Langley House Trust

House of St Martin

Inspection report

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Date of inspection visit:
31 March 2021
07 April 2021

Date of publication:
17 May 2021

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
The House of St Martin is a residential care home, part of The Langley House Trust, a Christian based organisation. It provides accommodation with personal care for up to 31 men. The focus of the service is to support ex-offenders or those at risk of offending with physical and mental health needs, dementia, substance misuse as well as people with learning disabilities and autism. 26 people lived there when we visited.

The home is a three - storey wheelchair accessible building with single room accommodation, some of which are en-suite. There is a large communal lounge/dining area, a smaller sitting room and inner courtyard area. It is set within a six-acre site.

People's experience of using this service and what we found
Most people we spoke with said they enjoyed living at the House of St Martin, but their experiences varied. One person said, "It's really good living here. I have made friends. I like listening to music, looking at the birds and watching the weather." A professional said, "Overall, the people that I see seemed to love it there."

Several people said there wasn't enough to occupy them. One said, "I'm a bit bored during lockdown, there's not much to do." Since we last visited the service in April 2019, the service employed an activity co-ordinator, who was organising group activities such as art and crafts and gardening. Wheelchair accessible transport was provided so people could go out for trips and drives, although trips into the community were restricted by lockdown when we visited.

People did not always have their needs met because of staffing and skill shortages. There was a high turnover of staff with heavy reliance on agency to safely run the service. Where staff were unfamiliar with people' needs, this had a negative impact on their experience of care. Staff did not have all the skills, training and support they needed to provide safe and effective care and treatment.

People were not prevented from receiving unsafe care and treatment as assessments, care plans and staff handover information did not include all the information staff needed to minimise risks to people's health, safety and welfare.

The incident reporting system was unclear. We were not confident all incidents were reported or followed up, so the provider could not rely on this information to manage known risks.

Quality monitoring systems were not effective. Three breaches of regulations were identified at the inspection in relation to safe care and treatment, good governance, staff and staffing skills.

We expect health and social care providers to guarantee autistic people and people with a learning disability

the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

This service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right support:
The model of care used at House of St Martin's did not fully maximise choice, control and independence for people with a learning disability. The National Institute for Health and Care Excellence recommends residential care 'should usually be provided in small, local community-based units (of no more than six people)'. The environment of care with 31 people living in one house with large noisy shared communal facilities were not ideally suited to the needs of people with learning disabilities, autism and mental health conditions. Some outbuildings which were being refurbished to provide additional space for people. This included plans to provide a small kitchen so people would have facilities to learn to cook and a new laundry, so people could do their own laundry.

Right care:
The care and support provided, did not always meet the needs of people with learning disabilities. Staff did not receive the training they needed, so they did not develop the skills to provide appropriate support. This was made worse because of high staff turnover and heavy reliance on agency staff, so people did not always receive care from staff they knew and trusted. People's care wasn't person centred. Care plans were not focused on people's strengths, abilities and individual goals.

Right culture:
The ethos, values, attitudes and behaviours of leaders and care staff did not always ensure people with learning disabilities led confident, inclusive and empowered lives. This was because the provider was trying to meet the complex needs of a wide range of people. Staff lacked the skills needed and the environment was not ideally suited to supporting needs of people with learning disabilities.

We discussed our concerns about how the House of St Martin supported people with a learning disability and/or autism with the manager, the Director of Operations and the Director of Quality and Compliance. We requested they review their Statement of Purpose about who the service is for and what they are trying to achieve. We will arrange a meeting with them to follow this up further.

Most people said they felt safe living at the service. Staff had a good understanding of signs of abuse and felt confident any safeguarding concerns reported were listened to and responded to.

Staff had received infection control training and followed up to date infection prevention and control guidance to help people stay safe. Staff used personal protective equipment (PPE) correctly and in accordance with current guidance to minimise cross infection risks to people.

People, staff and professionals spoke positively about the new manager who was making improvements.

People did not always to have as much choice and control of their lives as they wanted. Staff supported people in the least restrictive way possible and in their best interests; but documentation of best interest decisions needed improvement.

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

Rating at last inspection. The last rating for this service was Good. (Report published May 2019). The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

Why we inspected
We undertook this inspection to follow up concerns raised with us about staffing levels and skills and poor standards of care. Also, safeguarding concerns about bullying and intimidation by some people towards other more vulnerable people and by some staff. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the key questions of Safe, Effective and Well led.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective and Well led sections of this full report. We have identified three breaches of regulations in relation to Safe care and treatment, Staffing and staff skills and in Good governance. The provider has agreed to mitigate immediate risks by a voluntary undertaking not to admit any more people to House of St Martin until further improvements have been made.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for House of St Martin on our website at www.cqc.org.uk.

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

House of St Martin

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Two inspectors visited the service and a third inspector undertook calls with staff and visiting professionals to get their feedback about the service.

Service and service type
House of St Martin is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a new manager who has applied to the Care Quality Commission to become the registered manager. The provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was announced. We announced the inspection the day before we visited to take account of the safety of people, staff and the inspectors, with reference to the COVID 19 pandemic. We visited the service on 31 March and 7 April 2021.

What we did before the inspection
We reviewed information we had received from the provider and others since the last inspection. We sent

the manager an inspection poster with our contact details to circulate to staff to seek their feedback. We requested information about infection control policies and procedures and about the ongoing monitoring of safety and quality.

We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection
We spoke with six people who lived at the House of St Martin. We observed staff interactions with people in communal areas of the home. We looked at five people's care plans and at their medicine records.

We spoke with the manager, a new manager temporarily working at the home, the area manager and the Director of Operations. In total, we spoke with 10 members of staff which included senior staff, care and agency staff. We sought feedback from local health and social care professionals and probation services and received a response from nine of them.

We looked at staff recruitment, induction and training records. We reviewed a range of quality monitoring records, such as audits, regular checks, policies and procedures as well as servicing and maintenance records.

After the inspection
Following the inspection, we spoke with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. Feedback calls with people, staff and professionals continued after the visit.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

● People did not always have their needs met because of staffing and skill shortages. These emerged as key issues at the inspection. Difficulties recruiting and a high turnover of staff meant the provider relied heavily on agency staff to safely run the service. A professional wrote, 'Staffing has often been a challenge as the home expands and the needs of the clientele increase.'

● The staffing situation was fragile, given the number of staff who said they had already decided to leave or were looking for another job. Also, work pressures had continued to increase because new people continued to be admitted over the past three months, despite permanently employed staff leaving.

● Staff rotas were not flexible to make sure people's care was provided by an appropriate mix of staff, which took account of the skills, knowledge and experience needed. Staff had fixed rotas, with gaps filled by regular agency staff wherever possible, to try and provide continuity for people. The current working arrangements reduce staff flexibility.

● Where staff lacked the skills or experience needed, or they were unfamiliar with people' needs, this had a negative impact on the people's safe care and treatment. Delayed staff rotas made some people anxious as they didn't know if the staff they wanted to support them would be on duty, so they could not plan their week.

● People spoke of dignity concerns relating to being supported with intimate personal care by staff they did not know. For example, two people who needed personal care during the night told us they decided to wait until morning to receive the care they needed. This was undignified for those people and increased their risk of developing skin damage.

● Staff comments included; "Staffing is the main issue," "We are lacking in support." One staff said, "I think the staff work as best they can, but it can be very challenging with people and the staffing issues that we have."

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

● We spoke with the manager and the Director of Operations about our staffing concerns and they agreed to stop admitting people to the service, until the staffing situation was stabilised.

● Staff were safely recruited. Pre-employment suitability checks were carried out before staff started working with to demonstrate they were suitable for the role.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

● People were not prevented from receiving unsafe care and treatment as the provider was not taking all

necessary steps to prevent avoidable risk and harm.
● Assessment prior to admission, individual risk assessments, care plans and staff handover information did not include all the information staff needed to minimise risks to people's health, safety and welfare.
● People's care records gave information about the level of risk people posed to themselves and others. However, risk levels were not always reviewed or updated. For example, one person's risk assessment stated they should be accompanied by staff when going out. At the time of the inspection staff told us the person went out without supervision. The risk assessment did not give details of how or why this change had occurred, or details of measures in place to minimise risks.
● People had no risk assessments or care plans for staff to follow about their physical health or mobility needs. For example, about how to reduce the risk of falls or skin damage for people. This meant there was an increased risk those needs would not be met.
●The incident reporting system was unclear. Several incident reports we looked at lacked detail about the incident, how it was investigated, responded to or about mitigating actions taken in response, for example, about incidents of verbal and physical abuse. One staff said, "I'm not sure staff know the reporting process."
● We identified two recent incidents that should have been reported to safeguarding and Care Quality Commission (CQC), had not been reported, and one which was reported but was not on the database. We were not confident all incidents were captured, which meant the provider could not rely on this information to manage known risks.

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

● Staff we spoke with had more information about people's needs and risks than was captured in their records. One staff said, "We know their triggers, things can escalate quickly, so we care for one another." Another staff said, "Some (people) are more vocal than others. They can be very temperamental, and you need to be aware of how they are and what you are doing."
● Environmental risks were being managed with systems in place for servicing, maintenance and repairs. Recent improvements had been made such as new fridges and freezers in the kitchen. There were some hazards in the grounds still related to building works and waste/rubble/uneven ground which was due to be made safer in the next few weeks.

Systems and processes to safeguard people from the risk of abuse
● Most people said they felt safe living at the service. One person, said, "Yes, I would say that it's a safe place to live, most of the people are usually good at coming forward if they have any concerns."
● One person said they didn't always feel safe around others with behaviours that challenged the service, so spent more time in their room. Others described incidents of verbal and physical aggression involving more vulnerable people. People were not always confident staff had the skills to manage these situations.
● Where people had experienced difficulties, they said they had reported them to senior staff who acted in response. A professional wrote, 'When residents express concerns with me, the senior team are generally already aware and already dealing with the matter.'
● We followed up reports to CQC about alleged bullying by staff and by people towards others who lived at the service. We found the concerns identified to us had all been followed up and action taken. Mostly, these related to communication issues and increased tensions between some people, due to lockdown. One person said, "The staff here are good. There are some staff I don't get on with but I'm not sure why. I think it's because I trust some staff more than others."
● Staff had received safeguarding training and knew about the different types of abuse. They knew how to report concerns and were confident the manager took action to protect people.
● Safeguarding was discussed at monthly residents' meetings, where staff reminded people to report

anything, they were unhappy about.

Using medicines safely

● People received their prescribed medicines safely. Staff had received specific training and had their competency assessed to ensure they were able to safely carry out the task.

● Each person had their needs assessed to determine the level of support they required with medicines. This ranged from full support from staff to being able to self-administer their medicines and therefore maintain their independence.

● Some people were prescribed medicines, such as pain relief, on an 'as required' basis. There were no clear protocols in place to guide staff about when these medicines should be administered. Staff spoken with said they knew people well and how they would express pain if they were unable to request medicines. However, the lack of clear protocols could place people at risk of not receiving medicines in a consistent manner and therefore possibly experiencing pain or discomfort.

● The provider carried out regular audits of medicines practices within the home. This enabled them to identify any errors and fully investigate these to minimise the risk of reoccurrence. At the time of the inspection we identified one error which had already been noted by the provider's own systems and was being investigated.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support; induction, training, skills and experience

● At our last inspection, we identified gaps in staff training and recommended the provider reviewed their training needs to ensure they followed national guidance and legislation.
● At this inspection, previous gaps in training highlighted remained. For example, the service had no training to support staff to meet people's personal care, continence care, skin care needs. Also, there was no specific training for staff caring for people with specific health needs such as diabetes or epilepsy nor to meet the needs of people with learning disabilities. This increased the risk that staff would not be able to meet people's needs.
● Staff had not had care plan training so did not know how to write care plans about how to meet people's individual needs.
● Training monitoring information showed existing staff were behind on the training provided. For example, a person commented they thought some staff lacked skills in setting boundaries and managing people's behaviours that challenged others in the service. When we checked staff records of managing challenging and aggressive behaviour training, we found only six out of 14 staff who worked at the service were up to date with this training.
● A staff member said, "The training is very lacking. They (the provider) have this habit of throwing people in at the deep end which is so difficult with so many diverse issues." A professional said, "Staff are nice to people, but they are well out of their depth."

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

● To address some of the training shortfall, the provider said a manager who was due to stay for a month at House of St Martin, with a background in training, has had their stay extended to six months to help with this. The easing of lockdown has enabled staff to travel to access some of the provider face to face training they have missed.
● New staff underwent a period of induction when they started working at the service. One member of staff said they had completed initial training, had time to read people's care plans and did shadow shifts alongside more experienced staff.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law;
● People had their needs assessed before they moved into the home by staff who did not work at the House

of St Martin. Although the manager had some input, they did not have the authority to make the final decision about who was admitted or when. This resulted in a very varied group of people living together and meant staff needed a very broad level of skills, experience and training.

● Initial assessments of people's needs did not take account of the needs or risks of other people who lived at the home. For example, the placement of a person recently admitted failed quite quickly, as staff could not meet their needs.

● At the last inspection we identified that people's support plans were not always person-centred and did not give clear information about people's choices. At this inspection we found some support plans contained some information about people's choices, but others did not. For example, about the time a person liked to get up.

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

● We followed up previous concerns about a person not getting supplies of medical equipment they needed in a timely way and found these had been addressed.

● At our previous inspection, we highlighted people's support plans did not give full guidance to help staff to promote people's health and well-being. At this inspection, we found this had not progressed. For example, one person's support plan showed they had epilepsy. There was no care plan in place to give guidance to staff about how the condition may affect the person, or what action they may need to take. This potentially placed the person at risk of not receiving the care and support in a timely manner if they were unwell.

● Staff supported people to attend health appointments to see health care professionals such as GPs, dentists and opticians. People received one to one support from a psychologist who worked twice a week at the service. Staff worked closely with mental health services to support people with mental health and substance misuse needs.

Supporting people to eat and drink enough with choice in a balanced diet

● People gave us mixed feedback about the quality and choice of food. Some people said they enjoyed the food and there was plenty of choice. Other more critical comments included "Bland," "Lots of mince" and "Not enough fresh food and vegetables."

● There was a four- week menu so people had variety and choice. However, when we visited, the service did not have a chef. An agency chef, on the duty on the first day had left when we returned on the second day. As a temporary measure, care staff were working in the kitchen whilst a more permanent solution was found.

● Information in the kitchen lacked detailed guidance for staff about supporting people's individual nutritional needs. For example, about how to support people with diabetes to make healthy food choices.

● People had access to drinks and snacks throughout the day. People could make light meals and snacks using a microwave and they could help themselves to hot and cold drinks.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA , and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Staff had received training about the mental capacity act. The manager had made applications for people to be cared for under the Deprivation of Liberty Safeguards where they lacked capacity and required this level of protection to keep them safe.
● The manager gave an example of where a person had received medical treatment in their best interests. This had been in liaison with a medical professional and staff at the home.
● People's support plans did not show people's capacity to make certain decisions had been assessed or that any decisions had been made in a person's best interests. We discussed this with the manager during the inspection and they gave assurances that they would make sure this was put in place where appropriate.

Adapting service, design, decoration to meet people's needs
● People lived in a home which was well maintained and comfortable. The home was made up of an original house with a large modern extension. Each person had a single room which they were able to lock to maintain their privacy. Some rooms had en-suite bathrooms and there were adequate bathrooms and toilets for people. One person had recently moved to a newly refurbished room which was better equipped to increase the person's independence and sense of control.
● Since we last visited, the provider had purchased a transport vehicle which was suitable to meet the needs of wheelchairs users. This meant everyone who lived there could access their local community.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The service had a number of quality monitoring systems, but these were not working effectively to highlight, and address risks related to the three breaches of regulations found at this inspection.
- Poor reporting systems meant we could not be confident accidents, incidents and safeguarding concerns were reported on or followed up appropriately. This could mean further actions needed to mitigate risks and that statutory notifications may be missed.
- Monthly reports repeatedly highlighted staff had not completed necessary training and care plan reviews were overdue, but these had not been addressed
- Reports to the provider lacked important information about risks at House of St Martin related to staffing, complaints, incidents, risk management and safeguarding concerns.
- The complaints process was not always followed. Where people had made a complaint and were waiting to hear back, complaint records lacked detail about the investigation and its outcome. Some complaints people said were ongoing, were recorded as dealt with.
- People's care plans were not person centred or focused on meeting people's care needs and minimising any risks. The lack of person-centred care plans and skilled permanent staff meant people could not be assured about quality and safety of the service.

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

- People and staff spoke positively about the new manager and temporary manager. Staff said they were approachable, listened and acted on concerns. The manager was visible around the service. One staff said, "[Name of manager] is a good manager and seems to have a good handle on how things should be done."
- However, there was a lack of clarity about roles and responsibilities of other senior staff. The deputy manager and two senior staff mostly worked Monday to Friday and were largely office based. Care staff said they felt unsupported working on the floor, particularly at night and during weekends. A review of these roles was underway.
- Where concerns about individual staff attitudes or performance were identified, the manager had dealt with these through supervision and where necessary, more formal processes.

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

outcomes for people

● People currently living at The House of St Martin ranged from 19 to over 80 years of age with a variety of complex physical and mental health needs and cared for people with learning disabilities.

● Professionals we spoke with including commissioners, care managers, police and probation staff all raised similar concerns about the mix of people who lived at the home. They were concerned about whether staff could be equipped with the range of skills needed to meet people's varying and complex needs, alongside managing the risks. One said, "You have some very frail elderly people mixed with some very young people." Other professionals said: "The home doesn't seem completely clear on what type of service it provides" and "The mix of people has been a longstanding problem."

● The provider's aims and objectives included; 'Engage with and support service users through person centred care and support which will reduce offending behaviour and improve quality of life leading to opportunities for greater independence.' Each person was supposed to have a daily structured personal support plan and programme, but these were not in place. For example, one persons' support plan showed they hoped to move on to live more independently in the community with staff support. There was no detail about what support the person needed to reach this goal, or whether they had made any progress towards it.

● A staff member said, "I think some people could do a lot more than they actually do." Another said, "We do have an activity person who tries to improve people skills but it's very much dependent on what each person wants to do." A professional said, "There are some people that clearly wish to move on and it's not clear how they're going to be supported to do that."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People were consulted and involved in day to day decisions about the running of the home through monthly residents' meetings. Areas discussed included introducing development of a new gazebo and activities centre, staffing and reducing risks of COVID 19 by wearing face masks in communal spaces.

● A survey to seek people's views was last completed in September 2020. 11 of 14 people who responded said they would recommend the service to others. Most people said staff were polite and they knew who to talk to if they had a problem

● Staff had regular opportunities to have their say through monthly staff meetings and regular individual supervision. Discussions at a recent meeting included discussions about new referrals to the service, challenging behaviour incidents and introduction of staff 'walkie talkies' for improved security and communication. Also, about improved fire safety precautions and reminders to staff to complete overdue training.

Working in partnership with others; Continuous learning and improving care;

● Prior to the inspection professionals raised some concerns about communications regarding requests for information and attendance at multiagency meetings. However, they said this had improved under the new manager. One professional said; "Communication with the home is very good. The manager is very professional and gets things done."

● Staff described improvements under the new managers' leadership. For example, in staff induction, infection control and health and safety.

● The manager had improved quality monitoring, for example, introduction of regular medicine audits, updates to infection control and medicines policies and procedures. The manager outlined further improvements planned. For example, pendant call bells so people with mobility difficulties could call for help when in bathroom or around the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not prevented from receiving unsafe care and treatment. The provider was not taking all practical steps to prevent avoidable risk and harm. The incident reporting system was not used effectively to capture, record and respond appropriately to risks. People's risk assessments, care plans and staff handover lacked information staff needed about how to minimise risks. Regulation 12 (1) (2) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The providers quality monitoring systems for assessing, monitoring and improving the quality and safety of care were not effective. People's health, welfare and safety needs were not consistently met because the provider did not sufficiently manage and mitigate risks relating to their care and treatment. People's care records lacked detail to guide staff how to meet each person's individual needs. The provider did sufficiently listen to, record and respond to people's feedback about the quality and safety of the service to make improvements. Regulation 17(1)(2)(a)(b)(c)(e)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

People were at increased risk because of staffing and skill shortages. There was not enough suitably qualified, competent, skilled and experienced staff to meet people's care and treatment needs. Staff did not receive all the training, they needed to meet people's needs. A high turnover of staff meant a heavy reliance on agency staff which affected skill mix, quality and continuity of care.

Regulation 18 (1)