Care Quality Commission

Bupa Care Homes (ANS) Limited

Manley Court Nursing Centre

Inspection report

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Ratings

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

Overall summary

Manley Court provides accommodation and nursing care to up to 85 older people, some of whom had dementia. There were 76 people using the service at the time of this inspection.

This inspection took place on 16 and 17 April 2015 and was unannounced. The last inspection of Manley Court took place on 31 July 2014 where we found that the service was not meeting the regulations relating to the management of medicines and the safety of equipment. We asked the provider to take action to make improvements. They sent us an improvement plan on how they would address the issues and at this inspection we found that the provider had made the required improvements.

The service did not have a registered manager. The manager had submitted an application for registered manager to the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

Staffing levels were not sufficient to adequately meet the needs of people at the service. Staff were not properly supported and supervised to ensure they were effective in their roles.

The manager held regular meetings with staff to update them about the service. We saw that issues staff raised were not always addressed. Staff morale was low. Staff felt that they were not listened to and involved in the running of the service. There was high turnover of staff which was impacting on the morale of staff. People told us that the agency staff did not understand their needs.

People received care and support in a safe way. The service identified risks to people and had appropriate management plans in place to ensure people were as safe as possible. . Medicines were kept securely and people received their medicines as prescribed.

Staff were knowledgeable in recognising the signs of abuse and knew how to report it by following the provider's safeguarding procedures.

The manager understood their responsibility to protect people under the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).Staff had been trained in the Mental Capacity Act 2005 (MCA). People's capacity to make decisions had been assessed and best interests decisions were in place where required. People were not unlawfully deprived of their liberty.

People had their individual needs assessed and their care planned to meet them. People received care that reflected their preferences and choices. Reviews were held to ensure that the care and support people received reflected their current needs.

We observed that people were treated with dignity and respect by the staff. People told us they enjoyed the food provided and their nutrition and hydration needs were met.

Training programmes had been developed to ensure staff had the skills and knowledge to provide care to the people they looked after.

There were a range of activities that took place to keep people occupied. Those who were unable to participate in group activities were able to enjoy one-to-one activities in their rooms.

The service held meetings with people and their relatives to obtain their views about the service and to involve them in the running of the service. The feedback received was acted on.

The manager responded appropriately to complaints about the service. Systems were place to assess, monitor and improve the service to ensure it was of good quality and met people's needs.

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

We have made recommendations in relation to providing a system to control the temperature of the medicine room, about putting effective system in place to support, supervise and appraise staff; and about motivating staff and team building

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?

Some aspects of the service were not safe. Staffing level was insufficient to adequately and safely meet the needs of people.

Staff knew how to recognise signs of abuse and neglect and how to report it. People received their medicines safely as prescribed.

Risks to people were assessed and managed. Recruitment processes were robust and safe.

Requires improvement

Is the service effective?

Some aspects of the service were not effective. Staff were not properly supported and supervised to ensure they were effective in their roles.

The manager was aware of their responsibilities and role within the Mental Capacity Act 2005 and consent was obtained from people obtained before care and support was provided. People were not unlawfully deprived of their liberty.

People had sufficient to eat and drink and enjoyed the meals at the service. People received appropriate support with their health needs.

Requires improvement

Is the service caring?

Some aspects of the service were not always caring. People told us staff were kind and friendly, and treated them with respect. People's preferences in relation to how they wanted to be addressed and how they wanted their care delivered were respected.

People had advanced care plans in place and their relatives and representatives were involved in developing their end of life care.

Good

Is the service responsive?

The service was responsive. People were supported to participate in activities they enjoyed. The views of people and their relatives were sought on how to improve the service and these were acted on.

People received care and support which met their individual needs.

Complaints were managed and responded to appropriately.

Good

Is the service well-led?

The service was not always well-led. Staff told us that they were not listened to and the manager was not approachable and supportive.

There were various systems in place to check the quality of the service provided and actions were put in place to address areas of concerns.

Requires improvement

Manley Court Nursing Centre

Detailed findings

Background to this inspection

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

This inspection took place on 16 and 17 April 2015 and was unannounced. It was carried out by one inspector, a specialist professional advisor 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. The specialist advisor was a registered nurse.

Before the inspection, we reviewed the information we had received about the service which included notifications from the provider about incidents at the service. We also reviewed the improvement plan the provider sent us following our last inspection. We used these to plan the inspection.

During the inspection we spoke with six people using the service and seven relatives and friends. We also spoke with the manager and 11 staff including registered nurses. We looked at 11 care records, medicine administration record charts for the 76 people using the service at the time of our inspection and we did a random medicine audit of seven people. We also reviewed eight staff supervision records, 15 recruitment and other records relating to the management of the service including complaints, quality assurance reports and health and safety records.

We undertook general observations of how people were treated by staff and how they received their care and support throughout the service. We used the Short Observational Framework for Inspection (SOFI) during lunchtime. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

After the inspection, we spoke with three healthcare professionals.

Requires improvement

Is the service safe?

Our findings

At our last inspection, we found that the service was not safe. People's medicines were not always handled and managed safely to ensure people were protected against the risks associated with unsafe use of medicines. We also found people were not always protected from the use of unsafe or unsuitable equipment.

At this inspection, we saw that medicines were managed safely. Only nurses administered medicines in the home. Two nurses administered controlled drugs and signed for this. We observed the administration of people's medicines at lunchtime. People were informed of what medicines were being administered to them. The nurses checked the MARs and the medicine packs to ensure medicines were administered correctly. Medicine administration records (MAR) were clearly and accurately completed and appropriate codes were used where required. For example, where people refused their medicines or if they were admitted to hospital, a note was made in the person's daily log to explain the reasons for the refusal and action taken. This showed that people received their medicines in line with their prescription.

Medicines were stored safely and securely. Medicines were kept in a locked trolley stored in a locked room when not in use. All the medicines in the trolleys were within date and in use. Controlled medicines were kept in a secured and locked cabinet. Unused medicines were collected by specialist contractors for safe disposal and records were maintained for this.

Medicine audits were completed twice daily to ensure all medicines were managed safely. We reviewed the completed audits and it showed that for medicines in and out of the home were accounted for. We also conducted random audits for seven people's medicines and found that the medicines supplied and administered totalled with the balance in stock.

Medicines which required storage in a temperature controlled environment were kept in a fridge and the temperature monitored daily to ensure they were stored at the correct temperature. The temperature of the medicine room was checked twice daily and record maintained for this. We noted that the temperature for the ground floor medicine room was at 25.5 degrees at 3pm on the day of our inspection which was higher than the recommended temperature of 25 degrees. We discussed this with the nurses and they turned on the fans in the room to bring the temperature to the required level. We also discussed it with the registered manager and they told us they were in the process getting air conditioners installed in all the medicine rooms.

We recommend that an effective temperature control system is put in place in all the medicine rooms to ensure medicines were kept within the required temperature.

People were protected from the use of unsafe or unsuitable equipment. We found that equipment used for the treatment, care and support of people, such as hoists and profiling beds were regularly serviced and maintained. We also saw that equipment such as syringes, needles, nebulisers, plasters in the treatment/medicine rooms were within dates and were regularly checked to ensure they were safe to use.

There were not always sufficient staff on duty to meet people's needs. People told us that staff did not always respond to their call for help quickly. They said that it took staff 10 minutes to respond to the call bell but sometimes it took an hour. One person commented that, "Sometimes they're short of staff." The person explained that they liked to get up at 8 o'clock, but at least three times a week they don't get attended to until 11am. Another person told us, "There aren't enough carers and especially nurses". A third person said, "[Staff] are always in a hurry." A fourth person told us, "I don't always find staff to help me when I need help." All the staff we spoke with told us that they were not enough of them to meet people's needs.

One member of staff said "We are not coping with the level of work, attending to care, documentation, peg feeds, insulin dependent patients and patients with dementia. The residents are at risk." Another member of staff said "It is not possible to provide good care with the number of nurses on duty." And a third staff said "The risks to residents are high. We are not able to take care of them in the way it should be done. It makes me feel bad."

On the morning of our inspection at 11.30am, there were two care staff in the lounge with four people in one unit. After lunchtime, we observed in one unit three people shouting out loud from their rooms. The nurse in charge of the unit was with a professional but had to leave to attend to one of the people shouting and we also had to go look

Requires improvement

Is the service safe?

for a staff member to attend to the people. There were people wandering around seeking attention but no staff were visible. We were concerned that staff were not available to respond to people's needs promptly.

The professionals we spoke with commented that the nurses were very busy and sometimes they do not have time to accompany them to see the people and to feedback to them. We saw that records were not always up to date and information that needed follow up was not completed. For example, we saw that one person's care plans were not updated to reflect their current circumstances in relation to the Deprivation of Liberty Safeguards authorisation in place. Nurses commented that they struggled with their workload and only manage to complete day-to-to tasks. Staff also complained about the high dependency on agency staff. They commented that they were not always familiar with the service and with the people. Staff said that this added pressure on them as they often needed to depend on the permanent staff for guidance. The professionals we spoke with confirmed this and stated that some of the agency staff do not know the needs of the people they cared for.

We checked the staff rota and this reflected the number of staff on duty on the day of our inspection. The night was mainly covered by agency staff. We discussed our findings with the manager and they told us that they told us that they determined staffing levels based on occupancy and dependency levels. However, they said were aware of the issues raised and the provider was in the process of reviewing the staffing levels. We were concerned that there were not enough qualified, skilled and experienced staff to meet people's needs and people may be at risk as a result.

These issues were a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were cared for and supported by staff who were suitably qualified and knowledgeable. Recruitment processes were robust and safe. We checked recruitment records and saw that staff had completed an application form with details of their qualifications and experience. Interviews were conducted to check experience and skills for the job. The provider obtained two appropriate references and a criminal records check. The provider also checked that nurses employed had the appropriate qualifications and their professional registration was up to date.

People were cared for and supported in a way that promoted their health and well-being because the service had put systems in place to ensure that risks to people were identified and managed appropriately. Detailed risk assessments had been carried out for people and this covered issues such as pressure ulcer, falls, mobility, malnutrition, continence care, behaviour and mental well-being. We saw that action plans to manage identified risks were put in place to reduce these risks from occurring. For example, pressure relieving mattresses, body maps and repositioning charts were in place for people at risk of developing pressure ulcers. One person was recently admitted with Grade 4 pressure ulcer and we saw that referral was made to the tissue viability nurse who had provided their expertise on how to manage the pressure ulcers. There was an up to date wound care plan in place which included guidance on the regular dressing of the wound, providing nutritious food and four hourly turning. We saw evidence that staff were following the plan accordingly. People had moving and handling plans in place for staff to follow to safely support them and to reduce the risk of falls. People also had behavioural management plans in place where necessary to enable staff support them manage the risks associated with their behaviour in a safe way.

People were safeguarded from the risk of abuse and neglect. People told us that they were treated well. One relative said "My relative seems to be so much safer….If my [relative] wasn't treated well I would know." The service had a safeguarding policy and procedure in place. Staff showed an understanding of the various forms of abuse, the signs to recognise them in the people they looked after and how to report it in line with the organisation's safeguarding procedures. Staff also knew how to whistle-blow if required. We reviewed the record of recent safeguarding concerns and we saw that the manager had taken appropriate actions in accordance with their procedure. They had conducted investigations into safeguarding issues and, reported them to the local authority safeguarding team and the Care Quality Commission. We saw that the service had involved the local police in one case. This showed that the service took safeguarding concerns seriously and took appropriate steps to protect people.

Requires improvement

Is the service effective?

Our findings

People and their relatives told us that staff knew how to look after them well. One person said, "They look after me alright." A relative said, "They look after my relative very well indeed; they're really good here." Another relative said, "On the whole my relative is looked after well and most of the staff are very good at their jobs. There's one or two who should be told what's expected of them."

However, we found that staff were not adequately supervised and supported. Staff told us they did not feel supported or confident that when they raised issues regarding their work that it will be addressed and resolved by their manager. Staff we spoke with complained about poor morale and motivation, lack of support from their managers, stress due to level of workload and staffing levels. They told us these issues were affecting their effectiveness in their roles. Staff told us that they had raised these concerns with the manager and provider and they had not responded to it. One staff member said "I do not feel safe to work here, no motivation… low staffing levels." Another member of staff said, "I cannot remember when last I had supervision and appraisal."

Staff records we looked at showed that staff had supervision meetings with their line manager regularly. This included group supervision sessions and clinical supervisions. However, we noted that issues raised were not always explored with staff. For example, in two group supervisions, staff had raised concerns regarding communication issues in the service and concerns that they were afraid to write incident reports. There was no evidence that these concerns were discussed with the staff members or followed up. We spoke with the clinical manager and manager about these concerns. They told us they held various meetings with staff to discuss these issues but they were unable to provide us any documented evidence to show how they had addressed the concerns.

We recommend that the system for supervising and appraising staff be reviewed to make it more effective.

Staff told us that they were trained in their roles. Training records showed staff had received training on key topics such as infection control, first aid, safeguarding adults, health and safety, equality and diversity, dementia awareness, communication skills, medicines, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff had also received training in specialist areas such as diet and nutrition, pressure ulcer management, and supporting people with challenging behaviour. All nurses completed mandatory medicine management training. We saw that staff had refresher training as required to ensure their knowledge and skills were up to date. We saw evidence that all new staff had completed a period of induction which covered relevant topics on how to care for older people and people with dementia. They also went through a probationary period where their manager assessed their competency on their skills and knowledge gained in their caring role before confirming them permanently in post.

The service ensured that people gave consent to care and treatment in line with the principles of the Mental Capacity Act (MCA) 2005. Staff had been trained in the MCA and were able to explain how they obtained consent from people before delivering care and support to them. We saw that mental capacity assessment had been carried out in relation to specific decisions where there were doubts about the person's ability to make a decision. We saw evidence where a person had been assessed as lacking capacity, the person's relatives and appropriate professional had been involved to ensure that decisions made were to the person's best interests.

The service ensured that people's rights were respected in line with relevant legislation. At the time of our inspection, there were 12 people on the Deprivation of Liberty Safeguards (DoLS) and records we reviewed confirmed that appropriate processes were followed in relation to this. The manager understood their responsibility in relation to this and was working with the local safeguarding team to ensure that people who lacked mental capacity were not unlawfully deprived of their liberty.

People's nutritional and dietary needs were met. People told us that they liked the food provided to them. A person said, "It's wonderful. If I don't like the food, the chef will do me a big salad with everything." Another person said, "The food is not too bad, the kitchen looks after me." And a third person said, "The food is beautiful, but it has its off days." People's nutritional and dietary needs were assessed using the **Malnutrition Universal Screening Tool** (MUST) and the support they required was noted in their care plans. For example, people who had special dietary requirements such as diabetes, cultural food, pureed food or food

Requires improvement

Is the service effective?

supplements were stated in their care plans. People who needed support with eating and drinking and at risk of malnutrition and dehydration had care plans in place for staff to follow.

We observed lunchtime and saw that people were offered options for their meal from a menu and people could request for something different from what was on the menu where possible. There were staff around to support people with their meals in line with their requirements. We observed that people who stayed in their rooms were also provided with the support they required. People were asked if they were satisfied or wanted additional food. Staff asked people if they had finished before taking their plates away. We observed that people were provided with drinks and snacks throughout the day.

People were supported to access healthcare services they required. We spoke with a GP, podiatrist and a social worker who were providing care to people in the service. They told us that the service had improved in liaising with them to ensure people's healthcare needs were met. However, they commented that following up on information can be sometimes difficult due to the number of agency staff used. Notes of healthcare visits we reviewed showed that recommendations were actioned. For example, pressure ulcers were managed in line with an agreed plan. This showed that people received appropriate intervention to manage their health and well-being.

Good

Is the service caring?

Our findings

There were mixed comments from people and relatives about how they were treated by staff. One person said, "The carers always treat me well, all of them." Another person said, "The carers are OK, but some of them are reluctant to help. They need to help me a bit more." A relative said, "The young carers can be a bit lax at times; the [nurses] are wonderful." Another relative said, "The people are really good and so caring, they bend over backwards."

We observed good interactions between people and staff. Staff spoke to people in a polite and courteous manner. Staff treated people with respect, dignity and understanding. We saw staff provide reassurance to people when they became distressed. Staff sat with them holding their hands and chatting with them until they became relaxed.

Staff communicated with people in the way they understood. For example, speaking so people could understand what they were saying and by keeping eye contact. Another person was spoken to in their language. One relative told us they were pleased of interest staff had taken to learn some words their relative's language so they could communicate with them. They commented that, "The care staff are great."

People's dignity and privacy was respected. We saw that staff knocked on people's room doors and alerted people before they went in. Staff were gentle when carrying out a task and communicated appropriately. For example, we observed a member of staff supporting a person to eat their meal in their room and saw that they were patient and did not rush the person. Staff showed they understood how to respect people's dignity and they demonstrated this in various ways throughout our inspection.

People were supported in the way they wanted. Staff demonstrated they understood the needs of the people they looked after. Care records detailed people's personal histories including their backgrounds, interests, likes and dislikes and how they preferred to be cared for by staff. One member of staff described the cultural needs of one person and told us that this person liked to share their food with people as this was a normal practice from their culture. This was reflected in their care plan and the person's relative confirmed it and told us, "Staff know that they need to sit with my relative to eat. The staff do this without complaining." People received care from staff who understood their needs.

People were involved in decisions about their day-to-day care and support. Staff gave people choices of what they wanted to do and provided them time to decide. People's care records also indicated their choices of their day-to-day care. Staff told us that this could sometimes change, so it was important to always check with them again. We saw staff asked people what they wanted to do. We heard staff ask people after lunch "Do you want to join in activities or what would you like to do?" and they followed the instructions the people gave. Those who could not communicate were supported in line with their care plan. For example, some people were supported to bed to rest. Care records showed that people and relatives had been involved in care planning when people initially moved into the service and where required but they were not always involved when the care plans were updated. One relative said, "I haven't seen [my relative's] care plan." Another relative said, "I haven't been asked recently about the care plan but they follow what I tell them or what my relative needs."

The service provided end of life care to people who were nearing the end of their life. People had advanced care plans which detailed the care and support people wanted as they approached the end of life. This included people's decisions about whether they wished to be resuscitated in an emergency, hospitalisation, use of medicines and their religious requirements. Records showed that people, their relatives and GP had been involved in planning these aspects of their care. People had up-to-date do not attempt cardiopulmonary resuscitation (DNACPR) forms in place which were duly signed by their representatives and GP. Staff we spoke with understood people's care and the choices they had made in relation to their end of life care. The service liaised with palliative care nurses to ensure people's needs were met at this stage.

Good

Is the service responsive?

Our findings

People's care and support were appropriately assessed, planned and delivered in a way that met their individual needs. We saw that pre-admission assessments were carried out before people were admitted into the home. Following the assessment, a care plan was put in place which showed the person's needs in relation to their medical, physical, mental, social and cultural needs. Care plans were developed to show how these identified needs would be met by staff to promote the person's health and well-being. We saw that care plans were tailored to respond appropriately to people's needs such as people's health conditions. We saw that relevant health professionals had been involved to ensure the person's needs were met. Daily care logs we checked showed staff that staff followed the plans.

We saw that a positive outcome was achieved for a person who had regular seizures was monitored and it was better controlled. One relative told us that, "[My relative] is monitored very well for epilepsy, and [their] health problems are kept under control." Two care records of people with diabetes showed that they were supported appropriately to manage their glucose levels and there were accurate records of diabetic monitoring. Their GPs, podiatry and diabetic nurses were involved. Care plans were reviewed monthly or when required to ensure they were up to date and reflected people's needs. This showed that people were supported in accordance to their health care needs.

There were various activities in place which people could take part in if they wished either within a group or individually. People told us that they had enough activities to occupy them. We saw the activities coordinators actively encouraging people to join in a signing group on the first day of our inspection. We also observed a pottery making session in the morning of the second day of our inspection and a film show in the afternoon of the second day. We saw pictures of visits to seaside, shopping trips and parks. There were also a range of celebrations in the home that people and staff joined in such as summer barbecues and fairs, cultural events and Christmas concerts.

We saw staff doing gentle exercise with people and giving people hand massages and manicures. We observed that the activities coordinators also engaged people who received care mostly from their bed in activities such as reading, singing and giving them massage and manicures. People told us that staff also kept them occupied with playing games such as Sudoku puzzles, jigsaws and scrabble.

We saw minutes of a residents and relatives meeting where people and their relatives were consulted about the activities they wanted to see take place in the services. People told us that they had good relationship with the activities coordinators and could tell them what they wanted to do. One person said the activities coordinators often spent time with them chatting which they enjoyed.

People's religious and cultural needs were met. The service had links with local religious groups who visited regularly to conduct a service for people.

We saw that the service addressed complaints effectively. Records showed that complaints were investigated promptly and action taken to resolve them. People who had made a complaint received a written response to concerns they had raised. We tracked some recent cases and saw that the service had taken steps to resolve the issues raised.

Requires improvement

Is the service well-led?

Our findings

The service held meetings with people and their relatives to gather their feedback about the care and support delivered; and these were used to develop the service. For example, following suggestions made, relatives have set up a committee to develop activities for people. They had set up a gardening club which people enjoyed. They were also in the process of setting up community café for the service to bring people together and link with the local community.

We saw that the manager held various meetings with staff to discuss improvements required at the service. However, staff felt their opinions were not taken into account and they were not consulted or involved in how the service should be delivered. They told us that they were mainly told what should be done but not asked about views or how they felt about it. Staff made comments such as, "I do not feel safe because the manager is not approachable. I do not feel supported by the manager, I feel as if there is no manager in the home. I do not feel safe because of low staffing level and lack of managerial support our manager do not listen to us" and a third staff said "We don't matter. Nobody cares how we feel. The job should be done that's all that counts."

We noted that the morale of the staff team was low generally. Two staff we spoke with were in tears while they were speaking to us about their experiences. All the staff we spoke with told us that the staffing levels, pressure to meet targets with limited resources, high turnover of staff and lack of recognition from managers had affected their morale and motivation and was affecting their ability to care for people appropriately. We discussed these concerns with the manager and they told us that there had been changes taking place to improve staff performance and service delivery and this may be a factor. However, they agreed to address these concerns with staff.

Staff retention was poor. We saw that there was high turnover of staff. Staff told us and recruitment records showed that staff leave after a few months of starting at the service. This has created instability in the team which was impacting on the quality of service delivered to people. We noted that majority of the night shifts were covered by agency staff. People told us that most of the staff who looked after them at night do not know their needs or how to care for them. Professionals we spoke with told us that most times the staff on duty do not understand the needs of the people they cared for or what was going on around.

We recommend that the service seek ways to motivate staff and improve team building and staff retention.

The service ensured that lessons were learnt from incidents. The service kept a record of incidents and accidents such as falls, and medicine errors. All incidents were logged electronically and a summary of the incidents were reviewed regularly to identify pattern and trends. An action plan was put in place to minimise and reduce future occurrence. For example, risk assessment update to ensure the person got the support they required.

The service regularly monitored the quality of service provided. The manager undertook clinical audits where various issues regarding how people were cared for were reviewed such as pressure ulcer management, falls, diabetes, hospital admissions, safeguarding. The findings were discussed with senior staff and actions put in place for improvement. The regional manager visited regularly to complete personal care plan audits. We saw report of last audit which covered various areas of the service such as falls, safety, medication, nutrition and skin integrity and how other health care professionals are involved. We reviewed actions following the latest report and saw that they had been addressed. The provider also completed an annual 'Home Review Audit' which covered areas such as finance and administration, safeguarding, maintenance, staffing, training, environment, and health and safety. We saw action plan from the last audit and most of the actions had been implemented.

The health and safety officer from the provider carried audits which covered various health and safety issues such as fire, gas safety, electrical, repairs and maintenance. Areas of concerns from the most recent audit had been implemented.

The local authority commissioning team conducted monitoring visits annually or when required. Care delivery, medication, staff training and supervision, staffing levels, complaints, safeguarding issues and record keeping are looked at. We saw action plan following the visit in January 2015 and it showed action were being implemented.

Requires improvement

Is the service well-led?

The manager was in the final stages of completing their registration with the CQC as the registered manager at the time of our inspection. They complied with the conditions of its registration and sent notifications to CQC, as required.

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 18 HSCA (RA) Regulations 2014 Staffing **There were not sufficient numbers of suitably qualified, competent, skilled and experienced staff to safely meet the needs of people. 18 (1)**