Mrs Lalitha Samuel

Friars Hall Nursing Home

Inspection report

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Date of inspection visit: 3 June 2015
Date of publication: 27/08/2015

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?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This unannounced inspection took place on 3 June 2015. This was a comprehensive inspection, and looked at the five breaches in regulation found at the last inspection on 27 and 28 November 2014. The service was also inspected on 2 March 2015. That was a follow up inspection to ensure action had been taken on a breach of regulation to ensure people were protected from abuse or the risk of abuse. This breach had been complied with.

Friars Hall Nursing Home provides accommodation and support to older people and those with physical disabilities and dementia. The service is registered to provide accommodation for people who require nursing or personal care, treatment, disease or injury and diagnostics and screening procedures. The home can accommodate a maximum of 54 people. At the time of our visit 35 people were being accommodated.

A new manager had been appointed and CQC had received and were processing their application to become a registered manager. 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.

Summary of findings

Previous breaches were in relation to staffing numbers, medicine management, capacity assessment in line with the Mental Capacity Act, care and treatment that may have been inappropriate or unsafe and effective proactive monitoring of quality assurance. We found at this inspection on 3 June 2015 some improvements had been made.

The service had sufficient staff on duty with the correct qualification and skill to meet people's needs. The provider had systems in place to regularly review staffing levels to ensure changing needs were met. Staff were recruited appropriately, and were appropriately supported in the job roles and given opportunities for training and supervision.

The provider had appropriate systems in place to manage medicines being handled and administered safely.

Risks to people are adequately assessed and the risk reduced where possible. This related to all aspects of care including moving and handling where we had previous concerns. We saw staff respond appropriately to an emergency situation, but these situations would be further made safe by a resuscitation kit being available to trained staff.

People gave their consent before care and treatment was provided and staff had received training in the Mental Capacity Act (MCA) 2005. The MCA ensures that, where people lack capacity to make decisions for themselves, decisions are made in their best interests according to a structured process. People's legal rights may not be comprehensively respected because there was limited understanding and application of one aspect of the MCA. This related to the legal status of Last Powers of Attorney in relation to care and finances.

People experienced a good quality catering that met individual needs. Where people had been identified at risk of malnutrition medical advice was followed and people were seen to put on weight.

Staff were very caring and people were treated respectfully and their dignity was maintained. Relationships were good between staff and the people they were supporting.

We were unable to see that learning from complaints was used to develop and improve the service. A procedure was in place, but records were not available of investigations and responses. This was still being developed by the newly appointed manager.

People were involved in their care planning and were consulted about the service and how they wished to be cared for and spend their day. The new care plan format is being introduced, but as yet to become imbedded along with the regular monthly audits of the plans in place.

Quality assurance measures have been developed in some areas. These could be developed further to gather views, analyse trends and therefore potentially prevent incidences and improve practice. People and staff told us they had confidence in the new management appointed at the service.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Staffing levels were responsive to peoples changing needs. Recruitment of staff was robust.

Staff were trained in safeguarding people from abuse and understood their responsibilities

Risks were assessed and managed well and medicines were administered safely.

Good

Is the service effective?
The service was not always effective.

Training was provided for staff to assist them to carry out their roles. Staff did receive routine supervision and felt supported.

People were asked for their consent before care and support was provided. Many requirements of the MCA had been followed. Staff had received training, but understanding of Lasting Powers of Attorney needed to develop.

The service supported people to eat and drink and also to look after their health.

Requires improvement

Is the service caring?
The service was caring.

We observed good relationships between the staff and the people they were supporting and caring for.

People who used the service, and their relatives, were very positive about the way the staff provided care.

Staff were very caring, compassionate and treated people with respect.

Good

Is the service responsive?
The service was not always responsive.

People were involved in assessing and planning their care.

People's choices and preferences were recorded in their care plans and they were being supported to give feedback about their care.

The service had a complaints procedure in place, but records were not kept of investigations, and outcomes were not yet a lever for improvement.

Requires improvement

Is the service well-led?
The service was not consistently well led.

Requires improvement

Summary of findings

People, their relatives, and staff had started to be involved in developing the service.

Quality assurance systems were in place to monitor the delivery of the service, but could further develop to drive improvements.

Friars Hall Nursing 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 3 June 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. Our expert had expertise in older people and dementia care.

We gathered and reviewed information before the inspection. This included action plans from the provider and statutory notifications. A statutory notification is information about important events which the service is required to send to us by law. We also looked at information we had received from the local authority that included safeguarding referrals.

During this inspection we talked to seven people using the service, two visitors, 13 staff that were care staff, nurses, and support staff, the newly appointed manager, the clinical lead nurse and the provider. We reviewed a variety of documents including four care plans and associated care records, four sets of recruitment records, policies and procedures and other records related to the running of the service.

We observed how care and support was provided to people throughout the day, including during the midday meal on two floors. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Following the inspection we spoke with three health and social care professionals to gather further information about their involvement and experience of the service.

Good

Is the service safe?

Our findings

At our last comprehensive inspection of 27 and 28 November 2014, we were concerned that the registered person did not have suitable arrangements in place to ensure there was sufficient staff to meet people's needs. The provider sent an action plan to us explaining the improvements they were putting in place.

At this inspection people told us there were sufficient staff on duty. Throughout the inspection we saw that people were supported and responded to by adequate numbers of staff in a timely manner that ensured people were not left without support when they required this. We found Friars Hall Nursing home had an arrangement for assessing on a daily basis, the numbers of suitable staff they required to meet people's needs. The manager explained to us that whilst the home does not apply a formula to determine the number of staff necessary, they are vigilant and prepared to use extra staff, from their workforce, according the individual or the collective needs of people. The manager said, "It is the needs of people that we consider to determine how many staff are working." When we spoke with staff they told us the staffing levels were determined by their managers on a daily basis who took into consideration the needs and any changing needs of people. Staff told us they inform their managers of people needs and these are discussed daily to ensure people are provided with adequate levels of staffing.

We observed staff and managers meeting to discuss staffing levels during a brief yet formal meeting. Staff also informed us how they had sometimes been requested to work because people required extra support due to a change in their physical health or anxiety and related behaviour. One member of staff said, "We recently provided additional care for someone who required a carer to be with them at all times of the day". We were shown other examples of when additional staff had been used to provide additional support for other people who were anxious or whose behaviour required monitoring and when there had been staff absences. One person at the service was able to tell us, "The staff are not rushed". We concluded there were sufficient staff on duty.

There were robust recruitment procedures in place and that these had been followed for four members of staff whose records we looked at. Staff had been screened for a satisfactory Disclosure and Barring Service (a criminal records check) check prior to commencing employment and had appropriate registration with health care regulators, such as the Nursing and Midwifery Council. We saw that clear staff disciplinary procedures were in place and evidence that these procedures had been followed where this had been necessary.

At our last comprehensive inspection of 27 and 28 November 2014, we were concerned that there were not suitable arrangements in place to protect people against the associated risks with medicine management. The provider sent an action plan to us explaining the improvements they were putting in place. Friars Hall Nursing home had a written Medicines Policy that included a nominated clinical lead responsible for the management of medicines. Only registered nurses administered medicine and they had been trained in the management and administration of medicines in a care home.

The home had carried out a comprehensive review of medicines in April 2015. This had ensured there was rigorous and safe management of medicines in place. This included a clear protocol for the receipt, storage and disposal and administration of medicines that was in accord with guidelines set by the National Institute for Care and Excellence (NICE). Medication Administration Record (MAR) charts used for the monitored dosage system, blister packs of medicines, showed a consistent and accurate record of medicine's being administrated. We saw that 'as needed', or 'pro re nata' (PRN) medicine was administered according to NICE guidelines and was recorded with clear instructions about the medication and how it should be administered.

We observed that when PRN medicine was being administered, people were asked whether they wanted or required this medicine. Medicine was given in an unhurried and respectful manner that included people allowing them to choose how they would prefer to take their medicine such as with a drink or with some food or not at all. One person said, "I am usually quite happy to take my medication but I like to know what it is and staff tell me about it".

As part of the medicine review, the home had requested that each person's prescribed medicine was reviewed by their GP which had ensured that people were receiving the most appropriate and effective medicine. For example, we found examples where medicine had been changed to more suitable soluble forms, so that people could swallow

Good

Is the service safe?

these more easily, and other examples where medicine had been reduced to reduce risks of potential side effects or the effectiveness of the medicine. We found that the controlled drugs held by the home were stored and managed in accordance with the Misuse of Drugs Act 1971. We noted from records and from observation that nobody was self-administering medicine and there we no instances of medicine being administered covertly. This was confirmed by staff .People's medicines were managed safely.

At our last inspection of 27 and 28 November 2014, we were concerned that there were not suitable arrangements in place to ensure people were as safe as they could be when supporting them with moving and handling transfers using hoists. The provider sent an action plan to us explaining the improvements they were putting in place. We saw that risks had been assessed and actions taken to reduce these risks as much as possible. A relative told us, "As far as I can see [my relative] is safe here and when I see them moving people with the hoist there is always two carers and they always say that they are going to lift them and they talk to them whilst they are doing it". We saw that people's risks associated with their moving and handling, eating and drinking, pressure care, taking their medicines and their likelihood of having a fall had been assessed and were clearly documented in their care plans. Where needed suitable equipment had been purchased. Staff had access to individualised instructions where risk had been identified to enable them to safely support people.

During the inspection we observed an emergency where sufficient numbers of staff responded immediately. We later spoke with staff who were involved in this emergency and one staff member said, "This is something we are prepared for". We fed back to managers and provider that there was not an emergency resuscitation kit for use by trained staff, should this be necessary.

People's rights were protected and their safety upheld as far as was reasonably possible. One person said, "I feel safe here and they help me with anything I want". We spoke with seven staff who each told us they had received training to enable them to safeguard adults from abuse. We found that staff were able to inform us about the aspects that might impinge upon the liberty and safety of any person. All of the seven staff told us how they would report a concern or allegation of harm within the home, as well as to the local authority, should this be necessary. Records confirmed that 32 care and nursing staff out of 34 had received training in safeguarding people. Staff had access to an up to date policy and procedure. The manager was aware of their safeguarding responsibilities and they reported concerns effectively and appropriately.

Requires improvement

Is the service effective?

Our findings

At our previous inspection of 27 and 28 November 2014 we identified a breach of regulation because people's capacity to consent to their care and treatment had not been assessed. The provider sent an action plan to us explaining the improvements they had put in place.

We found at this inspection on 6 June 2015, that the management and care staff demonstrated an understanding of the Mental Capacity Act (MCA) 2005, and the majority of staff had received training in this subject. The MCA ensures that if people do not have the capacity to consent for themselves the appropriate professionals and relatives or legal representatives should be involved to ensure that decisions are taken in people's best interests.

We found that staff understood their roles and responsibilities with regards to the Mental Capacity Act and the potential for any person to be deprived of their liberty and how an application should be made for this if it was necessary. We saw from records that best interest decisions had been put in place for receipt of care and medication. However we did not find a good understanding of Lasting Powers of Attorney. Some care plans implied that relatives had this legal right to control people's finances and legal authority with regards to care and welfare decisions. This was also defined as 'next of kin' in some documents, which is not the same. However, the home could not evidence that they had checked the validity of those who claimed to have obtained lasting power of attorney. This meant that people's legal rights may not have been respected.

We looked to see how the Deprivation of Liberty Safeguards (DoLS) were applied. These safeguards protect the rights of adults by ensuring that if there are restrictions on their freedom of movement and liberty these are assessed by appropriately trained professionals. Documentation in people's care plans showed that where people's liberty was being restricted to protect them from harm or the risk of harm, appropriate requests had been made and authorised by the local authority in accordance with the law.

The staffing make up was a mixture of Nursing and Midwifery Council (NMC) registered nurses including Registered General Nurses and Registered Mental Health Nurse qualified nurses. Staff numbers consisted of seven nurses and care assistants and there were management plans to increase the nursing staff. We found that the home had recently encouraged and supported two overseas staff, who were qualified as nurses in their respective countries of origin to complete adaptation courses. The completion of these adaptation course that are linked to Universities, meant that they could become registered with the NMC and so increase the nursing staff numbers employed by the home.

The induction arrangements were insufficient to provide a comprehensive assessment of learning, and progress of new staff through a formal induction set. We found that new staff received a brief induction that included orientation to the home and the service, and training in mandatory topics, such as Safeguarding and Manual Handling. We spoke to the manager about this and they informed us that this was an area already identified by the home that should be improved and that there were plans to bring about an improvement through a rigorous and comprehensive induction programme.

Training for staff included dementia care and this that had been scheduled for all staff to attend in June 2015. All staff had received training in managing distressed reactions to situations or others, safeguarding adults from the risk of abuse and the Mental Capacity Act and Deprivation of Liberties safeguards (DoLS). Other training that staff had received included Moving and Handling and health and safety and fire prevention. We observed good practice of staff supporting people living with dementia and when moving and handling people. Care staff told us they had not received training in Diabetes although the nurses we spoke with were competent to provide care to people with diabetic related needs and care plans were comprehensive in there detail in monitoring and planning. All of the training was in the process of being reviewed by the manager who told us that a new and comprehensive set of mandatory subjects will be introduced for all staff with immediate effect. Developmental opportunities were encouraged and we found that one nurse had planned to commence an NVQ level 5 award in Management.

There were rigorous arrangements in place for all staff to receive regular, monthly or more frequent, supervision. This supervision was carried out on an individual bases and as a group supervision, where it was considered appropriate by the manager. There were records to show that this supervision had covered topics to ensure staff

Requires improvement

Is the service effective?

understood the best practice that was required of them in specific and several topics. Annual appraisals of staff were in the process of being compiled and at the time of this inspection were due to take place in March 2016.

Our observations throughout the day found that staff offered people choices and respected their decisions. One example was of a care staff reading to a person from a favoured book. After a while the person wanted to walk around and the staff member walked with them and gave options, "Do you want to go into the garden or go in here or there?" the person chose to sit down and she said "Do you want to continue with your story?" They said yes and they returned to the favoured book. This was a positive interaction for someone living with dementia, with the carer showing patience and giving the person choice.

One person told us. "The food is good and I like anything – they just bring it. Tea with biscuits is brought every time." The lunchtime experience for people was varied and we could see that improvements had been made and that more were planned. New tables and glasses had been purchased. We saw some very positive interactions from staff that sat with individuals and encouraged them to eat. We heard staff say, "Can you eat this for me – just a little bit more, Do you want a sandwich instead of this?" In another dining room we observed that some people were stood over whilst being supported to eat. This was not the norm within the service and we could see that practice of staff was developing. People were not always encouraged to be as independent as they could be. Adapted cutlery and plates were not used; napkins, seasonings and juice jugs were not on each table.

We spoke to a health professional linked to nutrition and they told us that the service made appropriate referrals and followed the advice given and therefore people had positive outcomes in respect of gaining weight and keeping nutritionally healthy. These referrals were based upon the service competing nutritional risk assessments that were regularly reviewed. We looked at the types of food provided and found this was appropriate to meet people's needs. We observed the 'soft diet' dinners being plated up and noted they were presented in an appetising way. There was a four week menu. Lunch on the day was an option of Baked Mediterranean Chicken or Broccoli bake. Once a week there was 'Residents choice'. This meant they could have anything they wanted for that meal. We found that where people needed additional supplements, milkshakes, cream shots and fruit shakes were all homemade. Night-time snacks were available for everyone.

People were supported to maintain good health and access healthcare service. People told us that staff supported them with their healthcare needs and worked well with other healthcare professionals. One person said, "The chiropodist comes, but not that often and the Doctor he comes and the Dentist if you want him." Where people had sore skin we saw that care plans on skin integrity had been completed and this had involved the individual and their families. In one case we were unable to see up to date photographic evidence of healing. This was due to pictures having been taken, but not developed from the camera. We were assured that where treatment had begun then skin was generally healing. Also in this one case a referral had been made to skin specialist for further advice. We spoke to a visiting healthcare professional who told us that the service generally worked well with their team and the pharmacist. They had seen improvements within the service but that there was an over reliance on external medical services expertise that needed to be developed further within this nursing home setting. In addition, we were told pain relief for one person at the end of life stage was not as timely as it could have been. The provider had worked in partnership with the GP and the surgery's nurse prescriber who had both attended and contributed to the reviews of people's medication.

Good

Is the service caring?

Our findings

People spoke positively about the staff that cared for them. One person told us, “The carers are caring and different people need different things – I am as happy as I can be here”. Another person said, “The staff are very nice and the girls are helpful”. Another person said, “They are helpful and they don’t get cross with me”. A visitor to the service said, “The residents are safe and the staff are all really nice and very friendly and very nice to them”.

We observed several examples of compassionate care and sensitive responses to people who appeared to be in need of support and encouragement to orientate themselves and to achieve things like opening their doors and reaching for their buzzers and assistance with deciding which clothes to wear.

We saw practical support was offered by staff when two people were seen to be in distress and for another person who had fallen during the inspection. Staff offered assistance with instructions and kindness and checked whether the person was hurt or injured. Following the incident one carer sat with the person stroking their hand and reassuring them, then another carer arrived and said. “Oh I saw your daughter in the shop this morning and she is coming this afternoon with your granddaughter”, to which the ladies face lit up. Both these carers were showing empathy and kindness.

Care plans contained very specific and detailed information and had involved the people receiving the service and their family. Relatives were invited to take part in formal reviews of care. The manager told us that a meeting had been held with relatives and that several matters had been actioned. This was corroborated by what we observed as different areas of the service had been given street addresses to aid people with their orientation. A relative who told us, “We had a resident meeting three months ago, with 12 relatives and two or three residents. We all agreed that the food was fine. They always put a ‘bib’ on my relative but the inference was that they needed more and this was taken on-board”. This showed us that people using the service can express their views and are involved in decisions about their care.

We observed staff talking with people who used the service, they were polite and respectful. Staff were seen to knock on people’s doors before entering, and doors were closed during personal care tasks to protect people’s dignity. People were dressed in clean appropriate clothing and footwear, and where needed glasses were being worn. We saw that ladies had styled hair, manicures and were wearing necklaces. All of which showed people’s individuality were respected and dignity was promoted.

Requires improvement

Is the service responsive?

Our findings

We asked people at the service if they knew how to raise any concerns. They told us they would speak with staff. One person said, "I would speak to the person in charge but I have not had any problems". There were posters in the home informing people and their relatives about raising a concern should abuse be a concern or suspected. We also saw the complaints procedure displayed.

We asked the manager about the complaints procedure and a log of complaints that would show us how the service had responded to and learned from concerns raised. The manager confirmed that a policy was in place, however in relation to learning from complaints, and action taken in response to complaints, there were no records available. They told us there had been no system in place when they had taken up post and that this was still being developed. Although the manager was able to verbally go through the last three complaints received, and was able to tell us what practical responses had been taken to respond and resolve the matter, there were no records to support this. Therefore the provider was unable to demonstrate how they routinely managed, monitored and learned from concerns and complaints.

This demonstrated a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager informed us that care plans had been reviewed and that where concerns had previously been identified then action had been taken. This included a review of risk assessments that informed changes in care plans. A very brief daily team meeting ensured that daily changes to people's health was noted and acted upon where necessary thus ensuring there was a responsive approach to care in place. When we asked one person about their involvement with care plans they said, "Care plan – no not really – how they help me comes up in conversation. I get appropriate care, some do more than they should, some are more friendly, it is pretty good here on the whole". The service was in the process of developing a new care plan format for all people. Care plans were being changed and developed for the better, but all were not completed in the new format.

We examined four care plans and found that initial assessments of people's needs were carried out by the managers. Other professionals were consulted and reports obtained where needed. We saw that specialist equipment identified as needed was in place. Assessments were thorough and formed the basis of a detailed and person centred care plan which people contributed to. We saw that aspects of plans had been shared with relatives. Care plans documented the help and support people required and stated exactly how staff should provide this. An example of this was the development of diabetes passports. These documents contained specific instructions of health care and review. They monitored physical wellbeing and included foot care. An aspect that is needed in diabetes care. Each plan contained details about the person's background and information about their life and people and things that were important to them.

People were supported to follow a variety of interests. The service employed staff who specifically did activities with people. These were advertised upon a board for people to see. Activities listed included: Wild Bird Talk, Strawberry Fayre, Musical sing-along and an Accordion recital. One person told us what was on offer for them, These were "Chair exercises, carol singing, quizzes of various kinds, people in to entertain us in some way – they are encouraging us to think."

On the day of our visit, the activities person was helping a person to celebrate a birthday and cake was being shared around with other people at the service. The hairdresser was visiting and several people were sporting new hair styles. The hairdresser told us, "I have ladies who are regulars but the gents come down for a cut and I fit them in. Having your hair done is like a prescription from the doctor – the feel good factor and a different place for them to come along too." We asked visitors about how their relatives spent their day, One said, "It is good here and she goes down and has her lunch there and she goes out into the gardens. When she got here she realised that she knew some of the other residents." A different relative said, "They try and get those out that can and have a mini bus and take them to a garden centre for afternoon tea. I had a phone call recently when someone came in with animals, a rabbit, snake and an owl".

Requires improvement

Is the service well-led?

Our findings

Our previous inspection of 27 and 28 November 2014 identified a breach of regulation because the provider was failing to continuously assess the quality of the service to drive improvement or identify where lapses had occurred. At this inspection we found improvements had been made.

A new manager had been appointed to the home, and a deputy manager had been appointed as a clinical lead. They had responsibility for aspects of clinical operation within the home and we found they were working in close co-operation with the manager. There were plans in place to develop the structure to have three nurse clinical leads with differing responsibilities. There was a structure of management and the manager had oversight of the nurses and their roles. This arrangement had ensured that there was a shared oversight of the plan to manage the service in matters relating to clinical and personal care.

We understood from staff that the manager operated an open door policy and made time to listen to people and that this had ensured that staff were confident about raising matters and concerns. One member of staff said, "The new manager is lovely and it is nice to be able to go to her". Another said, "She is kind respectful and has good rapport with the clients and she listens to what I have to say". People using the service expressed satisfaction as to how the service was managed. One relative said, "I had reservations last year when my relative came here – the atmosphere was not right and the staff were just doing their jobs. But with the change in manager and deputy manager and second entertainments organiser there is a complete change of atmosphere for the better". Another relative said, "It has changed as the staff interact more with the residents and the general atmosphere is better. There has definitely been a change from last September to now". The manager was visible to people and relatives and staff knew the manager. Staff were positive about the changes and were motivated to follow the leadership within the service.

Three staff informed us that the manager and team leaders made spot checks for the quality of moving and handling that staff were carrying out. Advice had been taken from the local authority in the form of hosting a moving and handling presentation day. We observed that medication administration records were checked as a matter of routine by each successive person administering medication for any error or mistakes caused by other staff. However, there was no system to record this. A recent and comprehensive review of medicines management had been conducted.

We saw a variety of audits completed that included the environment, maintenance and domestic services, including the cleaning schedules for the kitchen. These audits had a clear set of actions and recorded a percentage of compliance to measure improvement the next month it was completed. There was a monthly audit of pressure reliving mattresses to ensure they were safely in place where people had been identified as being at risk.

The manager had created a falls log to have oversight of falls and had developed a prevention strategy to lower the number of falls to people at the service. A new evaluation sheet had been developed to audit care plans on a monthly basis. This had yet to become embedded. We found there was room for improvement to be made to ensure there was a better system in place to inform and drive improvements to ensure care was monitored and good care could be assured.

There was no available evidence of a system in place for measuring feedback from staff or from people who used the service and their relatives about the quality of care or other matters. There was a formal complaints procedure in place but this was not supported by records of complaints and outcomes that showed where possible repeat complaints would not be experienced.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **The registered person had failed to establish and operate an effective and accessible system to receive, record, handle and respond to complaints made by people using the service. Regulation 16 (2)**