Nethercrest Care Centre (Dudley) Limited

Nethercrest Residential Home

Inspection report

Brewster Street,
Netherton
Dudley
West Midlands
DY2 0PH
Tel: 01384212785
Website: www.example.com

Date of inspection visit: 21 and 22 July 2015
Date of publication: 28/10/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection took place on 21 and 22 July 2015 and was unannounced. The provider provides care and accommodation for up to 43 older people who may have dementia. On the day of our inspection there were 37 people living at the home. This is a new legal entity previously under Mimosa Healthcare (13) Limited (in administration) and this is their first inspection.

The registered manager was present during our inspection. 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 and associated Regulations about how the service is run.

Summary of findings

People and their relatives told us they felt the service provided to them was safe and staff knew how to protect them from harm or abuse. We found that improvements were needed to ensure staff understood their role in recognising potential harm or abuse and in protecting people.

Medicines were not consistently administered as prescribed. We found errors in the arrangements for managing people's medicines which had led to some people not having their medicines. The provider had input from other agencies to improve their management of medicines but had not sustained this. Timely action was not evident where people refused their medicines or where stock had run out which could compromise people's health.

People told us there was enough staff but there was also evidence that at times staff were stretched.

Staff had received training to meet people's needs. The provider had recognised further training was needed and had been planned to support the development of the staff team.

We found that improvements were needed to ensure staff had regular supervision and support in order to reflect on their practice and develop their skills. We saw that appropriate pre-employment checks had been carried out for new members of staff.

People told us there was not enough to occupy them. Some pre-planned activities had taken place but the frequency of these was limited. People told us they were bored and relatives commented that regular enjoyable stimulation was needed.

People were not always consulted about their care. Appropriate applications had been made to the supervisory body to restrict some people's liberty and staff were aware of how to support these people in line with the law.

People said that the food they ate at the home was good and that they were able to make choices about what they wanted to eat. Advice had been sought where people needed support with their dietary needs.

We saw that people had positive relationships with the staff who they described as caring and helpful. People's privacy and dignity was respected but improvements were needed to support staff in communicating with people effectively.

People were not actively involved in planning their care and plans lacked personal information about choices, routines and interests although staff had an understanding of these. The review of care plans was not effective and out of date information was not amended so some people had plans that did not reflect their needs.

People knew how to raise complaints. The provider had arrangements in place so that people were listened to.

The leadership of the home had not been effective in sustaining the improvements needed to keep people safe. There had been a high volume of incidents at the home and although the ownership of the home had recently changed and the provider had a programme for improvement, they had not sustained some of the new initiatives recently implemented. Quality assurance audits were undertaken but did not identify some of the issues we found during our inspection.

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?

Requires improvement

The service was not always safe.

Staff had received training about the various forms of abuse that people may experience but had not always recognised or reported this.

A high turnover of staff and sickness levels had impacted on staff capacity to meet people's needs consistently.

Medicines were not always administered safely; checks were not regular enough to ensure people had sufficient supplies or received them as prescribed.

Is the service effective?

Requires improvement

The service was not always effective.

People and their relatives felt their health needs were identified and met appropriately.

Peoples nutritional and hydration needs were met.

Staff were not provided with effective supervision or support to develop their skills and enable them to provide effective care.

Improvements were needed to ensure people's capacity was assessed and the decisions made by them or for them were recorded.

Is the service caring?

Requires improvement

The service was not always caring.

Individual staff demonstrated kindness, respect and compassion but this was not consistent across the staff team.

Not all staff understood the importance of communicating effectively with people who had complex needs.

Is the service responsive?

Requires improvement

The service was not always responsive.

People were not actively involved in planning their care to reflect choices, preferences and wishes.

There was a lack of stimulation and people said they were bored.

People had been supported to express their views and were confident that they could raise any concerns and that they would be dealt with quickly and appropriately.

Summary of findings

Is the service well-led?

The service was not always well led.

There was a lack of an effective management structure.

The monitoring of the quality of the service was not robust to ensure that medicine management was safe.

Staff were not adequately supervised or trained although plans were in place to rectify this.

Requires improvement

Nethercrest Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 21 and 22 July 2015 and was unannounced. The inspection was undertaken by three inspectors and an Expert by Experience who had knowledge of supporting older people. We looked at the information we already had about this provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any safeguarding matters. These are called notifications and help us to plan our inspection.

We contacted other organisations such as the commissioners, Clinical Commissioning Group [CCG] and the safeguarding team for information.

We spoke with 16 people who lived at the home, two relatives, the registered manager, the provider's quality assurance team, a health care professional, five staff, three seniors, the deputy, the registered manager, the activities coordinator and the cook. We looked in detail at the care records for four people, and referred to five other people's care records for specific information. We looked at the medicines management processes and records maintained by the home about staffing, training and monitoring the safety and quality of the service.

Requires improvement

Is the service safe?

Our findings

The provider had notified us of a number of medicine administration errors. We were also informed by the local authority that as a result of repeated medicine errors in the home a pharmacist from the local clinical commissioning group (CCG) had recently undertaken a medicines audit at the home which identified errors. These included omission of doses due to lack of stock, medicine not being given as it was prescribed, and an incident where a person had drank another persons' covert medicine, [Medicine which had been authorised to be hidden in the person's food or drink].

We looked in detail at four people's medicines. We saw staff had not signed records when they should have to show they had given people their medicine. We also saw that medicines on the morning of our inspection had not been signed for two people. These omissions meant we could not be sure people had their medicines when they should. We found the provider's arrangements for ordering medicine were not effective. One person had not received their medicine for three days because the provider did not have any in stock. No action had been taken to ensure a supply of medicine was available for the person which meant they did not receive their medicine as prescribed. A senior staff member told us, "It will be ordered urgently today". We found there was a lack of effective follow up action and consideration of the potential impact on people's health where medicines were refused. For example a person had refused their medicine for three days. The deputy manager told us the person would be referred to the doctor by 'putting them in the doctor's book for the doctor visit to the home'. We saw the doctor was not due for another two days which would mean a five day period before the person would be seen. We reported this to the registered manager for immediate action.

We saw the provider had not maintained safe systems that had been put in place as a result of the support from the CCG. For example daily Medication Administration Records (MAR) audits had become weekly audits and did not include both floors therefore errors we identified had not been picked up. Audits on medicines were too infrequent to be completely effective. A medicine book which had been implemented to aid communication about medicine issues had not been in use for three weeks. Consequently information about the person refusing medicines and out of stock medicine had not been shared or followed up.

Competency checks had not been carried out on all of the senior staff who administered people's medicines which meant people continued to be at risk of errors and omission of their medicines. This is a breach of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulation 12.

One person told us, "They make sure I have my medication and stay with me until I have taken my tablets". Medicines were stored securely including controlled drugs and the controlled drugs register was correctly completed. Supporting information was available for staff to refer to when people were prescribed a medicine to be given 'when necessary or when required' and the nurse was aware of how and when to give these medicines.

People told us that they felt safe living at the home. One person said, "Yes I feel safe because there's staff around day and night". Other people told us they sometimes felt uneasy because of people's behaviour. A person told us, "There's one or two people here I would keep an eye on because they might just hit you". We saw care plans and risk assessments were in place with guidance for staff in how to manage people's behaviour and staff knew what do to support behaviour. However we saw some staff did not implement this guidance, for example a person had no interaction from staff until times they began to show agitation although staff told us they needed to occupy the person to reduce their agitation.

Staff told us and records confirmed that they had received training in safeguarding people from abuse. Staff were able to tell us how they would respond to allegations or incidents and we saw these recent concerns had been reported appropriately. We had received information from the local authority that there had been a number of safeguarding concerns related to poor care and medicine practices that had been reported by visiting healthcare professionals to the home and by people's families. This indicated that despite training staff did not always recognise that acts of omission or neglect place people at risk of harm and as such constitute a safeguarding concern. The registered manager told us that further training was taking place to ensure staff had the skills to keep people safe.

Risks to people had been assessed. For example we saw from the falls records that there had been several recent falls in the home. We spoke with one person who told us that they had had two recent falls. They said, "I am prone to

Requires improvement

Is the service safe?

falls, I used to fall at home I have a history of falling I don't know why". We saw they had been referred to the falls clinic so that risks related to their health condition were acted upon. We saw the person had walking aids to support them and staff we spoke with were aware of the risk and told us how they supported this person.

People had equipment such as pressure relieving mattresses and cushions to support them. We saw staff carried out repositioning interventions regularly throughout the day. People's monitoring records showed us that staff were recording these interventions regularly at the desired frequency to reduce risks to people's skin. We saw one person being supported to stand who told us, "They do this every couple of hours, get me to stand, it's for my blood to flow so I don't get sore". We spoke with a visiting health professional who told that they had no current concerns about the staff's ability to recognise skin blemishes and report these in a timely fashion.

We spoke with some recently recruited staff who confirmed that reference checks and Disclosure and Barring Service (DBS) had been undertaken before they took up post. We reviewed three staff recruitment files and saw the provider's recruitment processes for these staff were safe and that the relevant checks had been completed before staff worked with people. A staff member told us, "I had reference checks, a police check and other forms to complete before I started work". Proof of identity, references, completed application forms were evident in the files we looked at.

People told us that there were enough staff but at times they could be very busy. People said staff always tried hard to meet their needs. One person said, "Because of my disability if I need to go to the toilet I press my call button and they come more or less straight away". Another person said, "I wouldn't complain about the staff because they work hard but some people need more attention and there is not always staff for that".

We saw at times staff were needed to manage people's behaviours which left little time to spend with other people. One staff member said, "We can meet people's immediate needs but there's little time to engage with them". Another staff member told us, "Some people need more time to avoid their frustration building up". A relative we spoke with told us, "I've always found [family member's name] has the support they need, and staff make time to talk to me if I ask. I don't see staff have much time to spend with people and I think they must get very bored". There had been a high level of staff sickness and absence which had impacted on the staff's capacity to provide consistent care. We saw a review of sickness levels and staffing levels was underway to make sure there were sufficient staff to respond to people's needs.

Requires improvement

Is the service effective?

Our findings

People told us they were satisfied with the way staff provided their care. One person said, "Staff know what they are doing so I presume they have been given training to look after us". Another person said, "I think the staff are well trained because they know how to care for me and they know what they are doing".

Some staff had worked at the home a long time and told us their induction included getting to know people and how to meet their needs. However the sickness level and high turnover of staff had caused inconsistencies in how staff delivered people's care. In order to improve the standards the provider showed us they had implemented a new induction process. We saw that staff had been delegated to work alongside more experienced colleagues. Staff files that we looked at held documentary evidence to demonstrate that induction processes were in place. Staff we spoke with told us that they felt better supported and this was improving consistency when delivering people's care.

We saw staff used their training to support people appropriately throughout the day. Staff were able to tell us how they supported people at risk of falling or developing pressure sores and we saw they attended to people on a regular basis to provide pressure relief. We also saw they used hoist equipment safely when assisting people with their mobility. A relative said, "They really looked after [family members name] when they were very poorly it gave me peace of mind". The training records we saw confirmed that staff had been trained in these areas to meet people's needs effectively.

The new provider had a quality assurance team who had reviewed staff training and development needs and an action plan was in place to address these. Staff told us they were positive about the training on offer which included training in managing challenging behaviour which was relevant to supporting some of the people within the home.

All of the staff we spoke with told us supervision was irregular which was confirmed by the records we looked at. One staff member said, "I can't remember when I last had supervision". The registered manager told us that formal supervision had been difficult to sustain because there had been a high turnover of senior staff and it had not been possible to delegate a formal supervisory role to the current senior staff because they had not had the training to do this. We saw evidence that the provider was training seniors to develop the skills to undertake formal supervision of staff, although this had not been implemented at the time of our visit.

We saw that recent competency checks had been carried out and observational supervisions had been implemented although these were in the very early stages. Staff reported a positive impact from the observational supervisions. A senior staff told us, "I think I did about five medicine rounds with the deputy checking me, I was very pleased and well supported".

People told us that they made their own decisions about daily routines such as what time they got up or went to bed or when and where they ate, they said staff always asked them first. One person who lived at the home said, "They will always ask me if I want a shower I can say no". Another person told us, "They'd never do anything without asking first". We observed staff were not consistent in seeking people's consent. For example we saw a staff member gave no explanation to a person before they changed their position to provide pressure relief, another staff member put a clothes protector on a person without asking if they wanted it. In contrast we saw some individual staff fully appreciated the need to explain and seek consent where a person's refusals of support were evident. The staff member told us they would continue to explain to the person what it was they wanted to do and that this approach helped the person to understand and to make their own decisions.

We found the safeguards in place to protect people's important decisions about aspects of their life and care were not consistently recorded. Records showed consent had been inappropriately sought from relatives. Where a person had a do not resuscitate [DNAR] in place there was no clear documentation of their consultation with the GP. Not all of the staff we spoke with were able to demonstrate an understanding of the MCA and we saw from training records they had not all had training in this area. The registered manager showed us that training had been planned to address this shortfall.

The Care Quality Commission monitors activity under the Deprivation of Liberty Safeguards (DoLS). We were told that one person had a DoLS authorisation. We saw that a MCA assessment had been completed and an advocate had

Is the service effective?

been appointed in the absence of active relatives. Staff we spoke with were able to describe what they needed to do to keep the person safe and their care plan contained information about how the person should be cared for. We found staff had sufficient guidance of how this legislation impacted on the care they provided to the person. We saw appropriate referrals had been made to the supervisory body for three other people who might require their liberty to be restricted.

People told us that they enjoyed the meals and we saw they were offered a choice of what to eat. One person told us, “If I don’t like what’s on offer they will provide something else”. Another person said, “I love the food”. We observed that staff practiced in a supportive manner when assisting people with their meals. For example encouragement was given to people to eat their meals at a pace that suited them. Nutritional assessments with clear instructions regarding people’s dietary needs were in place to guide staff with any risk of weight loss or choking. We saw that referrals had been made to the GP and or dietician or speech and language team where a weight loss was identified. The weight records for people at risk had not been kept up to date; these had lapsed by several weeks. Although staff knew how frequently people should be weighed this had not been happening and could compromise how quickly weight loss could be picked up. Monitoring records were maintained to record people’s food and drink intake to help reduce the risk of dehydration or weight loss.

People’s health had included the input of relevant health professionals. Specialist advice from the diabetic nurse, mental health team and the district nursing service had been sought and implemented. A visiting health professional told us they were kept up to date by staff and that staff followed their recommendations. We found there had been a delay in seeking advice from the GP about a person who had been refusing their medication. This could compromise the person’s health.

Requires improvement

Is the service caring?

Our findings

We were told by the people who lived at the home that the staff were caring and helpful. One person told us, "If I was worried or had things on my mind staff would stop and talk to me and help me if they can". A relative told us, "They are very kind and patient with [family member name]". Some of the staff had worked at the home for a long time and told us this had helped to get to know people well and build positive relationships with them. We observed people looked happy in the company of staff because they smiled and chatted with staff.

Staff were able to explain the individual needs of people, their personal preferences and their characters. We saw they used this well in order to build a positive relationship with a person who regularly refused care interventions.

One person told us, "I've been here a long time and I get on really well with the staff, like most places there's the odd one who isn't that good". Staff we spoke with told us it was important to listen to people but some staff did not communicate effectively with people who had complex needs and there were some inconsistencies in the way staff supported people. We saw for example one person getting upset and agitated and staff reacted in different ways. The person had different responses from staff ranging from one not responding to them, whilst another staff actively talked to them and engaged them in a task to distract them. The latter being described as a positive intervention in the person's care plan to manage their agitated behaviour.

We saw that where people required support to express their views about their care an advocate had been appointed in the absence of active relatives. Most of the people we spoke with told us they couldn't remember being involved in planning their own care and did not know what was written in their care plan. Care plans did not evidence people's involvement in planning their care although people told us that staff did ask them on a daily basis and that they had a choice. People told us they had been enabled to express their views at resident meetings in which they had discussed menus, activities and changes to the environment. They said they felt that their views were listened to and acted upon.

People told us that staff respected their privacy and dignity. One person said, "When they support me with my personal care they make sure I have a towel covering me and only help me with the bits I can't manage". Another person told us, "Staff will knock on my door and ask if they can come in". We saw that staff discreetly attended to people's personal care needs; asking them quietly if they needed to use the toilet. We also saw staff prompted people to close toilet doors if they saw they were open when in use which protected people's dignity.

We heard staff refer to people using inappropriate terminology such as 'doubles' and 'singles', which referred to the number of staff needed to carry out a task. This was impersonal and task orientated. We also observed some staff chatting to each other when carrying out care tasks and not engaging with the person they were supporting which did not demonstrate a respectful manner. We were informed that dignity and respect training had been organised and that dignity champions had been identified.

We were told by relatives that staff were respectful when they visited. We heard staff talking with and providing support to visitors about matters of concern to them and updating them about their relatives care. Staff made visitors feel welcome and we observed them being offered refreshments. A person who lived at the home said, "What I do like is that my relatives can come and see me at any time which is good because there is so little to do here".

We saw that staff protected people's modesty when carrying out tasks such as hoisting people and ensured that their clothing was appropriately adjusted to protect their dignity. People had been supported to maintain their appearance and their personal hygiene. A relative told us, "I always find that [Name of family member] is clean and well dressed".

We saw people had made decisions about their care and these had been respected. For example people told us they chose the time they got up, went to bed, whether they stayed in their rooms, or in communal lounges, where they ate and what they ate. This ensured they retained a degree of control over their lives.

Requires improvement

Is the service responsive?

Our findings

People told us that when they first came to live at the home staff had asked them how they wanted to be supported and what they could do for themselves. However they did not feel fully involved in planning their care. A person said, "I don't know anything about my care or if it's written down anywhere but staff know how to look after me". People's care records identified any risks and actions needed to reduce risks but they lacked personal information about choices, routines and interests. The review of care plans was not effective and out of date information was not amended so some people had plans that did not reflect their needs.

Some people expressed dissatisfaction with the lack of interesting things to do, one person said, "I think there could be more things to do as its quiet with nothing to do apart from bingo and stuff like that". When we spoke with staff they were able to tell us about people's individual preferences and things that would make them happy. We saw some of this information was reflected in people's care plans. However we heard from people that they had little opportunity to do the things that mattered to them. For example we saw the interests of a person were recorded but the person told us, "There's never really any staff available to take me out". Other people told us staff were, "Very busy"' and "Nothing ever happens here".

Representatives from the church visited regularly and some people had planned trips out for shopping or lunch. However these opportunities occurred more for those people able to express an interest or wish to go out. We observed that during the day no activities took place until late afternoon when we saw a small group of people taking part in a floor game. Most of the people slept or dozed throughout the day. Staff told us there was a lack of interesting and stimulating things for people to do. There was a designated activities coordinator but the hours available were not effective to provide activities for the numbers and needs of people in the home. Equipment such as art and crafts, bingo, card games was available. An exercise session by an external activities provider took place monthly as did a visiting singer. Relatives we spoke with were concerned that there was a lack of regular stimulation and 'things to look forward to' on a daily basis. One relative saying, "They must be so bored sitting and watching".

We saw that meetings had taken place where people could raise any concerns they had and some action had been taken to make improvements from people's feedback. A range of newspapers, magazines games and other equipment had been purchased. Work was also being undertaken on the garden as a result of people's feedback. We saw a welcoming procedure had been introduced and key workers identified in the information sent/given to new people to improve communication.

A complaints procedure was in place and available in the reception area of the home. There was also an easy-read copy of the procedure available. People said they were aware of the procedure and were confident 'something would be done' if they complained. We saw a clear process was in place for receiving and responding to complaints in a timely manner. The registered manager had used complaints as an opportunity for learning. However there was evidence that staff failed to implement the learning from complaints or show a difference to the way they delivered care as a result of the analysis of complaints. For example there had been a regular theme of repeated medicine errors and incidents of neglect.

Requires improvement

Is the service well-led?

Our findings

People we spoke with said that they felt they could approach the registered manager for anything and relatives confirmed that she had always made time to talk with them about any issues or concerns they had. The provider had sought feedback from people and their relatives through a variety of methods including satisfaction surveys and meetings. One relative said, "There does need to be some improvements but I do like the home". We saw as a result of questionnaires and meetings some improvements had been made such as the new garden area, provision of games and equipment, redecoration of areas and the keyworker welcome packs.

The registered manager managed two homes on the one site. Her office was based at the nursing home location which meant for large parts of her day she was not visible in the residential home. Staff told us they did not think they saw the registered manager enough, one said, "It feels like we don't have a manager here because a lot of the time she's based at the other home". We heard and saw from relatives and people who used the service that they knew who the registered manager was and we saw that she knew people by their first name. One relative said, "Yes, if I need to see her she makes the time and is receptive". A person living at the home said, "We see her most days she says hello and has a chat".

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC) of important events that happen in the home. The registered manager had a system in place to ensure incidents were reported to the CQC which they are required to do by law. This showed that they were aware of their responsibility to notify us so we could check that appropriate action had been taken. Staff knew about and had used the whistleblowing policy where they were concerned about care practices or the conduct of their peers.

The service has a track record of being unable to sustain a positive culture. This was demonstrated by documentary evidence of a high level of staff disciplinary action. This had impacted upon the registered manager's availability to work alongside staff and direct their practice. Additionally staff had not received regular supervision and although staff meetings were regularly arranged not everyone attended. One staff member told us, "I have had no meetings or supervision and don't get feedback about how I am performing". A senior staff told us, "I haven't had a meeting with either the manager or external managers during the course of my induction". Some staff told us staff meetings enabled them to raise issues and discuss service provision. We saw from the minutes of staff meetings that staff had been given the opportunity to contribute to the development of the service. One staff member said, "I think the manager works hard, she knows what is going on, does communicate issues with us and tries to put things right but not all staff are committed and some don't feel supported". Another staff member told us, "We have meetings but when the feedback from outside the home is negative morale can be low; some staff repeat the same mistakes and it looks bad on us, I also think two homes is too much for one manager".

We saw there were similar patterns and trends to the issues emerging within the home which demonstrated although guidance was provided to staff to make changes, these were not being sustained. Systems were in place to identify and minimise risks but the volume of errors occurring meant at times the registered manager's leadership was reactive and the service did not run smoothly.

Not all of the staff understood their roles and responsibilities and supervision was not established in order for staff to reflect on their practice and develop their skills. We were made aware that some staff unrest was evident which was also affecting supervision. There had been a recent review of the management team structure and staff members reported that this was working well. Staff said there was less inconsistency and clearer leadership with having a deputy manager. Seniors told us that there was a clearer understanding between them as to who was accountable for aspects of the day and they felt that this was working well. Staff reported 'communication' was 'better'. Senior staff were becoming more aware of the need to delegate staff and tasks according to people's needs and staff skill and experience. One senior said, "It is better because we are now informing staff who they are working with so accountability is better and there is less of a 'clique culture'.

We saw evidence that where improvements had been identified and steps taken to implement change, this had not been sustained. For example despite an action plan from the local authority clinical commissioning group [CCG] to improve the safe management of people's medicines,

Requires improvement

Is the service well-led?

we identified the same errors were occurring. Likewise where safeguarding incidents had arisen about omissions in people's care the same issues were occurring. The registered manager had systems in place to review people's care and safety. There had been investigations into the contributing causes of incidents and disciplinary action had been taken with staff for poor practice. The volume of continual analysis of shortfalls had impacted on the registered manager's capacity to sustain improvements. The improvement plans to increase people's safety and decrease the likelihood of a repeat occurrence had not been effective. The registered manager said that despite training and disciplinary actions, improvements in the quality of care had been difficult to achieve and the high level of sickness and absence had impacted on this.

Some changes had taken place since the new provider took over in April 2015. The registered manager was supported by a wider management structure that included an operational manager, and a quality assurance team who were also providing staff training. Whilst these initiatives had not been in place long we saw improvements were being made. For example the registered manager was using a management tool to provide the provider and the external quality assurance team with an oversight of how the service was performing. This included information about the number of accidents, falls, safeguarding, complaints and disciplinary action. This ensured there was a clearer line of accountability and the support and resources needed to run the service were more readily available.

We saw that some improvements were planned and some already implemented in order to make changes. For example a full review of staff training had led to a training plan and some staff had commenced this. A supervision structure had been identified and senior staff were being trained to undertake this role. However we also saw examples of where improvements had not been sustained despite guidance to staff, for example in using the daily communication book, hand over sheets and following procedures where people refused medicines and needed the doctor. The weekly audit of medicines had also ceased. The overview of the service had not identified these shortfalls and as such improvements were still needed to ensure risks to people were fully mitigated.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider failed to consistently prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm.