Bupa Care Homes Limited

Broadoak Manor Care Home

Inspection report

Mulcrow Close
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Tel: 01744615626

Date of inspection visit:
20 July 2017

Date of publication:
27 September 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection was unannounced and took place on the 20 July 2017. In January 2017 the service re-registered with the CQC and therefore the service had not been inspection under this registration.

Broadoak Manor is registered to provide accommodation and personal care for up to 120 people. The service specialises in providing nursing care to older people living with dementia and physical health needs. The service consists of four houses, three of which provide nursing care, whilst another provides residential care for people living with dementia. At the time of the inspection there were 116 people using the service.

There was a registered manager in post within the service who had been registered since February 2017. 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.

During the inspection we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because audit systems were not always effective at identifying issues within the service. Equipment in two of the units had not been cleaned which placed people at risk of infection. We also identified two staff bathrooms that had been left unlocked and accessible to people, within which water exceeded safe temperatures. This placed people at risk of scalding themselves.

People's care records contained details regarding their sensory needs and in some examples we observed people wearing their glasses and hearing aids as required. However, in one unit one person was unable to locate their glasses. In the same unit there were eight pairs of glasses being stored in the lounge, however staff did not know who these belonged to, and the lenses were scratched and dirty. We have made a recommendation to the registered manager around ensuring people's sensory needs are met consistently.

Activities were available to people. However some people commented that they sometimes felt bored, whilst other people told us there was plenty to keep them occupied. This pointed at a disparity between the provision of activities in the different units. During the inspection we saw examples of activities taking place, and positive social interactions between staff and people. We raised people's comments with the registered manager so that she could look into this.

People received their medication as prescribed. We looked at a sample of medication in two units and found that the quantities being held were correct. Staff signed medication administration records (MARs) as required to show that medication had been administered. Medication was being given in a timely manner, and clear instructions were available for staff on when to administer this.

There were sufficient numbers of staff in place to meet people's needs. We checked staffing rotas and identified that there were consistent numbers of staff in post for each shift. Some people commented that

they sometimes had to wait if they pressed their call bell, however they told us they did not have to wait too long and they received the support they needed.

Recruitment processes were robust and helped ensure staff were of suitable character to work with vulnerable people. Checks were completed prior to new staff being employed to make sure they did not have a criminal history, or were not barred from working with vulnerable people.

Staff had received the appropriate training required for them to carry out their role effectively. For example they had completed training in areas such as moving and handling, dementia and safeguarding. People also commented positively on the support they received from staff, and we observed examples of good practice in their interactions.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. We observed examples of good practice where staff offered people choice, and people told us they did not feel restricted.

People were supported to have an appropriate diet that met their needs. Staff gave people the support they needed during meal times, for example by cutting food up or helping them to eat. The kitchen was well stocked with a variety of produce needed to meet people's nutritional needs.

Staff were kind and caring in their approach towards people. People presented as relaxed in the presence of staff and there was a lot of laughter and discussion. Staff offered reassurance to people where they were at risk of becoming distressed, and acted promptly to relieve any discomfort.

People's privacy and confidentiality was protected. Staff knocked prior to entering people's bedrooms, and ensured that doors were closed whilst helping people attend to their personal care needs. Records containing personal information about people were stored securely, and staff ensured that offices and cabinets containing this information were made secure when not in use.

People each had a personalised care record in place which outlined their needs and how staff should act to support them. These also included details of any risks associated with their needs, and the action that should be taken by staff to mitigate these risks. Personal information relating to people's likes and dislikes was also included, which helped staff to get to know the people they were supporting.

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.

Equipment in two of the units had not been cleaned and was stained and dirty which presented an infection control risk to people.

Staff bathrooms in two of the units were unsecured and the water temperatures in these placed people at risk of scalding themselves.

Staffing levels were sufficient to meet the needs of people using the service.

People received their medication on time and as prescribed.

Is the service effective?

Good

The service was effective.

Staff had received the training they needed to carry out their role effectively.

People's rights and liberties were protected in line with the Mental Capacity Act 2005.

People received a diet that was appropriate to meet their nutritional needs.

People were supported to access health professionals where required.

Is the service caring?

Good

The service was caring.

People's sensory needs were not always adequately met.

Staff were kind and caring in their approach towards people.

Positive relationships had been developed between staff and people using the service.

People's privacy and confidentiality was protected.

Is the service responsive?

Good

The service was responsive.

People's care records were personalised and contained accurate and up-to-date information about their care needs.

Activities were in place to protect people from social isolation; however people in one unit told us they did not always have access to activities. We raised this with the registered manager for her to address.

A complaints procedure was in place and the registered manager had responded promptly to this.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Audit systems had failed to identify issues relating to safety and infection control.

There was a clear management structure in place for staff. Staff were aware of their roles and responsibilities.

Meetings were held with people using the service and their family members so that they could feedback on the service and any issues they may have.

Broadoak Manor 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was unannounced and took place on the 20 July 2017.

The inspection was completed by three adult social care inspectors, a nurse specialist advisor and two experts by experiences who had a background in supporting people living with dementia. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we contacted the local authority safeguarding and quality monitoring teams. They did not raise any serious concerns about the service with us. We also contacted the local Healthwatch service who raised some concerns around communication between the service and people's family members. We followed up on the issues identified during the inspection.

This inspection started at 6am so that we could observed the practice of night-time staff, and ensure that people were being supported out of bed at a reasonable time. This was due to issues relating to the registered provider which have recently been identified.

Before the inspection, we reviewed notifications that the registered provider had sent to us as required by law.

During the inspection 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.

During the inspection we spoke with 17 people who use the service and seven people's family members. We looked at the care records for 10 people. We spoke with five members of staff, the registered manager and the area manager. We looked at the recruitment records for four members of staff. We spoke with two visiting health professionals. We also made observations regarding the interior and exterior of the premises, and looked at records relating to the day-to-date management of the service such as audits.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe within the service. Their comments included, "I feel safe because everyone looks after me", "I feel safe" and "I am not sure I could feel any safer". People's family members also commented positively on people's safety. Their comments included, "I feel confident in general. I've never had a reason to question [my relative's] safety" and, "[My relative] has been safe up to now".

Infection control processes were in place to minimise the risk and spread of infection in some areas but not others. For example, we observed staff wearing personal protective equipment (PPE) prior to carrying out personal care tasks. However in another example we observed staff transporting clinical waste in a wheel chair meant for supporting people to mobilise about the service. We found that wheel chairs and other equipment in two of the units were dirty and had not been cleaned. In the same two units we also identified five crash mattresses by people's beds which were not clean. Crash mattresses are used where people are at risk of falling out of bed, and are placed on the floor to prevent any injuries. We raised these issues with the registered manager who immediately instructed staff to clean equipment and crash mats.

In two of the units the doors to the staff toilets had not been locked and were accessible to people. There were signs placed above the hand basin with warnings of hot water. We tested the water and found it registered at 60 degrees Celsius which is well in excess of safe temperatures. Whilst no one had come to any harm because of this, there remained a potential risk of people scalding themselves. The doors were locked after we raised this with staff. We also raised this with the registered manager so that she could ensure staff kept these locked in the future.

People's views on staffing levels varied, however everyone told us they received the support they needed. Their comments included, "There always seem to be enough staff", "I think there's enough staff, I don't have to wait for help", "Sometimes I have to wait about 15 minutes if staff are busy" and "I have to wait if I press my bell at night". During the inspection visit we observed there were enough staff in post to meet people's needs, and we saw that staff responded promptly to call bells. Staffing rotas showed that staffing levels were consistent over a period of four weeks. This ensured that people's needs were met.

Recruitment processes were robust and helped protect people from the risk of abuse. New staff had been required to provide two references, one of which was from their most recent employer. They had also been subject to a check by the disclosure and barring service (DBS). The DBS provides employers with information about any previous criminal convictions, or if an individual is barred from working with vulnerable people. This helps employers to make decisions about the suitability of prospective staff.

Staff knew where to locate information and guidance about safeguarding people. They were familiar with the process for reporting actual or suspected abuse. Staff knew the different types of abuse and the signs and symptoms of abuse. Staff were confident about reporting any concerns they had about people's safety and they said they would not hesitate to do so.

Accidents and incidents were monitored by unit managers and the registered manager. Where incidents had

occurred or were at risk of occurring, action was taken to prevent issues from happening again. For example, where people were at risk of falling during the night their beds had been repositioned close to the floor and a crash mat had been placed next to them to prevent any injury should they fall out of bed. One person also commented to us that staff were quick to offer their help should they try to mobilise independently due to the risk of falls. This helped protect people from the risk of injury.

Risk assessments were in place to ensure people's safety. For example where people were at risk of falls, this was included in their care records along with information about how to mitigate this risk; by providing two staff during mobility tasks for instance. In other examples where people had health needs which may pose a risk to their wellbeing, for diabetes, this was clearly outlined in their care records along with the symptoms which may indicate deterioration in relation to their wellbeing. Personal emergency evacuation plans (PEEPs) were in place which outlined to staff how people should be supported from the premises in the event of an emergency.

Parts of the environment were monitored to ensure they were safe. Water systems had been checked to ensure they were free from harmful bacteria, and an appropriate risk assessment was in place in relation to this. Fire extinguishers had been checked to ensure they remained in working order. Equipment such as hoists and other electrical equipment had been checked and serviced to ensure they were safe to be used. This helped to protect people from the risk of harm.

We looked at medication processes in two units and found that people received their medication as prescribed. We reviewed a sample of six people's medication and found that the correct quantities were being stored. Medication administration records (MARs) were signed as required by staff to show that medication had been given. Where people were prescribed medication that was to be given 'as required' (PRN), there was a clear protocol in place for staff around when to administer this. In examples where people required their medication to be given at a specific time, such as people living with Parkinson's disease we observed this being administered appropriately by staff.

Good

Is the service effective?

Our findings

People told us that staff were good at their job and provided them with the support they needed. Two people's family members also commented that they felt staff had received the training they needed because they had observed skilled interventions by staff supporting people living with dementia. Other family member's comments included, "I think staff are well trained at what they do" and "Staff know exactly what to do for [my relative], they are very good with them."

Parts of the décor demonstrated that the registered provider had given consideration to people living with dementia. There were memory boxes outside some people's bedrooms which displayed items of significance and meaning to people. These acted to support people with their orientation and finding their way about the building. Communal areas were easily identifiable and some had been decorated by staff which made them distinctive and inviting. This is important as people living with dementia can become confused and disorientated. Using familiar objects and distinctive décor can assist with wayfinding and in turn impact positively upon people's wellbeing.

Staff had received the training they required to carry out their roles effectively. For instance staff had completed training in managing behaviours that challenge, dementia, moving and handling, safeguarding and the Mental Capacity Act 2005. Training was delivered via a mixture of classroom based sessions and e-learning. There was also an induction in place for new staff which included a period of shadowing experienced members of staff. The induction process also met the standards required by the Care Certificate, which is a national set of standards that social care staff are expected to meet.

Staff received supervisions and appraisals on a regular basis. Supervisions enable management to discuss any performance related issues, or identify areas of development that may be required. This also allows staff to discuss any issues they may have and set development goals. New staff received a probationary assessment which looked at their performance and supported management with making decisions regarding their suitability for the role. This helped keep staff accountable for their actions and support with their development.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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 and found that they were. The registered manager was aware of those circumstances where a DoLS would be required, and we observed that these had been put in place where needed.

Staff were aware of their roles and responsibilities in relation to the MCA and we observed examples where they offered people choice and control over their care. One person told us staff encouraged them to choose what clothes to wear during the day, and another told us they were free to choose where they ate their meals. We observed staff offering people a choice of drinks, and at meal times people had a selection of meal options to choose from. We observed people being supported by staff to get up in the mornings and saw that they were free to get up at a time of their choosing. This demonstrated that people's rights and liberties were being upheld.

People were provided with a diet which met their needs. During meal times staff supported those people who required additional support by sitting with them and helping them to eat, or cutting up their food so it was easier for them to eat independently. We also observed staff encouraging people to support themselves; intervening only where it was evident they were struggling. The kitchen was well stocked with a variety of food options including meat, sandwich fillings, tinned food, fresh salad and vegetables. There was a stock of cream and whole milk for those people who required a fortified diet to manage any risk of weight-loss. Kitchen staff were aware of the number of people on each unit who required a special diet. This helped ensure that people received the diet they required.

People told us they were supported their access their GP or other health professionals where they needed help to do so. People's care records contained details of any health assessments carried out by health professionals. During the inspection we spoke with a district nurse and a professional from the local falls team who informed us that the service was proactive in referring people onto them where required. This helped ensure people's health and wellbeing was maintained.

Good

Is the service caring?

Our findings

People told us that they liked staff. Their comments included, "They are all lovely. They are kind I have had no trouble with them. They speak to us nicely and ask us if we want anything or if they can help", "They care about everyone including me" and "Yes they all are very nice and treat me with kindness". One person's family member also told us, "The staff are fantastic, so caring and they all understand [my relative's] needs".

People's care records included information regarding any sensory impairment they may have. One person's family member told us, "They have put a ribbon on [my relative's] zimmer frame so they can find their own. [My relative] is partially blind so they can feel for the ribbon". We observed examples where people were wearing their hearing aids and glasses as required. However in one unit we observed a person asking for their glasses, but staff could not locate these. In the same unit we also found eight pairs of glasses stored in various places about the lounge the lounge. The lenses on these were scratched and dirty and staff did not know who these belonged to.

We recommend that the registered manager look at best practice in relation to ensuring that people's sensory needs are consistently met across the whole of the service.

Staff spoke kindly to the people they supported and we observed examples of positive interactions which demonstrated good relationships had been developed. In one example we overheard a member of staff complimenting a person, telling them, "You look really fine today. I like that top". Throughout the inspection we saw people and staff laughing and chatting together. Staff lowered themselves to eye level, or sat down next to people whilst talking which demonstrated good communication skills. The positive interactions between people and staff generated a relaxed a positive atmosphere throughout the service.

Staff acted to ensure people were comfortable, and minimise any discomfort. For example staff offered to place a pillow behind one person whilst they were sitting down to support their back and make them more comfortable. In another example staff were chatting to one person whilst helping to transfer them using the hoist, which helped to put them at ease. Where staff were helping people to walk, they were kind and patient, walking at the person's own pace so as not to rush them.

People told us that staff respected their privacy and dignity. Two people told us that staff ensured their door was closed and their privacy protected whilst attending to their personal care, whilst two people's family members also commented that staff protected their relative's privacy 'as much as possible'. During the inspection we observed examples where staff knocked prior to entering people's bedrooms, and ensured that bedroom and bathroom doors were closed whilst supporting people with the personal care needs. People's rooms had curtains in place which we observed were drawn whilst personal care tasks were being undertaken.

People's family members commented that they were made to feel welcome when they visited the service. One family member commented, "They always welcome me here" whilst others told us that they were made to feel welcome and offered refreshments by staff. In some of the units family members were free to visit

when they liked, but asked to be sympathetic during meal times. In one unit however we observed a sign which asked family members not to visit during certain times. One family member told us they had been turned away from this unit when trying to visit before work, whist another told us they did not mind the restrictions and worked around them. We raised this with the registered manager who told us she would look into the lack of consistency regarding visiting times.

People's confidentiality was protected. Records containing personal information were stored securely in offices. Staff were conscious to ensure that offices were locked when not in use, and records stored securely away.

People's future wishes had been considered and were recorded in their care records. For example, one person's care record outlined that they would like a family member to be involved in making decisions about their funeral. In other examples people who did not want to be resuscitated in the event of their health declining had the correct paper work stored within their care record so that this was accessible to staff. However, we discussed with the registered manager and clinical lead about making this information more accessible to staff in emergency situations. The registered manager told us they would look at ways to do this.

Good

Is the service responsive?

Our findings

When asked people told us they received the support they needed from staff. Their comments included, "Yes they provide the help needed", "They always give me the right support" and "They do try and help me". People's relatives also told us staff provided the support their relatives needed. Their comments included, "I am happy because they understand [my relative's] needs and they speak to them very gently" and "They know how to deal with dementia".

People had mixed views on the activities that were on offer. People in one unit told us they could play dominos or watch television, but on the whole did not feel there was a lot of options available, telling us they sometimes felt "bored". In another unit however one person told us how they sometimes brought dogs in for people to stroke. In the afternoon we observed staff bringing two puppies in. On another unit, one person's family member commented, "They have had baking and they were making jam tarts. There has been bingo, communion for those that wanted it and music. There seems to be something going on all the time". Whilst another commented, "The atmosphere is lovely. I have no complaints. They have bands and singers at times and sometimes the residents get a little bit of beer and wine on special nights". We raised some of the comments made In relation to activities with the registered manager so that she could ensure people's social needs were consistently met across the whole of the service.

Prior to starting at the service people received an initial assessment to ensure that their needs could be met. This included an analysis of their physical and mental health, mobility and personal care needs. This information was then used to develop long-term care plans which detailed for staff what support needed to be provided to people. This helped ensure that people were appropriately placed and supported within the service.

People's care records contained detailed and accurate information regarding their needs. For example, one person's care record contained details regarding the fragility of their skin, areas of deterioration and how this impacted upon them, i.e. the pain and discomfort caused to them. This person's care records showed that staff were monitoring the person's skin and had alerted the tissue viability nurse to support where they had noted a deterioration. Where people required their food to be administered via a tube directly into their stomach (PEG), a written regime was in place for staff to follow. We also observed an example where a member of staff updated records to show that a person had had a new catheter fitted, using the new label as evidence. This helped ensure relevant information was available for staff to provide the support required.

Care records were personalised and included information about people's likes and dislikes. For example, one person's care record outlined that they liked to sleep with the door ajar. During the morning of our visit we checked and found that staff had left the door slightly open. Another person's care record stated that they liked their nails painted and we observed they had nicely painted nails. Other people's care records contained details about their favourite foods and drinks. This helped staff get to know the people they supported and facilitated the development of positive relationships.

Care records were reviewed on a monthly basis to ensure they contained accurate and up-to-date

information. If changes occurred prior to the review being completed, care records had been updated to reflect this information. This ensured staff had access to the most recent information.

A daily written record was maintained for each person. Staff summarised in daily notes the care and support people received and reported any changes in people's care which needed to be monitored. Where people required their nutrition and fluid intake to be monitored due to a risk of malnutrition or dehydration, this was being completed. However, we identified in relation to this that there was no target fluid intake recorded on charts so staff could be sure that people were having enough to drink. We raised this with the registered manager who told us she would address this. Where people's blood sugars needed monitoring due to their diabetes this was documented, and where there was a risk of high or low blood sugars, increased monitoring was carried out, or support from the relevant health professional sought.

During the inspection we attended the morning handover on each of the four units. This showed that important information was shared with day staff by night staff. This enabled staff on the day shift to follow up on any concerns that were on going from the previous shift. For example, one person had been experiencing issues with their catheter. A member of the nursing staff had re-catheterised the person, but asked the nurse on the next shift to continue monitoring them. We also observed staff demonstrating a good knowledge of people's needs, and sharing their experiences to come up with a plan of action to ensure people's continued well-being. For example staff discussed one person who had presented as quieter than usual. They had taken action to test this person for an infection, and agreed to keep an eye on them through the day. The detailed handover procedures helped ensure that staff were aware of important information regarding people's needs.

There was a complaints procedure in place which was on display in the different units. This was accessible to people and their families should they need to make use of it. Where complaints had been made the registered manager had responded within a timely manner, and appropriate action had been taken in response to the issue. For instance, in one example the issue had been shared with the local authority as required in line with their safeguarding policy and procedure, and appropriate actions taken to rectify the issue had been taken.

Requires Improvement

Is the service well-led?

Our findings

Each unit within the service had a unit manager in post that was responsible for the day-to-day running of that particular unit. Each unit manager was answerable to the registered manager who managed the whole service. The majority of the people we spoke with could not always remember who the manager of their unit was; however people's family members knew who was in charge, and told us managers were approachable and that they would listen to any comments or concerns they had.

The service had a registered manager in post who had been registered with the CQC since February 2017. 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.

There were audit systems in place to monitor the quality of the service being provided however these were not always effective. A walk around was completed by the management team on a daily basis to identify and rectify any issues within the service. However, this process had failed to identify issues relating to the cleanliness of equipment within two of the units. In addition, staff we spoke with stated that they were not clear on whose responsibility it was to clean equipment. This shows that processes were not robust enough to ensure equipment was being maintained to prevent the risk of infection occurring.

During the inspection we identified a build up of eight pairs of glasses in one of the communal areas which were scratched and damaged. This had been identified as an issue during an audit within the unit in question. However action had not yet been taken to return people's glasses to them because staff had not been able to identify who these belonged to. A new process to help minimise the risk of people losing their glasses had not been put in place, as demonstrated through observations of one person who was unable to find their glasses on the day of the inspection. This had the potential to impact upon people's sense of wellbeing, and ability to communicate and interact with others.

In two of the units we identified staff toilets that had been left unlocked and were accessible to people using the service. The water temperatures in these exceeded the maximum safe temperature which placed people at potential risk of scalding themselves. This showed that the current process put in place by the registered provider was not sufficient to ensure people were adequately protected from the risk of harm. We raised these issues with the registered manager who took immediate action to address these concerns.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because audit systems were not always effective.

Accidents and incidents audits had been completed. These included the date, time, location of the falls that had occurred. An analysis had been undertaken to help track any trends or patterns that could be used to prevent these from occurring again in the future. We followed up on incidents that had occurred within the service and found that appropriate action had been taken to keep people safe.

The registered provider quality monitoring systems required the registered manager to input information regarding areas such as outbreaks of infection and accidents and incidents into the system. This enabled the registered provider to monitor these events and ensure that appropriate action was taken in a timely manner. The area manager also completed a monthly visit to the service to ensure that the quality of the service was being maintained.

There were clear management structures in place within the service. In a majority of examples management provided clear direction to staff about their roles and responsibilities at the beginning of each shift. For example during the morning handover (H – Unit) staff were reminded of their responsibilities to ensure people's safety and to report to the unit manager any concerns they had about people's health, safety and wellbeing so that appropriate action could be taken. As mentioned above however, staff told us they were not clear whose responsibility it was to ensure equipment was kept clean.

Team meetings were held on a regular basis which senior members of staff usually attended before cascading relevant information to all staff. Meetings were used to discuss areas of importance or learning that needed to be shared, for example lessons learnt from safeguarding incidents. This ensured that staff were kept up-to-date on developments within the service.

Meetings were held with people using the service and their family members on a regular basis. This gave people the opportunity to raise any issues, or hold discussions regarding any improvements with the registered manager. For example in one meeting some family members had raised concerns about staff being on their mobile phones whilst at work. Records showed that unit managers had subsequently raised this with staff as an area of practice to address. People had also been asked about the quality of the food being provided, and had given positive feedback. This showed that the registered provider had systems in place to gather feedback and had taken action to address any issues raised.

The registered provider is required by law to notify the CQC of specific events that occur within the service. Prior to the inspection we reviewed information that had been sent by the registered manager, and found that we were being notified as required. This showed that the registered provider was complying with the law.

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 17 HSCA RA Regulations 2014 Good governance Audit systems had failed to identify issues relating to infection control and the safety of the environment.