling equipment was last serviced on 14 May 2015.

We found that the premises were clean and tidy with no unpleasant smells. People we spoke with said there were no problems with cleaning. We noticed that a number of staff were wearing disposable gloves and aprons at all times, for example when escorting people to communal areas. This was not appropriate and may contribute to the spread of infection. We observed that a nurse changing a dressing used gloves and aseptic techniques. However, there was no clinical waste bin in the person’s room and the dressing that had been removed was taken across the corridor to a bin in a bathroom. An NHS infection control audit was carried out in February 2015 and recorded a score of 85%, with a number of actions required. The area manager told us that the actions were being addressed.

On the day we visited, there were 22 people living on the first floor, and 20 people living on the ground floor, some of whom required nursing care. Rotas showed that there was always a nurse on duty over the 24 period, with four care staff working on the ground floor and four on the first floor during the day, and two care staff on each floor at night. A lot of staff were on holiday when we visited, but their shifts had been covered.

During our visit we observed that staff did not appear rushed through the morning and people's needs were being met. People we spoke with had different views of the staffing levels. One member of staff told us "Staffing levels are fine." Another member of staff said “There is not enough staff on to cope with the work.” A person who lived at the home commented “Everything is rushed”. A member of staff said “In the past the residents were more independent. Now it is taking more hoisting and using slings as a lot are bed bound. The quality of care and time spent with the residents has changed.” Another member of staff told us they could not sit and chat with the service users as much as they used to. The area manager told us that an additional activities organiser was being recruited in order to provide more social interaction for people.

We looked at recruitment records for four members of staff who had started working at Nazareth House since our last inspection. We found that safe recruitment processes had been followed before they were employed at the home and the required records were all in place.

People we spoke with said they got their medication on time and one person added that when they asked for paracetamol they got it straight away. We looked at the arrangements for people’s medicines on the ground floor of the home. We found that storage was satisfactory and everything was locked away. We found that there were a small number of minor recording errors. The medication

Requires improvement

Is the service safe?

administration record sheets were not always very clear, which made it more likely that an error could occur. Repeat medication for the following month had been delivered and was being checked by one of the nurses. This meant that there was adequate time to find out if any items were missing from the order and make sure that no medication ran out. The nurse we spoke with told us that there was no 'covert' (disguised in food or drink) administration of medicines.

Requires improvement

Is the service effective?

Our findings

People we spoke with felt the staff were trained enough to know how to look after them. A relative said "I think the staff are trained very well. I feel confident that they give mum the care she needs. My mum was really poorly so they sent for an ambulance. Since she came back to the home they have built her up and she is great now." The specialist professional advisor commented "Staff appeared knowledgeable and knew how to care for the residents on the ground floor. They were aware of the daily routines and charts that were in place."

Training records showed that there was an annual programme of training for first aid, moving and handling, food hygiene, infection control, safeguarding, fire, health and safety, and control of substances hazardous to health. The records confirmed that most staff were reasonably up to date with all of this training, however one nurse had no date for moving and handling training and one carer had not updated this since 2011.

The service's action plan, that had been written to meet the requirements of the local authority, identified training needed and gave dates for when this was planned. We saw that training in areas including diabetes, medication, stroke awareness and tissue viability had been planned to take place in June 2015. Staff confirmed that this training had taken place, however we could not verify how many staff had attended. The action plan showed that training and updates in safeguarding vulnerable adults, the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards were planned to commence in August 2015 with a completion date of October 2015. This would ensure that people's rights were protected.

The records we looked at for four new staff showed that they had completed the basic training, but none of them had a completed induction record. Three had no supervision or appraisal record. One had a record of an appraisal with the manager. This consisted of an electronic tick list, with no evidence of discussion with the member of staff other than a one line comment saying the member of staff is happy in their role. These records did not give us evidence to show that new staff were supported.

Records showed that most staff had an appraisal in 2014 but only a small number so far in 2015. We were told that supervision records were kept in the individual member of staff's file. We looked at the files for two nurses and found that one nurse had a supervision meeting in June 2014 and May 2011, and the other had one supervision meeting in 2009, one in 2011, and one in 2014. A member of staff told us they had infrequent one to one supervision and couldn't remember the last time.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Persons employed by the service provider did not receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) is part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

Staff told us that there were people living at the home with a diagnosis of dementia and two of the care plans we looked at confirmed this. Where people are living under constant supervision and are unable to decide if they wish to live at the home, consideration should be given to making a Deprivation of Liberty Safeguard (DoLS) application. This helps to make sure the person's best interests have been taken into account and their legal rights protected. Nobody living at the home had been assessed to see if a DoLS application should be made on their behalf.

Where people may lack the capacity to make an important decision about their lives an assessment of their ability to make that decision must be made. We saw one care plan that had a Do Not Attempt Resuscitate (DNAR) form. This had a note on saying it was incorrectly completed and 'a metal capacity assessment needed'. This was dated February 2015, however we saw no evidence that an assessment of the person's ability to discuss a DNAR had been carried out.

Staff had not received training in DoLS and the Mental Capacity Act 2005 and those we spoke with had a limited

Is the service effective?

understanding of how this should influence the support people received. This showed that the provider had not acted lawfully and in keeping with the latest guidance about (DoLS).

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have suitable arrangements in place for people to consent to their care or follow legal requirements when people could not give their consent.

People told us they got a menu to choose from every day. Most of the people we spoke with thought the food was good, hot and tasty. One person told us "The food is very good here,", but another said "The food lets it down and I have told Peter (the manager) about this." This person found the meals lacking in seasoning and flavour and the food always seemed to be "steamed". One person told us she was vegetarian and there had been no problems with this. The service catered for her needs. One person requested ice cream, which wasn't on the menu, but was given with no problem.

The expert by experience observed "The dining area was bright with bright curtains and tablecloths to match. There were flowers and table mats with condiments." We saw that at lunch time people received the support they needed with their meals. One person told us "Because I am blind the staff tell me where my food is on the plate they do it like a clock so I can eat independently." Some people had their meal in their bedroom either by choice or because they were frail and being looked after in bed. We noticed that on several occasions meals were left uncovered in between plating and serving, and plated meals were not covered when being taken to people's bedrooms.

We looked at a sample of care plans and found that nutritional risk assessments were recorded and plans put in place where a risk was identified. People at high risk were weighed weekly. On the nursing floor, one of the nutritional plans had not been updated and was confusing. Fluid and nutritional intake charts were put in place for people identified as being at risk, however we found that these were not always completed consistently and therefore did not provide an accurate record of what people had received to eat and drink.

One person told us "If I am not feeling well the staff will get the doctor out for me". Records in people's care files showed us that people had received support to access a range of health professionals. This included podiatrists, dentists, GP, district nurses and attendance at medical appointments. We also saw that where people's care plans identified a need for glasses or a hearing aid, the person was supported to use these. We saw that where people required equipment such as a specialist bed, crash mat or pressure cushion these were used.

All bedrooms contained a wash basin and either an en-suite toilet or a toilet adjacent to their room that was shared with one other person. We saw that bedrooms were personalised and provided sufficient space for people's belongings and any equipment they needed. Both units had a large lounge and dining room as well as smaller seating areas. A downstairs conservatory provided privacy for people to take guests if they wished. In addition the home had an enclosed garden with seating and a chapel that people living at the home used as they wished. Adapted bathrooms and shower rooms were available so that people could receive support with their personal care. In addition we saw that call bells were located within easy reach in bedrooms and that grab rails, handrails, and a passenger lift were available to assist people with their mobility around the home.

Good

Is the service caring?

Our findings

People we spoke with said the staff treated them with dignity and respect. Comments that people made were “The girls know me well, it’s nice.”; “If I want to be on my own in my room, or to be private with my family, they respect that and leave us to it.”; “The staff help me to be independent.”; “The staff are really great, excellent, I have no complaints.” One person said “They are nice and kind to me, some very kind, some not." Another person said “The day staff are absolutely brilliant, they are very busy but brilliant. The night staff make me feel a bit of a burden.”

Visiting relatives told us “I always feel welcome when I visit, the staff always have a smile for me. I can access the kitchen whenever I want and I can bring treats in, no problems. If I was going to be in a home I would want it to be this one.” and “The staff know my mum really well they know she likes banana sandwiches”.

The expert by experience commented “The home was quiet with not much atmosphere. Both the lounges had people in asleep. The television was on, there were no activities going on at all, even in the afternoon. All the residents were clean and nicely dressed, everything co-ordinating. All the beds were clean with nice bedding. The gardens were beautiful. The rooms had pictures of family and cards in them, giving them a personal touch. They were homely and appeared clean.” We observed that people being looked after in bed had the TV on if they were awake or were left to sleep if they chose to.

Staff were aware of barriers to communication that may affect people and put measures into place to support them. We saw a member of staff sitting with one person speaking quietly but clearly into their ear so the person could hear them, the member of staff then gave the person time to consider the information before making a decision about their meal. We also saw that a white board had been used for one person with hearing difficulties. Staff explained that they used this to communicate information to the person and also to offer them choices. A member of staff said “If a person is not communicating properly I would sit and talk to them to find out what is going on and if there is anything we can do to make things better for them.”

The specialist professional advisor observed that, when providing nursing care “The nurse’s manner was warm and friendly and he alerted the resident of what he was going to do, also asking for consent from the person first.” All the people we spoke with said the staff always asked for consent before providing care. People were able to receive pastoral support from the nuns who lived in a separate part of Nazareth House and the nuns were available to sit with people who were reaching the end of their life.

One person we spoke with said they were assisted to have a bath weekly which was “acceptable” to them. We saw that people living at the home had received support with their personal care and appearance. A hairdresser was visiting the home on the day of our inspection and we saw her offering people the opportunity to have their hair done. We also saw that people had been supported to take a pride in their appearance and spoke to several people who had received support to colour match their clothes and jewellery. This supports people's dignity and their sense of wellbeing.

Requires improvement

Is the service responsive?

Our findings

We asked people if they had any complaints and looked to see if the provider had a system in place to handle them should any be made. One person who lived at the home said "If I have any complaints I go straight to the top." and gave examples of issues they had raised. A relative told us about a complaint they had made. CQC had received a complaint from a relative who informed us that they had raised this with the manager. A letter posted on the noticeboard in the staff room indicated that a complaint had been made by a member of staff in June 2014. None of these complaints had been logged and there were no records to show how they had been addressed.

A complaints procedure was on display in the entrance area, but this did not provide the required information about who people could contact within the organisation with any complaints or concerns, or details of external bodies for example CQC and the local authority who they could refer a complaint or concern to.

This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Receiving and acting on complaints.

During our visit people told us they were happy with the care they received: "The staff look after me, I have a choice in everything I do."; "If I ask a member of staff to get something for me they will." and "If I want to go to the toilet the staff they will take me, they are very kind." People we spoke with, including relatives, said they had not seen their care plan. One person told us "I have not discussed with staff how I want them to support me."

People said they would like to have more to do. They told us "The home is nice and clean there just is not enough going on."; "I like entertainment singing and dancing but we do not have enough of it it's a bit hit and miss."; "There is not enough activities going on."; "I feel like I am stuck in this chair I would like to go out more but there is not enough staff." and "Sometimes I use my walker and the staff walk with me, I feel I am sitting in the chair a lot longer than I want to."

We asked two members of care staff how they got to know about new people admitted to the home and their needs. They told us they were given this information verbally by the senior staff member on duty. They rarely had access to care plans or risk assessments. During our visit, the area manager told us that two new computers were being provided so that care staff could have easier access to, and more involvement with, the electronic care planning system.

Before our visit we received information of concern regarding the care of people who were at risk of pressure damage and who had developed a pressure sore. Care staff we spoke with were aware of pressure care and that they should observe for skin breakdowns daily when assisting with personal care. Appropriate equipment was in use to prevent pressure damage and we saw that pressure care mattresses and cushions were working correctly and were on the correct setting. People at risk were repositioned every two hours, however we found that repositioning charts were not completed consistently. Pressure ulcer dressings were changed every two to three days as advised by the NHS wound care specialist nurse and as stated in detail in the care plans.

Care plans contained a series of assessments of the person's needs. These included assessments of their health and personal care needs and how they communicated. We saw that these had been reviewed regularly and that where an assessment indicated the person required support guidance was generally in place for staff to follow. We looked at a care plan for one person who had a diagnosis of dementia. No specific care plan was in place for supporting them with this. This meant that staff may lack the guidance they needed to understand how the person's dementia may affect their daily lives and how to respond effectively.

We found that care plans were a little repetitive and generic rather than person-centred, however the pressure care plan was detailed. There were references to some person-centred observations such as how people liked to be addressed, what their communication skills were like, but there was a large section of generic care planning. For people who had dementia, the care plans stated what prompts were needed with personal care, the need for staff to spend time with them, use of hearing aids and/or glasses if needed, how many staff were needed to assist with personal care, and to be observant of non-verbal communication. Care plans contained some information about the choices people could make in their everyday lives.

Requires improvement

Is the service responsive?

We were told that activities mainly took place upstairs for the people who were more independent, but when entertainment was provided, people living downstairs were invited to join in. Other activities people told us about were bingo and crafts. The activities organiser was on holiday when we visited and we saw no activities apart from watching TV. One person told us they had their own laptop and internet connection. There was a library on the first floor. The area manager told us they were recruiting a second activities coordinator and interviews were taking place. There was a chapel was on site and a religious service was held twice a week. One person we spoke with said she chose this home because the religious aspect was important for her.

Requires improvement

Is the service well-led?

Our findings

A person who lived at the home told us "I have been to a resident meeting and put my views over but nothing changed." A relative told us "We had a questionnaire which we filled in but did not get any feedback." A relative said they had not been informed that the manager had left and was shocked to hear this. A member of staff said "Staff morale is very low at the moment. Management have been told but it seems to fall on deaf ears." Another member of staff told us "The staff are really down. You tell the management but it's like banging your head against a brick wall." Staff told us they had the same 'mandatory training' every year. They did not have any awareness of, or training about, mental capacity. Staff also told us they would like training about challenging behaviour. We saw two examples of inappropriate written communications from management to staff displayed in the home. We saw that a number of rooms were kept locked, for example the linen room. Nobody appeared to know why the room was locked as there were no hazardous substances kept in there and it appeared to be an unnecessary inconvenience for staff.

The registered manager had recently left the home and we met with the area manager who told us that she was currently spending two to three days a week at the home with additional support being provided by another manager from within the organisation who spent two days a week at the home. The area manager informed us that an interim manager had been appointed and was due to commence work shortly. They would work at the home until a permanent manager was recruited. The organisation had recognised the need for a new style of management.

Records showed that staff meetings had been held in October 2014 and on 8 May 2015. The area manager had held meetings with staff on 2 July 2015 and 20 July 2015 and the organisation's chief executive officer had visited. A meeting had been held for residents and families on 24 June 2015, however records showed that meals had been the only topic discussed. A person we spoke with was aware of a suggestions box and said they were going to make a suggestion about food.

Systems and documents were in place for auditing the quality of the service provided. We saw copies of monthly medication audits that had been carried out. We looked at the audits for the past three months and saw that these had not identified any areas for improvement. They were large documents that did not specify whose medication or which medication had had been audited. We were therefore concerned that this document was not providing a robust enough auditing process to identify areas for improvement. A senior manager from the organisation informed us that they had plans to review their documentation, including audits to make them more focused and user friendly.

A computer programme was used for writing and reviewing care plans. We looked at a sample of the electronic documents and saw that it was flagged up when the plan was due for review and when that review was overdue. The care plans we looked at had been reviewed regularly. This review process did not identify information that was missing within the plan. This included the information we identified as missing such as care plans for supporting people with their dementia and assessments of people's ability to make an important decision. Falls and accidents had been audited monthly, this helped to identify any patterns that may emerge that could be addressed.

We saw that surveys had been carried out in 2014 to obtain the views of people living at the home and their relatives. Surveys had been sent out in May and July 2014, but the numbers returned were small, ie eight in May and six in June. We saw no evidence that the information gave had been used for any purpose. A senior manager from the organisation told us that they were due to send out surveys for 2015.

The organisation were aware of the need to improve the service and, following meetings with the local authority and external and internal audits, they had identified areas for improvement and put together an action plan. We saw a copy of this plan dated 30 June 2015. It covered areas including training, use of equipment, infection control, moving and handling people, managing falls and pressure sores and care planning. We saw that clear dates for improvement had been set and that these had been monitored. We also saw that dates for other improvements had been set along with clear criteria for checking they had been met.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Persons employed by the service provider did not receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider did not have suitable arrangements in place for people to consent to their care or follow legal requirements when people could not give their consent.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **Complaints received had not been investigated nor had necessary and proportionate action been taken in response to any failure identified by the complaint or investigation.**