At Home in the Community Limited

Hallgate

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Hallgate is a care home situated in Hexham, Northumberland which provides personal care and support for up to five people with learning and physical disabilities. At the time of our inspection there were five people in receipt of care from the service. Our last inspection of this service took place in April 2014 when we found the provider was meeting all of the five regulations assessed at that time.

The inspection took place on 4 and 8 December 2015 and was unannounced.

There was a manager in post but they had not registered with the Care Quality Commission (CQC). The manager told us this was because the previous manager, who left the service early in 2015, had not formally deregistered themselves with CQC and they were waiting for this to happen first. A registered manager is a person who has registered with the CQC 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.

People appeared comfortable in the presence of staff and we saw they enjoyed good positive relationships. Safeguarding procedures were in place to protect people from abuse and there were channels via which staff could raise concerns.

People's needs and the risks that they were exposed to in their daily lives had been assessed, and these were regularly reviewed to help ensure that people remained safe. Regular health and safety checks were carried out on the building and aspects of care delivery, to ensure that people, staff and visitors remained safe. Emergency and business continuity plans were in place to give staff guidance about what they should do in the event of any unforeseen circumstances.

Medicines were managed safely with appropriate systems in place in respect of the administration, storage, ordering, disposal and handling of medicines. Recruitment processes were thorough and included checks to ensure that staff employed were of good character and suitable for the role to which they would be employed.

We identified concerns in respect of staff training which had fallen behind, or had not been delivered in key areas such as safeguarding. In addition, staff had not been provided with training specific to the needs of people that they supported.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. MCA is a law that protects and supports people who do not have ability to make their own decisions and to ensure decisions are made in their 'best interests' and it also ensures that unlawful restrictions are not placed on people in care homes and hospitals. The manager told us that no applications had been made to the local authority safeguarding team to assess whether people living at the home needed deprivation of liberty

safeguards to be put in place. The 'best interest' decision process was followed in practice, but these decisions were not always fully documented within people's care records. The manager gave their assurances that records held in relation to this would be improved. This meant the provider was not adhering to their responsibilities under the MCA 2005.

People's general healthcare needs were met and where there had been any concerns about their care, or a change in their needs, external healthcare support had been sought. People's care plans and risk assessments had been regularly reviewed and where necessary, amended accordingly. People's nutritional and hydration needs were met.

Our observations confirmed people experienced care and support that protected their privacy, dignity and staff promoted people's independence. Staff displayed caring and compassionate attitudes towards people and they enjoyed good relationships. Individualised care records were available for staff to follow and they were very aware of people's diverse needs and how to deliver effective, personalised care. People enjoyed regular activities within their daily lives and they were supported to enter the community safely.

Systems were in place to monitor the service provided and care delivered, although we found that these were not always effective in identifying shortfalls, such as those related to the application of the MCA 2005 and staff training. In addition, the management of the service had not been appropriately addressed in line with the requirements of Regulation 5 of the Care Quality Commission (Registration) Regulations 2009, in that the provider had not ensured that a suitable 'registered person' had formally registered themselves with CQC as the registered manager of this service. This matter is being followed up separately with the provider, outside of the inspection process.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 related to staffing, safeguarding service users from abuse or improper treatment and good governance. You can find the action we told the provider to take at the back of the full version of this 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?

Good

The service was safe.

Staffing levels ensured that people's social and personal care needs were met

Medicines were managed appropriately information and guidance was available to staff for them to support people with their medicines safely

Risks to both people and the environment within the home were appropriately assessed and managed. Accidents and incidents were monitored and measures put in place to prevent repeat events. Recruitment procedures were robust.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not receive training in key areas and in those areas relevant to the needs of the people that they supported.

The provider did not meet their responsibilities under the Mental Capacity Act 2005 (MCA).

People's needs were met and they were supported appropriately with nutrition and hydration. People were supported to maintain their general health and wellbeing and external healthcare professionals had input into people's care.

Is the service caring?

Good

The service was caring.

Staff and people enjoyed positive relationships with one another.

People were involved in their care and their privacy, dignity and independence was promoted.

Information was communicated to people in a pictorial format that met their needs and confidentiality within the service was maintained.

Is the service responsive?

Good

The service was responsive.

People received care that was appropriate to their needs and this care changed as their needs varied.

Care records were individualised and very detailed providing staff with the information they needed to support people appropriately.

People lived life to the full, attending day care centres and pursuing activities of their own choice.

Is the service well-led?

Requires Improvement

The service was not well-led.

There was a manager in post but the provider had not ensured that they had registered with the CQC as a registered person.

Systems were in place to check and monitor the quality of the service delivered, but issues we found at this inspection had not been identified by the provider through these systems.

People living at the home and staff were positive about the manager.

Hallgate

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 4 and 8 December 2015 and was unannounced. The inspection was carried out by one inspector.

A Provider Information Return (PIR) was not requested as part of this inspection, due to changes in the scheduling of our inspection programme. A PIR 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. Prior to our inspection we checked our systems and reviewed notifications that the provider had sent us over the twelve months prior to our inspection. Providers are required by law to notify CQC of deaths and other incidents such as safeguarding matters and issues involving the police. They enable CQC to monitor the service. We also contacted Northumberland safeguarding adult's team and Northumberland contracts team in advance of our inspection to gather their feedback about the service.

We spoke with three people, three people's relatives, the manager of the service and three support workers. We looked at five people's care records plus a range of records related to the operation of the service, including staff recruitment and training files.

Good

Is the service safe?

Our findings

People told us they felt safe living at Hallgate and they liked it there. One person said, "I like it here". Another person told us, "The staff are nice". We had no concerns about people's safety or how they were supported by staff when we observed staff caring for people. One relative commented, "I have never been worried about their safety there".

Staffing levels within the service were safe and sufficient to meet people's needs both in terms of their personal care and social needs. The manager told us that there were a small number of staff vacancies and that any gaps in staffing were covered primarily by staff from one of the provider's sister homes, or agency staff if necessary. We saw that staffing levels reflected the number of people within the home and that where people pursued activities within the community staffing levels were increased to support this.

Staff were aware of what constituted a safeguarding incident and how to escalate any concerns about people's care or treatment that they may have. Records showed there had been two safeguarding incidents in the six months prior to our inspection, both of which had been notified to Northumberland Safeguarding Adults team and other relevant parties such as people's families. Neither case progressed into safeguarding procedures. The service dealt with both matters appropriately and in line with their responsibilities to keep people safe. The manager had introduced a safeguarding log in August 2015 which they told us was designed to more readily locate and manage safeguarding information within the service. There was a safeguarding policy in place which gave staff detailed information to follow and guidance about how to report and deal with matters of a safeguarding nature.

Medicines were managed safely and staff followed best practice guidance when supporting people to take their medicines. There were policies and procedures in place for the safe administration, storage, disposal and recording of medicines given, and we saw that these policies were followed in practice. Information was available to staff about different types of medicines for them to refer to where necessary. We cross referenced three people's medicines stocks with their Medicines Administration Records and found that the remaining balances tallied with the medicines recorded as having been administered. Where people had left the home to spend time away with their families we saw that there was a robust system in place to sign medicines out and back into the home. The receiving party took responsibility for supporting the person to take their medicines. There was individualised information about when staff should administer medicines that were prescribed to be taken "as and when required" and also topical medicines such as creams and gels.

Risks that people were exposed to in their daily lives had been appropriately assessed and documentation was in place for staff to refer to about how to manage and mitigate these risks. These risk assessments were regularly reviewed and amended when people's needs changed. Environmental risks within the home had also been addressed. For example, a legionella risk assessment had been carried out and control measures were in place to prevent the development of this bacteria. Utilities and other equipment within the home were serviced regularly and health and safety checks were carried out on a weekly basis.

Emergency planning had been considered and a file was in place for staff to refer to should they need to take steps to protect people's safety in the event of an unforeseen incident. This file contained emergency contact details of management within the service and also local specialised external contractors who could be contacted, for example, if there was an electrical fault within the home. Each person living at the home had a personal emergency evacuation plan (PEEP) in place which detailed the assistance they would need to evacuate the home in an emergency such as a fire. Contact details of people's families and other relevant healthcare professionals had been made available to staff should they need to be located in a hurry. A business continuity plan had been drafted and detailed the actions staff should take in the first 24 and 48 hours and then the coming weeks after an unforeseen incident, such as loss of electricity, heating failure and staff shortages.

Accidents and incidents that occurred within the service, or when people were out and about in the community were recorded, monitored and reviewed. Accident and behavioural trend analysis forms were used to explore further the factors that may have led to an incident. Records showed that action had been taken where necessary to prevent repeat events from occurring, such as amendments being made to people's risk assessments or seeking input into people's care from external healthcare professionals. This showed the provider sought to promote and protect the health and safety of people and staff.

Thorough recruitment procedures were followed when staff were employed. We looked at four staff files and found that appropriate pre-employment checks were carried out including, seeking references from previous employers, Disclosure and Barring Service checks (DBS) and verification of potential staff's identity before they started work. The Disclosure and Barring Service carry out vetting checks on potential employees to ensure that they have not been barred from working with vulnerable adults or children. They also provide information about any criminal convictions that potential employees may have. By carrying out DBS checks the provider was able to establish the suitability of prospective employees for the role to which they would be employed. Application forms were also completed, interviews carried out and formal letters of appointment issued. We found the provider had thorough checks in place which, as much as possible, ensured they recruited staff who were of suitable character to work with vulnerable adults and this in turn protected people's safety and health and welfare.

Requires Improvement

Is the service effective?

Our findings

We reviewed four staff files and the supervision and appraisal support that staff had received. We found that overall, staff received regular supervision and appraisal, although one member of staff had not received an appraisal for over two years. We discussed this with the manager who said this would be addressed. Another member of staff told us they had recently completed their appraisal form, having now worked at the service for over 12 months, and a date was due to be set for a one to one appraisal meeting with their manager to review their performance.

Training records showed that staff had received training in areas such as fire safety and moving and handling, but they lacked formalised training in key areas such as safeguarding. In addition, staff told us they had not received training in areas such as learning disabilities awareness and autism, which were specific to the needs of the people they supported. One staff member's appraisal showed they considered they had dealt with challenging behaviour within the service well and this was an achievement. Records showed staff had not received training in this key area, despite people within the service requiring support with behaviours which may be perceived as challenging. The manager told us that two people who used the service attended Makaton classes to improve their communication skills and that one person used a Makaton application on their piece of technology to communicate at times. Makaton is a language programme which uses signs, symbols and speech to help people communicate. Although Makaton information was available to staff within the home, the provider had not arranged training in Makaton for staff. There were inconsistencies in training and a lack of oversight from the provider meant they had not ensured and satisfied themselves that staff were fully equipped with the correct skills and competencies in order to confidently and correctly support people. Staff told us that although they recognised gaps in their training, they did not believe people's care was affected by this and we saw no evidence that this was the case during our visits to the home. Staff appeared to know people and their needs very well and how to support them appropriately.

People's care records contained detailed information for staff to follow and newer staff told us that where their knowledge was limited, they had learned how to support people from more experienced members of staff who had worked with some of the people living at the home for several years. An induction was in place and although this introduced new staff into the service, it did not ensure they received key training. The manager also told us that the new care certificate was currently being incorporated into the provider's induction programme for the service. We discussed our findings with the manager. They stated that training was currently being reviewed across the organisation and our findings would be incorporated into any on-going discussions, with the aim that a list of key topic areas are identified as essential training for all staff working at this service.

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

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. The 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, in respect of care delivery and whether due consideration had been given to people's levels of capacity in a variety of areas. We found that decisions had been made in people's 'best interests' in line with the MCA. However, written evidence detailing how some individual decisions had been made, and by whom, was not always available. For example, a best interest decision had been made regarding one person's access to some of their own personal items, for their own safety. However, this was not appropriately documented as a best interest decision within the person's care records. We discussed this with the manager who said that records about such decisions would be reviewed immediately and in future, detailed information would be recorded and maintained.

People in receipt of care from the service had not been appropriately assessed in terms of their ability to manage their own finances, although the manager told us that they had been in contact with the commissioning local authority finance department, who were due to visit and assess people in respect of this very soon. We found robust accountability systems were in place for the management of people's finances and there was no evidence of any improper or inappropriate activity. We contacted the commissioning local authority finance team who confirmed that they were due to assess the arrangements in place at the service in respect of the management of people's finances and if necessary they would take steps to ensure that the provider's involvement in people's financial affairs was appropriate.

The manager told us that no-one currently living at the home had a granted DoLS authorisation in place and applications had not been made to the local authority safeguarding team for assessment. The need for these applications to be submitted had not been identified prior to our inspection. This meant that people could potentially have been deprived of their liberty, for example when they were restricted from going out alone.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, 'Safeguarding service users from abuse and improper treatment'.

People told us they were happy with the care they received. One person told us, "They look after me here. I like it and I like the staff". Another person said, "I go out. They help me". Relatives told us they had no doubt that medical attention would be sought for their family member whenever needed. One relative said, "They have been good when X (person) has been ill and had to go to hospital, they have gone with X (person) and stayed there and made sure we were informed. We have no complaints at all". Another relative told us, "The care is excellent. They are good; really, really good". We spoke with a general practitioner who was visiting a person who was ill during the first day that we inspected. They told us, "I have no concerns and I have not noticed anything that worries me when I have come here".

We spoke with one person's care manager who worked within the local authority commissioning team and they commented, "I think the service have been really good. X (person) has developed their skills and become more independent since going to live at the home".

Staff were very knowledgeable about people's care needs and they used such knowledge to provide personalised and effective care and support. Due to the nature of some people's conditions, staff told us they had learned to communicate effectively with people and to interpret their expressions and behaviours to establish their mood or what they were trying to communicate. Staff told us about people's behaviours and some of the challenges they faced and we saw that the information they gave us tallied with detailed information in people's care records.

Records showed that people were supported to attend routine healthcare appointments when required, such as those with an optician or in a specialist hospital setting. There was evidence that where required, people had input into their care from specialist healthcare professionals such as psychiatrists or specialist behavioural teams. This showed the provider supported people to maintain their general health and wellbeing and responded promptly to changes in their care needs.

People were appropriately supported with their nutrition and hydration needs. The manager and staff told us that no people living at the service had any specific dietary requirements although for weight management reasons some people were offered healthy food options. There was a variety of healthy food options available to people, and staff informed us all meals were home-cooked on the premises. Staff told us they consulted people about weekly menu options and that this was flexible with alternative foods being prepared if people did not like or want the meals planned for that day. We saw people enjoyed attractive-looking sandwiches at lunchtime, which they told us they enjoyed.

The premises had been adapted to suit people's needs. For example, the handrail leading upstairs had brightly coloured tape attached to it to draw people's eye and encourage them to use them. Bathrooms had been adapted as and where necessary and equipment was available in these areas to assist people and staff in the delivery of personal care.

Good

Is the service caring?

Our findings

We observed staff were caring and kind to the people they supported and there was a calm atmosphere within the home. Those people who could, told us that they liked the staff team who supported them. One person said, "I like the staff". It was clear that staff and people knew each other well and they were comfortable in each other's presence. We heard respectful conversations between staff and people taking place.

People's relatives told us that they found staff caring. One relative told us "The staff are fantastic. X (person) never goes out looking shabby".

People were well groomed and well presented. They looked happy and well cared for. Staff engaged with people when delivering care and support, and they were not rushed when assisting them. Staff informed people what they were going to do in advance of any interactions with them and people were involved in their care. One staff member said, "Come on X (person) lets go and wipe your nose because it is running". The person happily agreed to this and was led by the hand to their room for privacy and dignity reasons by the staff member. People assisted staff with food preparation in the kitchen area at mealtimes and they were encouraged to do so by staff.

People were involved in their own care via regular meetings with their keyworker who reviewed their needs with them and supported them to set goals that they wanted to achieve in their lives. Documentation across the service was presented in a pictorial format that met people's needs and showed the provider communicated with people appropriately. For example, there was pictorial information for people about how to make a complaint and care plans within their care records contained pictures. Environmental health and safety checks were carried out weekly by people who lived at the home, with support from staff, and the templates that they completed were pictorial. Some people had signed their care plans and other documentation which evidenced their involvement in their care planning and care delivery.

Records and documentation were confidentially stored and staff were discreet when having conversations about people in line with their care. We found that confidentiality was maintained.

People were respected and their dignity and privacy maintained. One person told staff they were going to go for a lie down in their room and the staff member replied, "Ok, that's fine, no problem". We saw staff knocked on people's bedroom doors before entering and waited to be invited in. Staff were mindful of people's dignity and people were encouraged to be independent in a variety of ways. Many people attended activities within the community. If possible, they were encouraged to travel to these sessions independently and this had been risk assessed. One person's care manager told us they had been supported to follow their cultural and religious hobbies.

Equality and diversity was considered and people were supported to meet their diverse needs. For example, one person who lived at the home was supported by staff to fulfil their religious and cultural needs through weekly attendance at a bible study group and local church. The manager told us that where necessary

staffing levels were increased to accommodate people's activities.

The manager told us that nobody using the service at the time of our inspection had an advocate acting on their behalf; other than those family members who were actively involved in their care. Advocates represent the views of people who are unable to express their own wishes, should this be required. The provider explained that they would contact people's care managers to arrange an advocate should they require one in the future, if they had no family members who were both willing and able to support them.

The home was decorated for the festive season with a Christmas tree in the lounge and other seasonal items around the home. One person had been supported by staff to go out shopping in the community for Christmas presents for their family and they were very excited to wrap them with staff.

Good

Is the service responsive?

Our findings

People told us staff would always help them with anything they needed. They made comments such as. "Staff help me all the time" and "I like all of the staff". People told us about the activities they pursued, what they liked and disliked and how they were looking forward to spending time with their families at Christmas. One relative commented, "I have always been happy with the care X (person) receives and X (person) is quite happy living there".

Care was person centred and had been assessed initially at the point that people entered the service. Staff explained that where people could not communicate easily verbally, they had learned to interpret their behaviours and what they meant. Detailed information about certain behaviours people displayed was retained within their care records for staff to refer to. Care records were individualised and written in the first person. They provided the reader with information about the person, including their health and care needs, communication skills, risks that they were exposed to in their daily lives, likes and dislikes, medication needs and goals for the future. Staff were provided with the key information they needed to ensure the care they delivered, was both appropriate and safe. There was evidence that care records were regularly reviewed and updated where necessary.

The service operated a keyworker system where individual staff members were allocated to support different people living at the home. These staff members held the responsibility for ensuring that the person they were keyworker for, received the most appropriate care for their needs and that their care records were reviewed regularly and kept up to date.

Care monitoring tools such as behavioural trend analysis charts, sleep charts, incident charts and seizure logs were in use where required. In addition, the provider carried out monthly health reviews which showed any health appointments that had been attended and any up and coming appointments or health issues that needed to be addressed. This showed the provider closely monitored changes in people's needs and had the ability to promptly adapt care delivery in response to this. Within the staff team a diary was in use to record up and coming appointments and to pass messages between the staff team to ensure continuity of care as much as possible.

Staff promoted choice throughout our inspection and people were offered options around where they spent their time, what they ate for their lunch and whether they went out into the community. People pursued a range of activities. Some people attended local day care activity centres during our visit and one person enjoyed telling us about horse riding sessions and 'Zumba' exercise classes that they attended weekly. People went out shopping for clothing, food and personal items with staff and one person enjoyed telling us about the pantomime that they had seen the previous week in Newcastle Upon Tyne. This showed the provider supported people to pursue activities they liked, which in turn developed their social skills and involvement within the community.

We reviewed how the provider handled complaints received within the service. Records showed there had not been any complaints received by the service within the last 12 months and the manager confirmed this.

There was no historic compliant handling for us to review but we saw the provider had a complaints policy in place, explaining how complaints would be handled and the timescales involved. There was also a pictorial complaints poster on the back of each person's door informing them of how to complain should this be necessary.

The manager told us that the provider issued questionnaires on an annual basis to people and their relatives in order to gather feedback about the service that they delivered. The results of these questionnaires from 2014 showed that people and their relatives gave positive feedback about the service and they were happy with the care and support that they, or their relation received. Relatives comments on these questionnaires included, "Staff at Hallgate are very helpful and X (person) seems very happy with all the staff" and "I think X (person) is happy and I think the care they receive is good".

There was evidence that the service worked well with external healthcare providers and sought to obtain the best outcomes for people. Families and a care manager told us they were kept informed of changes in people's care.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection there was a manager in post who had managed the service for the majority of this year, however, they had not applied to become the registered manager of the service with CQC. We discussed this with the manager who advised that they had been formally recruited to their post from an internal position some time ago and it was their full intention to submit their application as soon as practicable. They said they had not done so as the previous manager, who had left the service in early 2015, had not yet deregistered themselves from the CQC register. We informed the manager of the need to submit their application without delay.

The provider had some good systems in place and was introducing new tools to help them monitor the performance of the service. However, these systems had either not identified the issues that we found at our inspection relating to the application of the MCA 2005 and training, or where they had been identified, they had not been appropriately addressed. People were potentially being deprived of their liberty but no action had been taken to ensure that the provider acted in accordance with their responsibilities under the MCA 2005. Training in key areas such as safeguarding and topics relevant to people's needs had not been undertaken and this had not been addressed. In addition, the management of the service had not been appropriately addressed in line with the requirements of Regulation 5 of the Care Quality Commission (Registration) Regulations 2009, in that the provider had not ensured that a suitable 'registered person' had formally registered themselves with CQC as the registered manager of this service. We are dealing with this matter outside of the inspection process.

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

The manager told us that they submitted monthly returns about each individual living at the home to head office and also a monthly report about service issues such as meetings held, staff hours worked and whether any support was needed. These monthly returns included information such as activities and incidents people had been involved in that month and any behaviours they had displayed. A new operational monthly report had been introduced two months prior to our inspection and this asked the manager for information related to, for example, how many safeguarding incidents there had been in the last month, any changes to staff hours, any challenges and successes that month and general information about how the manager felt the service was performing.

The provider had systems in place to monitor the service including auditing of health and safety within the home and medicines management on a monthly basis. There was no care plan audit in place but care records were reviewed regularly and we found they were relevant and up to date. Individual records about what actions had been taken in response to each accident or incident that occurred at the service were recorded and the manager told us these were sent to head office for review by the provider's compliance team who then made recommendations of any further actions that may be required. The compliance team had recently been established and the manager told us that one of their roles would be to come to the service and carry out an internal audit, which they welcomed.

We received positive feedback from people, their relatives and staff about the manager. People told us they liked the manager and their relatives and healthcare professionals said they felt the manager engaged with them appropriately. One member of staff told us that they felt as if sometimes issues raised were not addressed and feedback from management on such matters was limited. A relative said, "X (manager) has been good" and another relative commented, "X (manager) is excellent, she does seem to get things done; maybe not straight away, but they get done". One person's care manager told us they were kept well informed by the manager of any concerns or issues related to the care of the person they supported.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People who used the service did not have their capacity formally assessed to ensure they were not being inappropriately deprived of their liberty. The service had not followed the Deprivation of Liberty Safeguards. Regulation 13 (5).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People who used the service and others were not protected against the risks of inappropriate or unsafe care because an effective system for monitoring the service was not in place. Regulation 17 (1)(2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People who used the service and others were not protected against the risks of inappropriate or unsafe care because staff were not appropriately supported through appropriate training. Regulation 18 (2)(a)