Queensbridge Care Limited

Queensbridge House

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

This inspection took place on 10 April 2015 and was unannounced. Queensbridge House provides accommodation for 27 people who require nursing and personal care. 24 people were living in the home at the time of our inspection. Most of the people living in the home have been diagnosed with a type of dementia. This service was last inspected in November 2013 when it met all the legal requirements associated with the Health and Social Care Act 2008.

Queensbridge House is mainly set over two floors which are accessible by stairs or a lift. A further three bedrooms and the main office is set on a third floor. The home has two lounges, a dining room and a conservatory. People have access to a private secure back garden.

A registered manager was in place as required by their conditions of registration. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2014 and associated regulations about how the service is run.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

People and their relatives were positive about the care they received however we found people's safety and well-being was compromised in a number of areas. Although staff had a good understanding of people and responded to their physical and emotional needs; some people's individual risks were not being assessed fully or monitored. Staff inputted 'real time' information about people's daily lives and activities in to the electronic care planning system. However, staff were unable to access this information and collectively read about the overall well-being of people which would give them guidance.

People's medicines were not managed effectively. The record balance of prescribed and over the counter medicines stored in the home was not accurate. Staff had not been given a recent refresher course in the administering and managing medicines to ensure their practices were current. We have made a recommendation about good practices of managing people's medicines and the training of staff.

Staff were knowledgeable about recognising the signs of abuse. There were sufficient numbers of staff to meet people needs although there were gaps in some of the staff recruitment processes which are intended to ensure the suitably of staff was checked before they care for people. Formal support and training for staff was not effectively managed and monitored to ensure people were being cared for by staff with the appropriate skills.

Staff knew people well enough to understand their preferences; however they were not familiar with the Mental Capacity Act 2005 and their legal responsibility on how to support people who lacked capacity. Some people's mental capacity to make day to day or significant decisions had been assessed or recorded but the records were not clear and accessible to staff.

People and their relatives were positive about the care and support they received from staff. They were supported to maintain their health and well-being and access additional care and treatment from other health care services when needed. People who had specific dietary needs were catered for. Most people ate in the dining room however the dining experience for some people was restrictive. Other people chose to eat from individual tables in the lounges although the table heights were not ideal to eat from. The home's environment was safe but it did not support people with dementia and help to orientate them to overcome their lack of memory. We have made a recommendation about creating a home environment which supports people living with dementia.

The home had recently been taken over by a new provider who had proposed changes to the structure of the building. Some quality assurance audits were carried out by the registered manager; however there were no quality audits carried out by the new provider. The home's policies had not been updated to reflect current legal practices and the protocols of the home.

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. Some people's individual risks were not being assessed, managed or recorded. Whilst staff knew people's risks they did not have access to people's electronic care plans to give them guidance.

The recorded balances of prescribed and over the counter medicines stored in the home were not accurate. Staff had not received up to date training on administering and managing medicines.

The systems to check the employment history of new staff were not always thorough.

People were cared for by suitable numbers of staff who understand how to protect people for avoidable harm and abuse.

Is the service effective?

Requires improvement

The service was not always effective. People were being cared for by staff who had not been frequently trained or formally supported to meet their needs. The skills of new staff were not fully assessed before they became a member of the team and cared for people.

Whilst staff supported people to make decisions about their care, they did not always understand the concept and principles of the Mental Capacity Act and how this impacted people.

People's dietary needs and choices were catered for. The seating arrangements for some people while eating was not ideal.

People were referred to the appropriate health care professionals if their needs changed.

Is the service caring?

Good

The service was caring.

Staff were kind and compassionate to the people they cared for. People were treated with dignity and respect and their views were listened to.

Staff adapted their approach and communication so that people understood them.

Relatives made positive comments about the approach and attitude of the staff.

Is the service responsive?

Requires improvement

The service was not always responsive.

Summary of findings

Most people's care needs were assessed, recorded and reviewed. However staff had limited access to people's care records and therefore did not have recorded guidance about people's needs.

The home's environment was not dementia friendly. Activities were provided around the home for people individually or in groups.

Staff responded promptly to people's individual concerns. Relatives told us their concerns were listened to by staff and acted on.

Is the service well-led?

Requires improvement

The service was not always well-led.

The home's policies had not been updated and some did not reflect practices in the home.

Some quality assurance audits were carried out. Not all accidents and incidents were analysed for patterns and trends.

The registered manager and senior team provided support to staff.

Queensbridge House

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 2014, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 10 April 2015 and was unannounced. The inspection was led by an inspector and accompanied by a second inspector and an expert by experience. An expert by experience is a person who has personal experience of caring for older people.

Before the inspection we reviewed the information we held about the service as well as statutory notifications. Statutory notifications are information the provider is legally required to send us about significant events.

We spent time walking around the home and observing how staff interacted with people. The majority of people living at Queensbridge House were unable to communicate their experience of living at the home in detail as they were living with dementia. We used the Short Observational Framework for Inspection (SOFI) during the lunchtime period. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with eight people, six relatives, six members of staff and the registered manager. We looked at the care records of five people. We also spoke with one health and social care professional. We looked at staff files including recruitment procedures and the training and development of staff. We checked the latest records concerning complaints and concerns, safeguarding incidents, accident and incident reports and the management of the home.

Requires improvement

Is the service safe?

Our findings

People's personal risks were identified and recorded on the electronic care planning system. Most people had risk assessments in place which related to their health and welfare. This helped to protect people from harm or deterioration in their wellbeing such as a reduction of their food and fluid intake. However there were no clear risk assessments for people who had very specific and individual risks such as going out alone.

Staff were aware of people's individual risks but told us although they could input details about people, they did not always have access to the electronic system to fully read people's risk assessments. They relied on comprehensive and detailed verbal handovers between each shift. An agency member of staff said, "The handovers here are very good. Excellent communication and I have been shown how to put information onto the computer screens. I do it as I am going along." In some situations, staff had identified and were managing people's risks but had not requested further professional support and assessments to give them clear guidance on how to support people with specific needs. For example, one person had been identified as at risk of choking. Staff had given them a soft diet but had not referred this person to the speech and language therapist for further guidance.

People's care records were fragmented as their risk assessments were not always reflected clearly in their care plan. For example the mobility of one person who had returned from hospital had changed. They initially required a stand aid hoist to stand and transfer however we were told they were now able to stand and transfer with some support. This new practice was not reflected in their records. A risk assessment was not in place for another person who needed staff support to move up and down the bed. The registered manager relied on senior care staff to inform her of any changes in people's needs and risks when reviewing people's individual risks. We were told that staff would soon be trained to access and update people's care records.

People's risk assessments were not always clear and accessible to staff to give them the correct guidance to deliver safe and individualised care.

This is a breach of Regulation 12 Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were not always managed correctly. People's medical records which recorded when people had received their medicines did not contain their photographs or allergies which would help reduce any confusion about people's medicines. Although this information was held on the electronic care record system which not all staff could access. The ordering of new and repeat prescriptions was carried out by a senior member of staff in conjunction with the pharmacist. An accurate audit of the continual balance of medicines held in the home was not available as the remaining balance from the previous period was not recorded. The senior member of staff confirmed they did not record 'carried forward' amounts of medicines. This had resulted in excessive amounts for some medicines being stored. For example, repeat orders of one person's medicines had unnecessarily been carried out when they were not required.

Records showed that some people had been given over the counter medicines; however there were no records of the GPs agreement to these medicines being administered. There was also no checking system in place to record stock levels of these medicines. A senior member of staff told us that the GP reviewed medicines on a fortnightly basis.

Staff were observed administering medicines safely, and made sure people took their medicines before they signed their medicines records. A medicines fridge contained medicines for cool storage and the temperatures were recorded each day. The temperature of the medicines room, described as being 'really hot' by staff, was not recorded. Additional systems were in place to manage the recording, storing and disposing of medicines which could be misused. Most medicines which were identified as no longer required were recorded and disposed of safely. However a liquid medicine, which had been opened in December 2014, should have been disposed of after three months according to the guidance on the label.

The details of people who were prescribed creams or medicines 'as required' were completed in their care records and recorded on their medicines records when administered. People's care records provided some detail about how people preferred or were supported to take their medicines. For example, one person care records stated 'one carer to support and supervise while taking medicine'. We were told that no one managed their own medicines or were given their medicines covertly.

Requires improvement

Is the service safe?

The registered manager told us that they carried out a monthly audit of the medicines however they were reverting back to an older auditing system due to a new contract with a new pharmacist. After our inspection, we were sent one example of the records of an audit carried out in February 2015.

There was no documented evidence that staff's competency for managing medicines was being regularly checked and monitored. Staff had not received any refresher courses on current practices in management of people's medicines. Generally good practices were seen when people received their medicines. However poor practice was seen on one occasion, for example, we found that medicines for two people were left on top of the medicines trolley unattended.

We recommend that the service considers current guidance on stock control of people's medicines and seeks advice from a reputable source on staff development in managing people's medicines.

Whilst some good recruitment practices were in place to ensure that people were being supported by suitable staff, these practices were not consistently thorough. For example, the reasons for one staff member leaving their previous employer had not been identified and there were no details of the previous employment history of another staff member. Disclosure and Barring Service (DBS) criminal checks had been carried out on all staff before they started to work with people. A DBS check lists spent and unspent convictions, cautions, reprimands, final warnings plus any additional information held locally by police forces that is reasonably considered relevant to the post applied for. However, the registered manager could not evidence that employment and criminal checks had been carried out on agency staff who worked in the home. The registered manager said, "We get our agency staff from the same place and we always make sure they are supported and know about the people who live here."

People were cared for by suitable numbers of staff. On the days of inspection we found that suitable staffing levels to meet the needs of the people were in place. The registered manager told us they aimed to have additional staff in the mornings and evenings to support people. One member of staff was responsible for running the 'breakfast club' to ensure that everyone had their breakfast and drinks and to promote independence. Staffing levels had been adjusted in the evening to support people who may become more restless or agitated in the evening. Agency staff were used in the event of unplanned staff absences to maintain these staffing levels.

Staff were knowledgeable about recognising the signs of abuse. They had received training in protecting people during their induction period although there was no evidence that staff had received a recent refresher course to update their knowledge and current practices. We were told the registered manager was planning to attend an advanced safeguarding course for managers but this had not yet been booked. All staff told us they would report any concerns of abuse to the manager or the Care Quality Commission however some staff were unaware of how to contact the local authority safeguarding team. There were no contact telephone numbers for any external safeguarding agencies in the home's safeguarding policy to guide staff.

People's finances were being managed safely. A system was in place to ensure there was a record trail for each person's income and expenditures. Staff supported people with their finances and signed and witnessed all transactions. A regular audit system was in place to help eliminate the risk of people being financially abused.

Relatives told us they felt their loved ones were safe at Queensbridge House. We received comments such as "I have peace of mind, that mum is well looked after." and "I have seen nothing but kindness."

Requires improvement

Is the service effective?

Our findings

People were not always supported by staff who had received up to date training. Staff had carried out training considered as mandatory by the provider, such as safeguarding people and health and safety training. The home's training policy referred to 'identifying induction and training needs through a suitable and effective programme'. The present system was not evident in identifying staff training needs. For example, the training chart identified when staff had received different aspects of their training, but there was no clear monitoring system to confirm the skills and competency levels of staff or if they required a refresher course in specific subjects.

New staff were required to watch a series of care related DVDs such as safeguarding people and then complete a work book. Records showed that most staff had completed these work books however some of these workbooks were not named, signed or dated and there was no evidence that some of the work books had been checked by a competent assessor. Some training such as moving and handling and first aid had not been supported with a practical course to ensure good practices were being embedded in the care and support staff delivered. One senior member of staff had been trained as a moving and handling trainer though these skills were not being used by the home. One staff member said "If someone needs a hoist then the Occupational Therapist will come in and teach us how to use it."

The registered manager accepted the training certificates of staff who had previous health care experience however there was no evidence that action had been taken to ensure their the competency and skills levels had been maintained.

Four members of staff were trained to be dementia link workers and attended events to keep their knowledge about supporting people living with dementia updated. The majority of other staff had attended a dementia awareness course run by the local authority. Most staff communicated well with people and demonstrated some good practices for supporting people with dementia. However some staff said they felt they needed more dementia awareness training. For example, one staff member said, "I do wish we had further training in dementia support."

Records showed that staff had received formal support meetings with their line manager, although the frequency and records of these meetings were not always consistent for some staff. Staff told us they had received formal support meetings and appraisals but were unclear when they had received it. One staff member told us, "I think I had supervision eight months ago." However they told us they felt supported by their team and senior staff. One member of staff said, "There's always someone to ask if I need support or help."

Staff skills and knowledge to care for people were not always checked and monitored. **This is a breach of Regulation 18, Health and Social care Act 2008 (Regulated Activities) Regulations 2014.**

Most staff had undertaken a national vocational qualification in health and social care. The provider had recently sourced a new training facility but this had not yet been implemented. The registered manager was aware of the new care certificate guidance and would be implementing it within the new training regime. The care certificate gives providers clear learning outcomes, competences and standards of care that will be expected from staff.

Staff and the registered manager were not always clear about the principles and concept of the Mental Capacity Act (MCA) and the associated Deprivation of Liberty Safeguards (DoLS) The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely.

Staff were able to tell us how they supported people who had limited mental capacity to make day to day decisions. However, they were unable to describe the process of how they would support someone if they had to make a specific decision about their life. Although people's electronic care records included an assessment of their mental capacity when needed; the assessments were unclear and did not obviously relate to specific decisions. Again these

Requires improvement

Is the service effective?

assessments were fragmented and did not provide clear guidance to staff. Not all staff had received up to date training in Mental Capacity Act (MCA) and the associated Deprivation of Liberty Safeguards (DoLS).

The registered manager had sought advice about one person who occasionally refused to come back into the home if they went out. A DoLS application form had been submitted to the local authority to authorise the restriction of this person's liberty in the least restrictive way. When asked, the registered manager was unsure of the outcome of this application without reading the application and related documents. Therefore they were unsure if they were legally allowed to restrict this person's liberty. We were told that this person no longer refused to come back to the home if they went out but this had not been updated in their care records. The registered manager told us that she had applied to carry out a management course in understanding the impact of MCA and DoLs on people living in the home.

Staff did not fully understand the principles and concept of the Mental Capacity Act and how this impacted on the right of people to make decisions about their care. **This is a breach of Regulation 11, Health and Social care Act 2008 (Regulated Activities) Regulations 2014.**

The majority of people preferred to eat in the dining room. The space in the dining room was narrow and restricted. There was limited space around the tables when the dining room was full. Some people had to leave their walking frames outside the room. This restricted people's movement and independence especially when they wanted to leave at the end of their meal. Some people ate their meals in the lounges. Four of the six people who ate their lunch in the lounges, struggled to eat their meals off unsuitable height tables.

People were supported to maintain a healthy and well balanced diet. Staff knew people well and knew people's preferences and choices in their meals. People who spoke with us said they enjoyed the food. People were offered a choice of two hot meals except for Fridays when they were offered a fish meal and a roast on Sunday. Staff told us they would provide alternative meals if the person disliked the meal that was offered. People with specific dietary needs and preferences were catered for. Pre-made meals were bought in frozen and heated up by staff. The meal containers provided staff with the nutritional values for each meal. Portion sizes were flexible and dependent on people's appetites. People's food and fluid intake was recorded electronically and monitored if they were identified as being at risk of malnutrition or dehydration. People were given adapted and coloured crockery which helped them to eat independently.

Whilst most people were left to eat without interaction from staff, we did observe staff encouraging people with poor appetites to eat. One person told a staff member she was not hungry and wanted to be left alone. Staff monitored this person and tried varied approaches to encourage them to eat. Staff communicated their concerns in the kitchen and it was noted on the computer screen. One staff member said, "Once we enter it on the screen, this will go into her care plan and it will raise an alert as she is not eating well at the moment."

When people's care needs changed they were referred to the appropriate health care service for additional support and treatment. People's GP regularly visited the home to reassess their needs.

Good

Is the service caring?

Our findings

People who were able to express their views told us they were happy living at Queensbridge House. One person said, “Oh yes dear, They are kind here.” People’s families were invited to visit the home at any time. Relatives were asked to ‘log in and out’ on a computer screen inside the front door for fire safety reasons when they arrived and left the home. They were also given the opportunity to leave any comments on the screen about their visit. All this information was held by the central electronic system. Relatives were positive about the care and support that people received. Relatives said comments such as: “They are lovely, very caring, I am very happy with all aspects of mums care.”; “I knew as soon as we visited mum would be happy here.” and “Super staff who genuinely care for mum.”

We observed staff interaction with people throughout the day of our inspection. Staff cared for people respectfully. They were caring and compassionate. The staff knew the residents well and demonstrated that they knew individual preferences and choices. We saw many warm exchanges between people and staff. Staff spoke to people as they passed by each other in the corridor or helped them move around the home. They communicated well and used age appropriate language and demonstrated understanding by using open questions and waiting for answers. Staff were able to tell us about people’s needs and what they liked to be called. They gave us examples of how they supported people if they become upset. We saw senior staff members prompting junior staff if they were not communicating effectively.

People’s dignity was valued. One senior staff member said, “I always check and make sure the staff have cared properly for the residents. Such as, I make sure the men have been shaved.” Another staff member said, “It’s so important to make sure we knock on people’s doors and that we make sure doors are closed when we are doing personal care.” People’s privacy was respected.

Staff talked to people in a confidential manner if they were amongst other residents. Those people who were mobile moved around the home in a calm and relaxed manner. People were guided and supported if they felt lost or disorientated in time. One staff member sat with a person to ensure they drank their milky drink with additional supplements. This staff member spoke to this person about their past and where they were born. They reminded the person of the time of year and affirmed this by looking at the warm weather outside.

During our inspection, an activity was carried out in the garden. People were offered sun hats or to sit in the shade as it was a warm day. Staff chatted to people and encouraged people to join in the activity. Staff adapted their approach and level of communication so that people with different cognitive and communication needs understood the activity.

Requires improvement

Is the service responsive?

Our findings

Staff were knowledgeable about the individual needs of people. People's physical needs and general well-being were recorded on an electronic care planning system; however they were not always centred on people's emotional and social needs. The electronic care planning system was difficult to follow and did not provide the reader with an easy overview of each person. The main system was monitored and updated mainly by the registered manager. Around the home staff could enter in 'real-time' information about people's well-being into password locked computer screens such as people's dietary and fluid intake after a meal or when somebody had been to the toilet. This information linked to their main care plan. The system was able to alert the registered manager if a person was at risk or their needs had considerably changed such as not eating.

Staff frequently entered information into the computer screens about people. However there were limited opportunities for staff to access or refer to this information and read people's up to date care plans as staff were unable to access the full electronic system. Not all staff had access to people's care records on the electronic system so relied on verbal communication to update themselves on any changes of people. For example the turn chart for one person who needed to be turned in bed every two hours had not been fully completed. One staff member said, "I know she would have been turned but not all of us can see the chart, so we tell each other during the shift." We were told that senior staff were very supportive and gave clear guidance and updates of any changes in people's needs. Staff raised with us that they were concerned that they were not able to access and read people's electronic care records. However, it was evident that staff communication was good to enable them to share information about the well-being of people.

This was raised with the registered manager who told us they were speaking to the provider and plans were in place to update the system and adequately train staff in using the system such as reviewing people's needs; running monitoring reports and monitoring identified risk.

People's care records were reviewed twice a year. Relatives were invited to the review meetings. One staff member said, "We see most people's relatives on a regular basis, but the reviews allow people time to express their views and see how their relative is getting on."

Staff mainly responded well to people's needs. However, there were elements of the - environmental which was not 'dementia friendly' such as limited visual clues which help to orientate people around the home. The home had a dementia policy which detailed how they specialised in supporting people with dementia such as picture menus and a list of activities that are recommended for people with dementia. There was little evidence of some of these practices. The design and decoration of the home did not promote the well-being and independence of people with dementia. There were limited opportunities to help people become familiar with their environment such as coloured walls or personalised memory boxes outside their bedrooms.

We recommend that the service considers current guidance on dementia friendly environments.

Designated activities staff provided a range of activities across the day in the home, although some of their time was allocated to people who attended the day care facility attached to the home. We were told by an activities coordinator, "That although an activities plan is in place, it is very loose and flexible. We go by the mood of the residents and the season or the weather." We were told of themed activities such as horse racing, tea tasting and fruity Fridays that had occurred. External entertainers such as singers and musicians visited the home regularly. One member of staff said, "Music goes down very well here." People's participation and ability to engage in activities were recorded in an 'activities observation tool' on the electronic system. The registered manager told us that the level of activities would improve once the home had been extended and the day care facility developed to provide more recreational space.

Two members of staff were trained in 'dementia care mapping'. This tool helped staff to observe evaluate and record the quality of care being given from the perspective of the person living with dementia. Regular audits of this tool had been carried out to identify if there were any gaps in the quality of care people received.

Requires improvement

Is the service responsive?

Relatives were confident that their voice was heard and felt that the registered manager was open and responsive. One relative said, “She is very approachable and really supportive.” Another relative said, “We are kept informed of all changes.” One formal complaint had been received since our last inspection. This was dealt with in line with the home’s complaints policy.

Requires improvement

Is the service well-led?

Our findings

The home's policies and procedures had not been updated to reflect current practices and legislation. For example the policy to guide staff on how to make safe recruitment decisions referred to the Criminal Records Bureau (CRB) which was replaced by Disclosure Barring Service (DBS) in December 2012. Some of the policies were generic and did not reflect the home practices. For example the recruitment policy stated that each new member of staff would be required to complete an equal opportunities monitoring form however there was no evidence of this in the staff files.

The home's service user guide and dementia policy explained the ethos of dementia care and how people who lived in the home would be cared for. Some staff had received additional dementia training and we saw several examples of person centred care practices; however there were elements of stated dementia care which were not evident. We spoke with one health care professional who agreed with these findings. The registered manager and a senior staff member were booked to attend a dementia conference to reinforce their knowledge of the principles of dementia care. We were told that the home had run an informal dementia awareness workshop for relatives in the past. The registered manager had not updated her knowledge in current practices and changes in the legalisation. However we were told that the new provider was supporting staff in their personal development.

Accident and incidents were recorded. The registered manager recorded and analysed the incidents when people had fallen, however other accidents and incident were not analysed for any patterns or trends within the home therefore potential risks to people had not been identified.

The culture of the organisation was fair and open. Relatives spoke positively about how the home was run. One relative said, "I can honestly say the staff and manager here have been brilliant." The home had recently been taken over by new providers. Staff were mainly positive about the takeover but some told us they felt 'unsettled'. One staff member said, "The new owners are brilliant so far. They visit regularly and talking to us about improvements to the home." We were told that they were 'open to new ideas' and were planning to extend the home to provide more space and develop a day care centre.

The registered manager had been in post for several years and had supported staff through the change of ownership. The registered manager had an 'open door policy' which was demonstrated during our inspection as staff were comfortable in seeking advice from the registered manager. Staff told us they were generally happy working at Queensbridge House. However, we received mixed comments from staff about the support they received from the registered manager. For example, one staff member said, "The manager is busy in the office all the time, so I would ask the seniors if I needed advice." Although another staff member said, "She is smashing, very approachable." We were told the senior team were always available to support and advise the staff in their roles. An action plan had been put into place which had addressed the concerns that staff had highlighted in a recent staff survey.

The registered manager was aware of some of the areas of concern such as staff access to the electronic care planning system and staff training and was working with the new provider to drive improvement. The registered manager monitored the quality of the service by carrying out some monthly checks. We were provided with copies of housekeeping and cleaning schedules after our inspection as well as call bell audits as the registered manager could not access these audits during our inspection. Other annual external checks had been carried out such as service checks on the lifts, hoist and other electrical equipment. The home had a new fire system in place and all staff had been trained in fire safety. There was no evidence that the provider carried out their own internal quality assurance checks of the service being provided. However, we were told that the new provider visited the home regularly and was working staff to understand the service provided.

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	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person is not acting in accordance with the 2005 Act. Staff did not have a full understanding of their role when obtaining consent lawfully.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services did not always have an assessment of their needs and preferences of care or treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Persons employed by the service provider had not received appropriate support and training as is necessary to enable them to carry out the duties they are employed to perform.