Lifeways Community Care Limited

Abbeymoor Neurodisability Centre

Inspection report

Market Lane
Swalwell
Newcastle Upon Tyne
Tyne And Wear
NE16 3DZ

Tel: 01914880899

Date of inspection visit:
22 August 2018
07 September 2018
13 September 2018

Date of publication:
19 October 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We conducted the inspection from 22 August to 12 September 2018. It was an unannounced inspection which meant that the staff and registered provider did not know that we would be visiting.

The last inspection took place on 3, 9 and 11 January 2018 and we found the provider was not meeting the fundamental standards of relevant regulations. We rated Abbeymoor Neurodisability Centre as 'Inadequate' overall and in two domains. We identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which related to safe care and treatment, safeguarding, staffing and good governance.

Local commissioners had also raised concerns and the provider had devised an action plan detailing how these would be addressed. They prioritised the order in which these issues would be addressed, with high risk areas being resolved first. Since then they have been working to make improvements. The provider had taken the decision to limit admissions until they felt confident that the service was effective. Only one person had been admitted to the service since November 2017.

Abbeymoor Neurodisability Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Abbeymoor Neurodisability Centre accommodates up to 40 people across two floors, each of which have separate adapted facilities. The service specialises in providing nursing care to people living with degenerative neurological conditions or an acquired brain injury. At the time of this inspection, 29 people were in receipt of care from the service.

The new manager became the registered manager in September 2018. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like 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.

When we visited, the provider had started to make improvements and had started to reduce risks by working with staff to change practices, improving care records and risk assessments, and improving the environment. However, these actions needed to be embedded and further developed.

Staff had described other people has having a learning disability but this was not accurate. Staff also recorded that people had mental health needs but not what these were or how the person was to be supported. We discussed this with the registered manager and found staff needed training around understanding these conditions. We also highlighted that the service is not registered to accommodate people living with learning disabilities or mental health needs.

One person had recently brought a bed from their own home but we noted they had bumped their foot twice on the bed. The service had not completed an occupational assessment to determine the suitability of

the bed. Following the first day of our visit the registered manager requested an occupational assessment of this equipment.

An external contractor had completed a fire risk assessment, but this did not provide a plan for the management of evacuation, identify clear risks. Following the first day of our inspection the provider put measures in place to improve the fire routes and evacuation procedures.

People could not access nurse call alarms in bedrooms, the communal areas or bathrooms and no consideration had been given to providing new technological solutions. We discussed this with the registered manager who following the first day of our inspection commenced sourcing equipment people could use to activate the call alarm system.

The provider and registered manager had been working with staff to ensure they were supporting people's autonomy. We saw some improvements had been made around staff practices but at times staff did not speak with people when attending to their needs and arbitrarily placed people in the lounges.

Staff had completed a full range of training around making safeguarding alerts and recognising when people were making a complaint.

Care records were being improved but at times key information was missing and some were inaccurate. Capacity assessments and 'best interests' decisions had been introduced.

Staff were expected to check everyone every 15 minutes. We could not find out why this level of observation was needed. We found staffing levels were not in place to meet these current expectations and no consideration had been given to alternative means for monitoring people's safety.

Staff did not demonstrably use techniques such as picture boards or computer assisted technology to assist people to communicate their views.

Staff needed to review the procedures for administration of covert medicines and where information about people's percutaneous endoscopic gastrostomy (PEG) feed regimes was stored.

People were supported to maintain a healthy diet and to access external professionals to monitor and promote their health. However, the meal time experience needed to be improved.

The regional operations director had reviewed staffing levels and employed additional staff during the day and overnight. Appropriate recruitment checks were carried out. The service had been commissioned to provide reablement programmes and work was being completed to redesign the environment so this could be supported.

The provider ensured maintenance checks were completed for the equipment and premises. However, we found that there were many areas of the service in need of refurbishment.

We found the quality assurance procedures had improved and the registered manager was critically reviewing the service. However, the system of review needed to be fully embedded.

We identified three continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which related to safe care and treatment, staffing and good governance.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Action was being taken to ensure risks were monitored and managed appropriately. Action was being taken to ensure people lived in a well-maintained service. People's medicines were managed safely.

However, work was still required to ensure these plans were effective. Fire risk management plans and fire routes needed to be improved.

Staff were more adept at recognising signs of potential abuse and reporting concerns to senior staff. The provider had ensured there were sufficient skilled and experienced staff on duty to meet people's needs. Robust recruitment procedures were in place.

Is the service effective?

Requires Improvement

The service was not always effective.

People were provided with a choice of nutritious food and their on-going healthcare needs were managed. The care records were being improved but staff needed to ensure that there were always accurate.

Staff were being supported to gain the knowledge and skills they needed. But, had not received any training around working with people who experienced learning disabilities or mental health needs.

People's consent was not always sought. The documentation linked to the application of the Mental Capacity Act 2005 was in place, but staff needed to develop the skills needed to implement them.

Is the service caring?

Requires Improvement

The service was not always caring.

People were treated with respect, but their independence was

not always promoted.

Staff knew people and used this knowledge to provide care, but at times were not speaking with people when undertaking care tasks.

People did not always contribute to making decisions about their care and treatment.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The service was not always tailored to meet the individual needs of people in receipt of care.

We saw people were encouraged and supported to take part in activities. A programme was needed to support the aim of providing a reablement programme.

The people we spoke with were aware of how to make a complaint or raise a concern and ensured concerns were investigated and resolved.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The quality assurance processes were in place but needed to be fully embedded.

There was a registered manager in post. The provider had been making changes at the service but these were at an early stage and therefore it was unknown if these would be sustained.

People and relatives' views had previously not been sought and the provider was currently in the process of addressing this issue.

Abbeymoor Neurodisability Centre

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 registered 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.

This unannounced inspection was undertaken from 22 August to 12 September 2018. The inspection team consisted of an adult social care inspector and an assistant inspector.

Before the inspection, we spoke with local authorities' commissioning teams and reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are reports about changes, events or incidents the provider is legally obliged to send CQC within required timescales. We also reviewed reports from recent local authority contract monitoring visits and attended multidisciplinary meetings held about the service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with 10 people who used the service and six relatives. We also carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us. We spoke with the registered manager, deputy manager, three nurses, a senior carer, seven care staff, two members domestic staff team and the activities coordinator.

We observed the meal time experience and how staff engaged with people during activities. We looked at seven people's care records, as well as records relating to the management of the service. We looked

around the service and went into some people's bedrooms, the bathrooms and communal areas.

Requires Improvement

Is the service safe?

Our findings

The service was rated Inadequate at the last comprehensive inspection in January 2018. The provider had acted, and this rating has changed to requires improvement.

When we inspected in January 2018 we found that staff were not identifying safeguarding concerns. Risk assessments were not always accurate or up to date. Some people had been given one-to-one hours, but the staff were not sure who had this in place therefore they could not be assured that they were meeting all the contractual agreements. The building needed refurbishment.

We wrote to the provider asking them to outline how they would make the necessary improvements. The provider sent us action plans detailing what they would do and by when.

At this inspection we found the provider and registered manager had been critically reviewing the service and had made improvements. However, areas remained that needed to be addressed.

We found that staff had improved the risk assessments, but the provider's documentation needed to be enhanced so that it assisted staff to identify clinical risks. For instance, people at the service had epilepsy and some were at risk of going into 'status', which means they have continuous seizures and this can be a life-threatening condition. In these people's care records there were no risk assessments or care plans about their epilepsy. We raised this following the first day of the inspection and when we returned the registered manager had ensured staff had created care plans but we found these still needed to be very clear about how to reduce potential risks.

One person had recently moved to the service and brought their bed with them. This had plastic bed rails with a set of wooden bars in the centre of them. When reviewing the accident reports we saw that on two occasions the person had banged their foot on the wooden bars. We asked what action had been taken to check that this bed remained suitable for the person. No one had identified this as a risk. Following our discussion, the registered manager contacted the person's relative and asked for a copy of the occupational therapist assessment and asked for a new assessment.

We found that the existing lifts were small and people who used adapted wheelchairs could not fit in them. Staff told us that people on the top floor that used adapted wheelchairs had to change into ordinary wheelchairs to use the lift. We saw that for some of these people they could not sit upright and therefore would not be able to use the lift. Also, the lifts were too small to accommodate stretchers. This meant that people could not safely leave the top floor.

Although a fire risk assessment had been completed by an external contractor this did not provide a plan for the management of evacuation or identify clear risks. The risks included, there was only one fire route from the main garden and this was next to the kitchen, this route was narrow and blocked with items and there was only one evacuation chair. The deputy manager told us that evacuation sledges were on order but the whole fire management needed a comprehensive review. Following the first day of our inspection the

provider ensured a comprehensive review of the fire evacuation procedures were completed. They allocated funds to allow the pathways to be widened so that people who used adapted chairs could easily leave the garden area. The registered manager was in the process of obtaining quotes for this work.

We found that staff were expected to complete 15-minute checks for all the people who used the service. We raised that would require one person to be continually going around checking people and with existing staffing levels it potentially would not be feasible. We discussed technological solutions with the registered manager, which would reduce the need to do 15-minute observations.

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

The provider ensured maintenance checks were completed for the equipment and premises. These had identified a wide range of areas where improvements were needed. Following this review the provider had commenced a full refurbishment programme and had installed a new conservatory as well as improving some of the bathrooms. We found that there were areas of the service that remained in need of refurbishment, such as the flooring, bathrooms and paintwork was scuffed. We found that the ramps leading from the conservatory and to the courtyard were either too narrow to accommodate the larger wheelchairs or had insufficient turning space for people in wheelchairs to get out of the patio doors and then onto the ramp. The ramps were steep and did not to comply with the Disability Discrimination Act 1995 requirements around ensuring the appropriate gradient was maintained. We discussed with the registered manager who confirmed work was to start on enlarging the ramps and refurbishing the service. They told us that the provider had allocated £250000 for them to use to refurbish the service.

People who used the service told us they felt safe.

Comments included "No complaints", "The staff are always there if I need them" and "It is good here and I'm very happy."

Staff understood what actions they would need to take if they had any safeguarding concerns.

The regional operations director had reviewed staffing levels and employed additional staff during the day and overnight. There were two nurses, a senior and four care staff working overnight and during the day there were two nurses, a senior and nine care staff. In addition to this the registered manager, deputy manager, activities coordinator and ancillary staff worked in the service.

We discussed with staff, hygiene, the infection control process and the availability of personal protective equipment (PPE). Training had been completed in infection control and there was ample PPE available. We found Personal Emergency Evacuation Plans (PEEPs) were available and up to date for the people who lived at the service. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency.

The provider's recruitment processes minimised the risk of unsuitable staff being employed. These included seeking references from previous employers and Disclosure and Barring Service (DBS) checks. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions. The provider had checked that the qualified nurses remained registered with Nursing and Midwifery Council (NMC).

Appropriate arrangements in place for obtaining medicines, checking these on receipt into the service and storing them. We looked through the medication administration records (MAR's) and found medicines had been administered and recorded correctly. Adequate stocks of medicines were securely maintained to allow continuity of treatment. All staff who administered medicines had been trained and had completed competency checks to ensure they could safely handle medicines.

Requires Improvement

Is the service effective?

Our findings

The service was rated Inadequate at the last comprehensive inspection in January 2018. The provider had acted, and this rating has changed to requires improvement.

At the inspection in January 2018 we found that the service had been commissioned to provide reablement programmes but we found these were not in place. Set times were in place for morning and afternoon refreshments and if people wanted a drink they had to go to the dining room at these times. People were unable to get refreshments as and when they wanted them. We found that staff operated in ways that reduced people's level of independence.

At the last inspection we found staff had received training in the MCA 2005 and DoLS authorisations but did not apply this to their practices. We found no evidence that staff had completed mental capacity assessments, yet people had been prevented from having access to key codes, see their friends and make decisions about their care. The care records only contained a pre-admission template and therefore following people moving to the service, there was no other document for staff to use to assess their current care needs. This lack of a comprehensive assessment had led staff to using care plans as the assessment tool and meant that numerous care plans were generated.

We wrote to the provider asking them to outline how they would make the necessary improvements. The provider sent us action plans detailing what they would do and by when.

At this inspection we found many of these issues were resolved.

The provider had developed an assessment tool and the staff had used this to review all people's current needs. We found this had improved the amount of information that was available, but gaps remained. We found documentation in the care files that was not contained in the assessment. For instance, one person had recently been extremely unwell following an epileptic seizure and had needed to be nursed in an intensive care unit, but this was not recorded in their assessment. Nor was the fact that they had epilepsy.

People were described in the assessment documents as having learning disabilities and mental health needs but there was no information to verify this or outline what the symptoms of these conditions were. We discussed this with the registered manager and found that it was not the case that people had learning disabilities.
The provider had employed a clinical director to oversee further development of the care records.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. 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 make a particular decision, any made on their behalf must be in their best interests and as least restrictive as possible.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS) authorisations.

In depth and bespoke capacity assessments were carried out for each person using the service. However, people's needs were not always clearly described so it was difficult to determine what condition of the brain or mind affected their ability to consent. Staff referred to one person as having psychosis due to behaviours they had witnessed, which was not in their care plan, when questioned they were unsure if the person had had a mental health assessment and whether they were under the provision of a neuropsychiatrist. They had deemed this person to lack capacity on that basis but without evidence that this was an accurate diagnosis they could not be sure this was the case.

We found the registered manager had worked with staff to encourage them to support people to become more independent. However, this was not embedded and people upstairs were offered drinks at set times. One person asked us if it was 11am so that they could have a cup of tea. People were then asked by staff to come to the kitchen if they wanted a hot drink. We discussed this practice with the registered manager who told us they were working to change the culture at the service. The provider was in the process of fitting kitchens that people could use and the registered manager felt this would assist staff to promote and develop people's independent living skills.

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

Records showed staff had received training in subjects that the provider deemed to be mandatory, such as moving and handling, health and safety, safeguarding and first aid had been updated. However, we found that staff had not be trained in working with people who lived with learning disabilities or mental health needs. This lack of training led to staff misidentifying people's needs. We found that were people had developed cognitive impairments because of an acquired brain injury the staff stated this was a learning disability, which was not true.

Staff did not understand what symptoms people would present if people had mental health needs or what actions they would need to take if people relapsed. This lack of knowledge impacted their ability to appropriately care for people.

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

We found that the nurse was unaware of how many people on the upper floor received an adapted diet. Staff appeared to be familiar with people's eating habits and preferences. On the ground floor, four people ate in the dining room and each person sat by themselves. People weren't encouraged to have meaningful interactions during the dining experience. People who were PEG fed did not go into the dining area and were not encouraged to participate in communal experiences.
Staff had been supported with regular supervisions and appraisals. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff.

We saw that a full refurbishment programme had been commenced but work was still to do to ensure the physical environment was improved.

One person said, "I like the staff and they are good at the job."

We found staff ensured people were appropriately referred to other healthcare professionals. We saw advice had been sought from other health care professionals when needed, such as a dieticians and mental health professionals.

Requires Improvement

Is the service caring?

Our findings

The service was rated Requires Improvement at the last comprehensive inspection in January 2018 and this rating has not changed.

At the last inspection we found that the culture within the service compromised people's dignity and staff did not understand people's diverse needs. Staff had acted in a very paternalistic manner, did not follow equality and diversity polices and adopted overly restrictive practices. We found since then the registered manager had been working with staff to ensure they met people's needs and were respectful. However, we found although some improvements had been made staff still adopted paternalistic behaviour and objectified people. For example, people were moved around the service without being asked and place in front of the television without staffing checking that this was what the person wanted to do.

We spent time observing care practices on both floors. Staff were not always sensitive to people's needs, people who were chair bound were left in communal lounges for long durations of time unaccompanied. Staff also told people where to sit instead of promoting choice and relationships.

We saw that people who used adapted wheelchairs were left in lounges with the television switched on to daytime programmes like Jeremy Kyle. People were not asked if they wanted to watch the programme. In one person's care records it stated that they enjoyed listening to music, but this choice was never offered.

People did not have access or the ability to use the nurse call alarms in these lounges. Staff irregularly entered the lounges. This meant staff could not be aware if people needed support. We discussed technological developments that could assist people call for assistance such as pressure pads linked to the nurse call that could be activated by the person pressing their head on the pad.

The people we spoke with felt they were well cared for and staff treated them with respect. Comments included, "I think the staff are kind and caring", "It's alright here" and, "They are nice."

We did observe respectful and caring practices. For example, a staff member was painting a person's toe nails and spoke to them with kindness throughout. The person also reached out to the staff member for comfort when their medications were going to be administered and the staff member stayed to console them.

We found no information was available in care records to outline people's communication methods. The registered manager told us that some people used word boards to make their needs known but we saw no evidence of this being used in practice.

Staff told us that advocacy services were available. An advocate is a person who works with people or a group of people who may need support and encouragement to exercise their rights. However, we found no information to show who had access to these services. One person had been living in the service for over 18 years and was able to lead a fairly-independent lifestyle. From discussions with this person we found that

staff had never spoken with them regarding a step-down service or the possibility of supported living. An advocate had not been involved in their care.

Requires Improvement

Is the service responsive?

Our findings

The service was rated Requires Improvement at the last comprehensive inspection and this rating has not changed.

At the January 2018 inspection, we found that the care records were inaccurate and did not clearly detail people's current needs. We found that staff had not always acted to follow up changes in people's condition, for instance, staff had not made referrals to dietitians when needed. We found that the staff had not been bringing people's concerns to the attention of the then registered manager. We heard how the previous registered manager had undermined staff and made them reluctant to raise any concerns or issues.

We wrote to the provider asking them to outline how they would make the necessary improvements. The provider sent us action plans detailing what they would do and by when.

At this inspection we found that the provider had introduced care record templates. Staff had now completed these in detail and ensured people's needs were outlined. We found these had improved the level of information available. However, we still found some were inaccurate. For instance, one person's care records stated they had 'profound learning disabilities' which they did not and other care records stated people had mental health conditions but not what these were. No care plans were in place to support staff work with these people or people who had epilepsy.

Also, staff put information into care records that could not be verified and was presumptive. For example, in one person's file it made statements about commitments to celibacy that were not relevant to the care they were receiving. Staff did not act to support people's religious beliefs. In one person's 'end of life' care plan it stated they had been a Mormon preacher and would like a preacher to see them when they neared the end of their life. There was no information about where the local Mormon church was or who to contact. Also, staff had not established if the person had been practicing as a Mormon before they became unwell and if they would like to continue going to their local church.

We also found at times the information in the care records was inaccurate. For example, one person had documents stating they had capacity to consent to receiving medicines. However, these were given in yoghurt and staff had not considered this may mean they were given covertly. No information was available to show how staff made the person aware of what medicine they had.

We queried how the registered manager could be assured that records were accurate when were some were not. They told us that regular audits were completed, and these would pick up issues. However, the recently completed audits had not identified these problems.

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

We found that when accidents occurred such as people experiencing repeated falls the registered manager

had completed detailed incident analysis to determine why. This meant action could be taken to reduce the risk of incidents reoccurring.

We found the provider and registered manager had held several meetings with people and relatives. During these meetings they had asked people to share all concerns they had. We found people had raised a number of issues that the registered manager had thoroughly investigated and resolved.

People told us that the activities coordinator was good at their job and there was a range of interesting events happening. People said, "There are things to do." Another person stated, "I really like the activities."

When we visited the activities coordinator was on holiday. We observed that staff completed activities with people on a one-to-one basis such as pamper sessions or playing board games. If people did not join these activities we found there was no items such as newspapers, jigsaws, doll therapy or other such items people could use on the units. For most of the time people were sat in front of the television. The deputy manager told us that the provider was looking to employ another activities coordinator and review the aim of the activity programme.

At the time of our inspection people were receiving end of life care, when this was appropriate. Staff understood the actions they needed to take to ensure pain relief medicines were available. Care records contained evidence of discussions with people about end of life care so that they could be supported to stay at the service if they wished.

Requires Improvement

Is the service well-led?

Our findings

The service was rated Requires Improvement at the last inspection and this rating has not changed.

At the inspection in January 2018 we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which related to safe care and treatment, safeguarding, staffing and good governance. The service had not notified us about DoLS authorisations and other significant events. The provider had not identified these shortfalls and addressed them.

We wrote to the provider asking them to outline how they would make the necessary improvements. The provider sent us action plans detailing what they would do and by when.

At this inspection we found that, although the registered manager had been reviewing the service and making changes not all the issues had been resolved. We again found the quality assurance procedures were not effective. For instance, the tool the provider had supplied for reviewing care records had not picked up that key information such as whether people had epilepsy were missing. Also, the systems had not identified that completing 15-minute checks for everybody was not feasible with the current staffing level or allowed the staff to explore if this was actually needed.

The quality monitoring systems had not picked up variations in the contents of the care records and that some records contained inaccurate information. We found staff needed to ensure appropriate measures were in place when supporting people to take medicines. The system had not picked up that staff were not using equipment to support people to communicate or that the nurse call alarms were not effective. They had not aided staff to consider the practice of removing set times for drinks or consider what technological solutions could be used to assist people to request assistance.

We found staff time was not organised effectively to meet people's needs, for example, the meal-time experience needed improving, the audits had not noted that people were not engaging in communal meal-times or that the PEG prescriptions being kept in people's rooms added unnecessary complexity to the process of supporting people to have their nutritional supplements.

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

Since the last inspection a new registered manager had been appointed. We found in the four months they had worked at the service they started to make changes. They assured us that the provider was committed to ensuring the service operated in line with regulatory requirements and we found that a whole range of resources were being made available to improve the environment, train staff, alter staff practices, bring in new documentation and improve governance at the service. The registered manager had immediately addressed the issues we raised on the first day.

Services that provide health and social care to people are required to inform the CQC of deaths and other

important events that happen in the service in the form of a 'notification'. The registered manager had submitted the required notifications. This meant we could check that appropriate action had been taken.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured the service was delivering safe and effective care. Regulation 12 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not established systems or processes, which operated effectively to ensure compliance with the legal requirements. Regulation 17 (1)

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 Staff had not received the support, training, professional development, supervision and appraisal needed to enable them to carry out the duties they are employed to perform. Regulation 18 (2)