Compleat Care (UK) Limited

Five Bells Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 21 December 2015 and was unannounced.

The service is located in an old building in the centre of the village of Folkingham, Lincolnshire. Accommodation is provided within the main building, in apartments in the garden or in flats adjacent to the home. The home is registered to provide personal care for a maximum of 28 older people or people living with a dementia. There were 22 people living at the home when we inspected.

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not have enough care workers to meet people's needs, infection control processes were inadequate, the environment was not adequately maintained and the provider was not identifying risks to the quality of care people received. You can see what action we told the registered persons to take at the back of the full version of this report.

The provider had completed a staffing tool to identify the staffing levels needed to support people. However, we saw that staff were not always available when needed and at times people had to wait for care. Staff had received training and support to provide safe care to people, however, training was not always implemented into day to day care.

The provider had failed to maintain the building and furniture and equipment to an adequate standard to keep people safe and support their well-being. The infection control processes in the home did not keep people safe from the risk of infection. In addition management audits did not identify where improvements were needed.

Medicines were safely administered; however, records did not always support staff to know what medicines were needed. Staff were kind and caring but at times they focused on the tasks and did not consider the impact on person centred care.

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. This is usually to protect themselves. The registered manager had not fully understood their responsibilities under the MCA and DOLS. Therefore people were not protected from inappropriate care when they could not make decisions for themselves. Where people could make decisions their choices were respected.

The provider had systems in place to keep people safe from harm and to take appropriate action if a person was at risk of harm. Staff knew how to raise concerns and the registered manager responded appropriately when concerns were raised.

People were involved in planning their care to meet their individual needs. However, care plans did not fully record these details. There was a lack of support for people to maintain hobbies and interest and people spent a lot of time watching the television.

Staff told us they were supported by the registered manager and people and their relatives told us the registered manager involved them in the development of the service. However, the registered manager and the provider had failed to identify the concerns we found during our inspection and audits to assess quality were ineffective.

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 consistently safe.

Infection control processes did not keep people safe from the risk of infection.

There were not always enough staff to meet people's needs in a timely manner.

Staff knew how to keep people safe and the registered manager took appropriate action when concerns were raised.

Medication administration records did not always support safe administration of medicines.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The environment and furniture was not maintained to an appropriate standard.

A lack of understanding of the Mental Capacity Act (2005) meant that people's rights were not always protected.

Staff received training and supervision to ensure they had the skills needed to provide safe care. However, at times the training was not always embedded into the day to day care provided to people.

People were supported to maintain a healthy weight and had access to drinks.

Is the service caring?

Requires Improvement

The service was not consistently caring.

At times staff were focused on tasks and did not provide person centred care.

Staff were kind and caring and involved people and their relatives in planning their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans did not support staff to meet people's individual needs with person centred care.

People were not supported to maintain hobbies and interests.

Complaints were not always resolved to support people's choices.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems to identify, assess and monitor the quality of service people received and the risks to people were ineffective.

People were supported to input into the development of the service.

Five Bells Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 21 December 2015 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed other information we held about the provider including information on events they are required to tell us about by law.

During the inspection we spoke with seven people living at the home and two visitors to the home. Some people had problems with their memory and were unable to tell us about their experiences of living at the home. Therefore, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with three care staff, the cook and the registered manager.

We looked at five people's care records. We also looked at the medicine administration charts for people living at the home. We looked at records relating to the management of the home which included staff training, complaints and the quality assurance records.

Requires Improvement

Is the service safe?

Our findings

People told us they were happy with the cleanliness of the home. One person said, "It's spotless. As far as I'm concerned, there's nowhere better." Another person told us, "They do a thorough clean of my flat about once a fortnight."

However, we found infection control processes did not always keep people safe from the risk of infection. There was an odour in some people's bedrooms. In one room the odour was strong and we found that the commode had not been emptied. The registered manager was with us and told us that this should have been completed by the care staff when they had assisted the person to get up. We checked other commodes and saw that some had been cleaned but others had not.

In addition we saw a number of the bed frames were stained with a yellow/brown liquid and one of the pressure mats also had dried urine on it. We found one person's pressure mattress had a hole in the cover and so would not protect the mattress from becoming a source of infection. In addition the provider had not always provided appropriate equipment to help people stay safe from infection. For example, in the upstairs toilet the bin lid had to be lifted off by hand.

The cleaner was off sick when we visited however, we saw that care staff were covering their shift and cleaning was being completed. Staff covering for the cleaner were aware of the infection control processes in place. For example, they knew which colour cloth were used to clean each area. They also knew that there was a cleaning schedule that they needed to work to.

However, we saw that they equipment available to them did not always support infection control. For example, the mop buckets were old and had a build-up of lime scale which increased the risk of infection. In addition, some areas were not cleaned effectively. For example, we saw that light pulls were not cleaned effectively and taps and sinks had lime scale deposits.

The laundry facilities did not support a system to manage the washing to reduce the risk of infection. In addition we saw dirty laundry was left on the floor increasing the risk of cross infection.

We found the cook followed some of the infection control guidelines in the kitchen. For example, they kept records of the fridge and freezer temperatures and ensured that the food was served at temperatures which ensured bacteria was killed. However, we found that they did not work consistently to reduce the risk of infection. For example, we saw they had left a joint of meat defrosting out on the side and some carrots in the fridge had black mould spots.

This was a breach of Regulation 12(2)(h) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 safe care and treatment.

There were not always enough staff to meet people's needs in a timely fashion. Although the registered manager had completed a staffing tool to identify how many staff were needed to meet people's needs they

had not taken into account the lay out of the accommodation with garden apartments and flats which could only be access by going outside of the main building. This meant at times staff were spread out and not available in the location people needed. We found on arrival that the call bells rang continuously for 20 minutes with people requesting assistance.

Staff told us that staffing levels varied from day to day. They also told us it was hard to ensure there were enough staff available if anyone went off on long term sick. They also said that there were meant to be planned activities but that they often got missed and that people were often left in front of the television. We spent time in the lounge and saw there were long periods when no staff member was in the lounge or based there, despite 10 people being in there much of the time. Unless a person was being supported to move or drinks being provided, there was no interaction between staff and people living at the home. Another member of staff told us that at times care was rushed due to the level of staffing.

We saw at times people received poor care due to inadequate staffing levels. For example, we saw one person was walking around looking for a member of staff as they wanted to go to the toilet. Another person had been left at the dining room table after lunch in a wheelchair. They told us that they were cold and wanted to move but there were no staff around to help them. In addition anyone living in the external apartments or flats who needed two care staff to provide care was restricted to receiving their care by the day time staff. One of the people in the apartments would require two staff to support them if needed to move in an emergency and this happened there would be no staff to support people in the main building. This was because there were only two members of staff on duty at night and one had to stay in the main building at all times.

This was a breach of Regulation 18(1) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 staffing.

We found environmental risks had not been identified. For example, the front door to the home was unlocked and there was no obvious reception apart from a signing in book in the passageway which is not visible from the office opposite. Visitors could enter the main building walk around the home unobserved. We discussed this with the registered manager who assured us that the door was locked at night. We saw one person's bathroom light was half pulled away from the ceiling. When we turned the light on the bulb blew. We discussed this with the registered manager who arranged for the maintenance person to look at the fitting. We saw a new fitting was in place before the end of our inspection. We also observed that in some areas of the home carpets were frayed and could be a trip hazard. In addition some of the chairs in the dining room had loose arms which would come away if a person leant on them.

We saw that the building was not maintained to a standard to support people's safety and well-being. The dining room had been extended with a conservatory, but the conservatory was cold and there was a draught which meant that the dining room was not warm enough for some people. Two people complained of feeling cold while waiting for their lunch. A blanket was put around one person and care staff fetched a jumper for the other person.

In one bedroom the door lock was not fitting properly and so there was a cold draft into the room which could present a hazard to the health of an older person. In another bedroom there was a board over the wall near the door. The registered manager explained this was because a previous resident had knocked a hole in the wall. The repair looked unsightly and had not been decorated. We saw other areas where fittings such as sockets had been moved and the area had not been made good.

In people's bathrooms the pull cord was not always long enough which meant that people may not be able

to switch on the light and would be at increased risk of accidents such as falls. In one person's bathroom we saw that there was no toilet seat available. In another bathroom there was no light fitting over the lightbulb. The furniture in people's bedrooms was old and worn. For example, chairs were stained, bedframes had stains on the fabric and bedside furniture was scratched. In addition some of the linen used was not of an acceptable standard with yellow stains.

This was a breach of Regulation 15(1)(e) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 premises and equipment.

Records showed that some risks to people while receiving care were identified and corresponding risk assessments and equipment were in place. For example, where people were at risk of pressure ulcers we saw they were supported to use pressure reducing cushions. However, we also found that at times extra monitoring was in place without the risks being identified in the care plans. For example, we found that a large number of people living at the service had pressure mats within their rooms, but we found little evidence within plans as to why these were necessary.

People living at the service were cared for by staff that were able to respond well to emergencies. For example, in care notes we saw that the correct procedure had been followed when a person was unwell and the right treatment sourced. In addition the provider had access to 24 hours support and advice from healthcare professionals via a video link.

The provider had in place systems to ensure they checked staff had the appropriate skills and qualifications to care for people before offering employment. For example, we saw people had completed application forms and the registered manager carried out two interviews, one of which was a practical interview. Appropriate checks including two references and a disclosure and barring service check were completed before staff started work at the service. This ensured that staff were safe to work with the people who lived at the service.

People told us they were happy with the way the staff managed their medicine. While many people did not know what their tablets were for, they were not unduly worried and trusted the staff. We found that medicines were ordered, stored and disposed of appropriately. We observed a member of staff administering medicines and saw that this was done in a methodical way to reduce the risk of errors. In addition staff were aware that some people needed their medicines at set times for pain and symptom management and to improve the quality of their day.

We found that the Medicine Administration Record (MAR) did not always accurately reflect the prescription on the medicine. For example, one tablet which was prescribed to be taken four times a day was being treated as only needing to be administered if the person showed signs of needed it. Therefore staff were not always supported to administer medicines in line with the prescription. Some medicine was crushed but not clear if advice had been received from GP or pharmacist to see if this affected the way the medicines was absorbed.

When medicine errors had occurred they had been identified and changes introduced to reduce the risk of the same error reoccurring in the future.

People living at the home and their relatives told us they felt safe. One relative said, "I have peace of mind. It's taken a load off our minds knowing he's safe." While a person living at the home said "It's completely safe here."

Staff told us they were happy to raise concerns if they were worried about people. They said that they would initially raise concerns with the registered manager and then if they were not happy with the response they would go to the provider and the Care Quality Commission. However, they were unaware of how to raise concerns with the local safeguarding authority which is the regulatory body with the power to investigate concerns.

Records showed the registered manager had responded appropriately when concerns were raised. For example, we saw that a staff member had raised a concern around catheter care that was a potential safeguarding matter and this was dealt with the same day and staff retraining put in place. The registered manager told us that they kept staff informed of actions taken so they could be confident issues were resolved.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

At the time of our inspection no applications had been made to authorise a DoLS. The registered manager told us they had identified one person who may be at risk of being deprived of their liberty and had spoken to the authorising authority to get advice on how to submit an application. However, during our inspection we identified that more people may have been at risk of being deprived of their liberty as they did not have the ability to make decisions about where they wanted to live. For example, staff told us about one person who was living in the main house but who will try to return to one of the flats as they used to live there. We raised our concerns with the registered manager and identified that they did not have a good understanding of when an application may be needed.

We saw where people had the ability to make a decision their decisions were recorded and respected. Where people were unable to make decisions for themselves the care plans recorded if anyone had the legal powers to make decisions on their behalf. This meant it was clear who was able to give consent for treatment or if a best interest meeting was required. A best interest meeting is where relatives and health and social care professionals discuss and agree what action to take what is in the best interest of the person receiving care.

People told us they were happy with the quality of meals provided for them. One person told us, "It's excellent. Occasionally there's a choice but I just take what they offer. They know my dislikes and will offer me something like quiche instead." While another person said, "I'm on a soft diet as they've had to take lots of my teeth out with the cancer, so I have soup or they puree the meal. I'm well fed."

People told us and we saw that were offered hot and cold drinks on a regular basis. There was only one main meal on offer each day. However, we saw and people told us that the cook knew their likes and dislikes and would offer them something different if they did not like the set menu. Staff offered the potatoes and vegetables to people so they could personalise the meal to their own tastes. However, we saw that this appeared to be a chaotic process and people began to eat their meal before they had been served all their food.

People's ability to maintain a healthy weight was assessed and where people were struggling to do so their

care plan identified that they should follow food first approach before using supplements from the GP. However, staff were unable to tell us what a food first approach looked like. We saw one person who needed full support with their meal had chosen not to eat. A member of staff spent time with the person and encouraged them but respected their decision and made them a cup of tea when they indicated that was what they wanted. We saw later in the afternoon they again encouraged and supported the person to have something to eat.

Where people needed support to eat this was offered, for example, we saw staff offered to cut people's meat up. However, we did notice that some of the cutlery was old and worn and did not support people to be independent. For example, we saw that the knife blades were loose and wobbled in the handle.

People told us they were supported to have regular contact with other health and social care professionals as needed and that a GP would visit them the same day if they were unwell. One relative told us, "[My relative] is automatically in the feet diary for visits. The nurse comes three times a week to dress his leg." Another person said, "They called the doctor straight away when I wasn't well."

Staff employed by the service had a detailed induction to ensure they had the skills needed to care for people safely. Induction and ongoing training was provided by a dedicated trainer who was employed three days per week. Staff on induction also undertook a shadowing period that was initially set at two weeks, though this could be shorter or longer depending on the skills of the individual. In addition new staff were employed on a probationary contract and received regular supervision to monitor their progress. Records showed where the registered manager felt a person needed a longer probationary period this was put in place and monitored in supervision.

Staff told us and records showed that they received regular update training following their induction to refresh and update their skills to ensure they were working to the latest good practice guidance. Staff also explained how they had an annual appraisal and supervision with the registered manager four times a year to discuss their work, any further training requirements and professional development. Records showed us that staff were able to raise any issues and concerns at their supervisions and that these were followed up by the registered manager who reported back to staff so they knew what action had been taken. However, at times staff still lacked the skills needed to provide safe personalised care for people. For example, we saw infection control processes were not always followed and staff were unable to tell us how they supported people at risk of malnutrition.

Requires Improvement

Is the service caring?

Our findings

The people we spoke with were happy that the staff were caring and felt they were treated with dignity and respect. One person told us, "They're very good. They've got a sense of humour. And they don't look down on you." Another person said, "The staff are very nice people, very respectful." While a visitor told us, "They're lovely. So kind and we've never had a problem."

We saw that staff spoke kindly to people and involved them in their care. For example, a staff member asked the person if they needed care before carrying it out, but there was little interaction regarding anything other than care. People using the service told us that they did not get to really talk to the staff as they were always busy.

One person told us they were worried about lunch as no one had been to see if they wanted to go down. We raised this with the care staff who had not been to see if they would prefer to eat in the dining room. The person was fetched for lunch but this was after most people had eaten and other people were escorted to the lounge while the person was still eating. We also saw there were not enough chairs for everyone and the person was requested to sit in a wheelchair even though they were independently mobile. We saw that there were no foot rests on the wheelchair and the person's feet could not touch the floor. They were also they were left for a long while alone at the table after lunch. We saw a visitor spoke with them and they asked the visitor to move them out of as they were in a draft and were cold. This was not a pleasant experience for the person.

We saw care staff encouraged a person to go into the lounge after lunch and as the person was cold they discussed sitting by the radiator with a blanket. We saw they took the person's pressure relieving cushion with them but one care worker threw it down the corridor to another to take into the lounge. This showed a lack of respect for people's property and may cause damage to the cover. In addition it was a risk to other people walking around the home. Once in the lounge the person was offered a choice of where to sit and a blanket as they were cold.

People and their relatives told us that they had been involved in planning their care. One relative told us, "I was involved in [my relative's] care plan when they came and they're good at keeping me informed about [my relative]." Another family member told us, "The caring is very good. I feel involved in [my relative's] care as they give me their ideas and how we can help [my relative]."

People also told us they were free to make decisions about the day to day care they received, that they felt confident in the staff caring for them and that they were supported to be independent where possible. One person told us, "I'm free to get up and do what I like but they'll help if I need it." A relative told us, "They [staff] encourage [my relative] to do what they can… but they help him with his personal hygiene."

We saw that people were supported in their decisions. For example, during lunch one person stood up and went to the lounge, unnoticed. When a carer noticed that the person had gone, they took her dessert and offered it to them in the lounge.

Care plans contained information to support staff to communicate effectively with people. For example, they recorded that a person needed time to think before responding and that choices offered should be simple.

We saw people were not support people to be accurately informed about and time. We saw a clock which had not been altered when British summer time ended six weeks before our inspection.

People's personal information and care plans were kept securely in the staff office and access was limited to authorised people only to ensure people's privacy was not invaded.

Requires Improvement

Is the service responsive?

Our findings

Staff were knowledgeable about people's needs and told us that they would read people's care plans when they had time. However, care plans had minimal information about how care should be personalised to meet people's individual needs and there were often contradictions in information that would make it hard to determine the right care for the person. For example, we saw one care plan stated that a person was self-medicating and then also state that they were not self-medicating.

Senior care staff told us that they reviewed care plans and they did this with the person receiving care or their family if they were unable to make decisions. We saw that they had responded to one person's increase in needs and had agreed with the person and their family that they would move out of their apartment into a room in the main building.

Care plans did not reflect an understanding about person centred care. For example, we saw one care plan recorded that a person called out a lot for no apparent reason. There was no understanding that the person may have a reason, but that staff had just not understood what it was. There was no recording of how they were to support the person when they shouted or what might trigger the shouting.

The registered manager told us that there was no dedicated activities person and that staff were expected to support people with activities, hobbies and interests. However, people and their families told us that there was often not much to do and they spent the time watching television. One person said, "We have people who come in and sing, not very often though. There's nothing planned every day, we just watch television." Another person told us, "There's not too much on. The staff are very motherly so you don't feel like you need organised things. We've got the TV and can chat a bit. I'd like to do more things, but it's pleasing everyone else too, isn't it?"

On the day of our visit, there were no planned activities. The people in the lounge watched the TV. There were no staff in the room interacting with anyone or regularly monitoring people. We saw one person who was a keen artist had space to pursue their hobby and was supported to do so by their family. However, another example showed that a person enjoyed scrabble and the board was observed in their room, but nothing in the care notes indicated staff had played scrabble with this person.

The provider had a complaints process for dealing with any issues. There was only one complaint recorded in the last 12 months. This had been satisfactorily resolved. Information on how to raise a complaint was on the wall in the reception area. However, it was not easy to see and the writing was small which may make the information inaccessible for some people living at the home.

People told us that they were able to raise any concerns they had with any of the staff who supported them. One person said, "I've no grumbles. The manager is ok. I see her around most weeks." Another person told us, "I'd talk to the section leader in the dark blue."

However, we found complaints were not always dealt with in a caring manner. For example, we saw that one

person had said they did not get on with certain care staff, and the response recorded in their care records did not empower this person to uphold their choice, and offered no alternative. This had not been treated as a formal complaint by the provider.

Requires Improvement

Is the service well-led?

Our findings

We saw that the registered manager lacked the knowledge to ensure people were provided with a high quality service. They had not been able to identify that the audits completed to monitor the quality of the service provided to people were at times ineffective. During the inspection we identified a number of concerns in relation to the environment, infection control and ongoing maintenance to the home which put people's safety at risk and meant they received a poor quality service. We saw that an infection control audit had been completed but had not identified the concerns which we found. In addition the registered manager did not have an effective environmental audit in place to ensure the home was maintained to an acceptable standard. When we asked for a list of their planned work the registered manager told us the maintenance person was going to walk around the building the following day to create a list of jobs which needed completing. We saw the audit checklist completed 8 December 2015 incorrectly identified that all furniture was in a good state of repair.
The registered manager did not ensure staff had strong and consistent leadership as they had failed to ensure their own skills were sufficient to recognise and develop a quality service. For example, we saw that the registered manager had failed to understand their legal responsibilities under the Deprivation of Liberty Safeguards (DoLS) and as a consequence people had not been appropriately referred for an assessment. This lack of knowledge was reflected in the staff's approach to the DoLS. One member of staff told us that people did not need DoLS as if they wanted to go for a walk staff would take them out. This showed they had not understood people's rights under the Mental Capacity Act 2005. This meant staff were not inspired to recognise and provide a quality service to people.

We also found that the oversight from the provider also failed to identify that the service provided to people did not meet identified good practice guidelines. The registered manager was new in post and had not been a registered manager previously. They told us that they were supported to develop in their role and could raise issues with the managing director and the provider if they needed support. In addition there were regular weekly meetings with the managing director to discuss the ongoing management of the home. The provider and registered manager had identified that the key challenge at present were the skill levels of staff. However, they had failed to identify issues and develop an effective plan to ensure improvements in infection control and the environment.

This was a breach of Regulation 17(2)(a)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 good governance.

In addition, the provider had failed to notify us about a number of incidents which they were required by law to tell us about. Notifications had not been received by the Care Quality Commission when concerns had been raised about people's safety. We discussed this with the registered manager who said they would ensure notifications were submitted going forwards. We took this information into account when we rated the home.

People told us they were happy with the way the service was run. One relative told us "They're very approachable and listen. I feel involved in [my relative's] care." While a person living at the home said, "I

think it's a good place. My son looked at quite a few before deciding on here."

People told us that they had been supported to input into the development of the service and invited to meetings to discuss elements such as care, food or the environment. One person told us, "I think they're quarterly meetings. They listen to the moans and groans – I'm sure some things happen after." A relative said, "We get a letter and they involve family too." We saw that the registered manager responded to ideas raised. For example, we saw people had suggested having menu's on the table and these were in place.

Staff told us that the registered manager was supportive and worked hard to run the service. One person told us, "[Registered manager] has a good understanding, you can go to her and she knows what to do." Staff at the service felt able to approach the registered manager with issues confident that action would be taken. For example, we saw evidence that as a result of a concern raised extra supervision was put in place for one employee to improve their performance. In addition there were regular staff meetings to update staff on concerns and planned improvements.

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 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 12 HSCA RA Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks of cross infection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider failed to maintain the premises and equipment to an appropriate standard.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to assess the risks to people or the quality of service they received.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure that there were always enough staff to meet people's needs.