Durham Care Line Limited

De Bruce Court

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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 18 September 2018 and was unannounced. A second day of inspection took place on 20 September 2018 and was announced.

De Bruce Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. De Bruce Court provides personal and nursing care for up to 46 people. At the time of our inspection there were 15 people living at the home who received personal or nursing care, some of whom were living with a dementia.

A registered manager was not in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

This service first registered with the Care Quality Commission on 9 October 2017; this was the first inspection of this service.

During this inspection we found breaches of Regulations 17 (good governance) and 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. This was because: medicine records for 'when required' medicines lacked detail; records relating to the administration of topical creams were not always accurate; care records were not always clear and up to date; staff had not completed training specific to people's individual needs; staff supervisions were not up to date; the provider did not have effective quality assurance processes to monitor the quality and safety of the service provided and to ensure people received appropriate care and support; and the provider had failed to notify the Commission about significant events in a timely manner.

You can see what action we told the provider to take at the back of the full version of the report.

People had mixed views whether they felt safe or not. Most people said they felt more staff were needed but we saw people's needs were attended to in a timely way, which meant there were enough staff. However, we did notice call bells continued to ring when staff were already in attendance, which could cause some people to become anxious or upset.

A high number of agency staff were being used daily due to the number of staff vacancies. People tended to speak more positively about the permanent staff and less positively about the agency staff.

A thorough recruitment and selection process was in place which ensured staff had the right skills and experience to support people who used the service. Identity and background checks had been completed

which included references from previous employers and a Disclosure and Barring Service (DBS) check.

Accidents and incidents were recorded and dealt with appropriately, but there was no regular analysis to look for trends which may have reduced the risk of future accidents and incidents.

The environment was clean and well-furnished but it was not consistently dementia friendly.

People had maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People told us they enjoyed the food available. The meal time experience needed improving to make it more pleasant.

Staff were not always caring as sometimes they concentrated more on the task rather than the individual they were supporting. People gave us mixed feedback about the standard of care provided.

People did not always have access to important information about the service, including how to complain and how to access independent advice and assistance such as an advocate.

People's risk of social isolation was increased as they did not have frequent access to meaningful activities.

The provider's quality monitoring system was ineffective at identifying and generating improvements within the service.

People and staff said the service needed a permanent manager and stable staff team to make the necessary improvements.

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.

The guidance for staff on 'when required' medicines was not always clear. Record keeping in relation to topical medicines was not robust.

Thorough background checks had been carried out before staff began their employment.

Staff understood their responsibilities in relation to reporting safeguarding concerns.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not completed training in people's individual needs.

Staff supervisions were not up to date.

People said the food had improved and they enjoyed it.

Is the service caring?

Requires Improvement

The service was not always caring.

People and relatives gave us mixed feedback about the quality of care provided.

Some staff were task-focused and did not provide support in a person-centred way.

People were mostly treated with respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's individual support plans were not always reviewed when needed.

Care records did not always contain up to date information.

People and relatives knew how to complain.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider's quality assurance system had not identified all the concerns we identified during this inspection.

The provider had not made timely notifications to the Care Quality Commission.

Staff spoke positively about making improvements to the service if they had the right manager in place.

De Bruce Court

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 18 and 20 September 2018. The first day of the inspection was unannounced which meant the provider did not know we would be visiting. The second day of inspection was announced so the provider knew we would be returning. The inspection team was made up of one adult social care inspector, an inspection manager, a specialist advisor (a registered nurse with expertise in older people's care and quality assurance) and one 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.

We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

The provider completed a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We contacted the commissioners of the relevant local authorities, the local authority safeguarding team, and other professionals who worked with the service to gain their views of the care provided at De Bruce Court. Before the inspection professionals who worked with the service told us about their concerns regarding the management of the service and the quality of care delivery.

During the inspection we spent time with people living at the service. We spoke with seven people and five relatives. We also spoke with the provider's head of care delivery (who was overseeing the home in the absence of a manager), two nurses, the provider's regional catering lead (who was covering as the chef was absent), the provider's behavioural lead, two senior care assistants, four care assistants and one member of domestic staff.

We reviewed two people's care records and four staff recruitment files. We reviewed medicine administration records for three people as well as records relating to staff training, supervisions and the management of the service.

Requires Improvement

Is the service safe?

Our findings

Medicines were not always managed safely. Some people took medicines 'when required', such as painkillers. There were not always detailed guidelines for staff to follow which explained when a person may require these medicines. For example, what signs or symptoms a person may display if they were in pain and not always able to communicate their needs. Staff described when they would administer 'when required' medicines, so the risk of people not receiving such medicines when they needed them was reduced, but there was no clear guidance for staff to refer to.

Topical medicines application records (TMARs) to record when people's prescribed creams and ointments were administered were in place, but records relating to topical medicines were incomplete. Staff told us where people's creams needed to be applied and how often, but incomplete records meant we could not be sure prescribed creams had been administered in the right way or at the right frequency, in line with the instructions on people's prescriptions.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were recorded as administered on an electronic hand-held device. We saw people received their medicines at the time they needed them. We found no inaccuracies in relation to records regarding routinely prescribed medicines. Medicines were given from the container they were supplied in and we saw staff explained to people what medicine they were taking and why. People were given the support and time they needed when taking their medicines. People were offered a drink of water and staff checked that all medicines were taken.

Medicines that are liable to misuse, called controlled drugs were recorded and stored appropriately. Records relating to controlled drugs had been completed correctly. The temperature of treatment rooms and the clinical fridges were within recommended limits for safe storage, although we noticed gaps in the daily temperature records.

Accidents and incidents were recorded and dealt with appropriately. Action following an incident or accident was evident, for example medical support was sought in a timely way. However. regular analysis of accidents and incidents had not been carried out. This meant trends had not been identified where they may have existed and additional control measures to reduce the risks to people could have been implemented.

Two bathrooms we viewed contained clean linen, continence products and cleaning equipment which meant the risk of cross contamination from bodily fluids was increased. When we spoke with the provider's head of care delivery they rectified this immediately. We noted that bins in bathrooms and toilets were not foot operated which increased the risk of cross contamination. By the second day of inspection new foot operated bins had been ordered.

We checked that each person had a personal emergency evacuation plan (PEEP) which contained details about their individual needs, should they need to be evacuated from the building in an emergency. We found these were in place and contained clear step by step guidance for staff about how to communicate and support people in the event of an emergency evacuation. However, we found two people who used the service did not have a PEEP. When we spoke with the provider's head of care delivery they rectified this immediately.

Health and safety checks were carried out regularly to ensure people's safety. These included fire safety checks, window restrictor checks and regular servicing of equipment used in care delivery such as wheelchairs and hoists. Other maintenance checks such as electrical and gas safety checks were up to date.

The service employed 33 staff. The provider's head of care delivery, one nurse, four acting senior care assistants, two care assistants and four members of agency staff (one agency nurse and three agency care assistants), were on duty during the days of our inspection. Staff rotas we viewed showed these were the typical staffing levels for the service. The service also employed an administrator, kitchen staff, a domestic and maintenance staff. Night staffing levels were one nurse and four care assistants. Two people received one to one care during the day. We saw staff were flexible regarding the start and finish times of this dedicated support, depending on the daily choices of the people in question.

There were two nurse vacancies at the time of our inspection which the provider was trying to fill. The provider was also in the process of recruiting care assistants. Agency staff were being used to cover nursing and care assistant shifts daily. People, relatives and staff we spoke with felt too many agency staff were used. When we asked the provider's head of care delivery about this they said they had experienced difficulties retaining staff but a recruitment drive was underway to fill the current vacancies.

Most people, relatives and staff felt there were not enough staff to attend to people's needs. One person told us, "There aren't enough staff on duty and they get worn out." Another person said, "When I press my buzzer I have to wait and wait and wait. It's not the staff's fault. They are great when they come as they do everything for me, but we desperately need more staff." We saw people's needs were attended to promptly which meant there were enough staff to meet people's needs. However, we noticed that call bells were often ringing for long periods of time, despite staff being in attendance. Staff said they sometimes forgot to cancel the call bell when they reached the area where a person needed support. This meant that call bells often sounded unnecessarily, which could cause some people to become upset and anxious. We mentioned this to the provider's head of care delivery and health and safety officer and they said they would look into this.

We asked people if they felt safe living at De Bruce Court. Some people told us they felt safe, while others said they felt less safe. One person told us, "I don't feel safe as some of my things have gone missing." Another person said, "I feel safe as the carers really look after me."

One person and several staff members told us they didn't feel safe accessing the external areas of the home due to insufficient exterior lighting. When we asked the provider's head of care delivery about this they said this had already been reported to the provider. We spoke with the provider's health and safety officer who said additional lighting would be sought to address this.

A log of all safeguarding concerns was kept up to date and staff had access to relevant procedures and guidance. Staff told us, and records confirmed, they had completed training in safeguarding vulnerable adults and this was updated regularly. Staff understood their safeguarding responsibilities and told us they would have no hesitation in reporting any concerns about the safety or care of people who lived there.

Recruitment practices for new staff members were robust and included an application form and interview, references from previous employers, identification checks and checks with the disclosure and barring service (DBS) before they started work. DBS checks help employers make safer recruitment decisions by preventing unsuitable people from working with vulnerable people. This meant there were adequate checks in place to ensure staff were suitable to work with vulnerable people.

Risks to each person's health and safety were assessed and managed. These included risks associated with nutrition, mobility and skin care. Control measures to minimise the risks identified were set out in people's care plans for staff to refer to.

The home was clean, well-furnished and there were no malodours.

Requires Improvement

Is the service effective?

Our findings

Staff training in key areas such as safeguarding, mental capacity, health and safety and equality was up to date, but staff had not completed training specific to people's individual needs. For example, some people at the service needed support with catheter and diabetes care, while others had mental health issues or a personality disorder, but staff had not completed training in these areas. By the end of the inspection the provider's head of care delivery had arranged training in these areas.

One relative we spoke with said staff were well trained, but other relatives, people and staff said staff needed more training. One person commented, "The staff are not very well trained." One staff member said, "I think staff need more training in everything."

Staff supervisions were not up to date. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. The provider's supervision policy stated staff should receive five supervisions and an appraisal every 12 months. We found that between January and July 2018 six out of 31 staff had received two supervisions, 11 staff had received one supervision and 14 staff had not received any supervision.

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

The provider's head of care delivery acknowledged that supervisions had not happened as planned and told us that a new supervision planner had been implemented in recent months.

New staff completed an induction to the service and were enrolled on the Care Certificate. The Care Certificate is a standardised approach to training and forms a set of minimum standards for new staff working in health and social care.

We reviewed people's records relating to nutrition. Food and fluid charts were in place for every person but it was not always clear why people needed their food or fluid intake monitoring. Fluid charts were not always completed fully as fluids were not always totalled and there was no daily fluid intake target set. Staff we spoke with knew how much fluid people should have daily and what action to take if daily targets were not reached, but this was not always captured in people's records. The provider's head of care delivery took immediate action to address this during the inspection.

Comprehensive assessments of each person occurred before a care placement was agreed or put in place. This meant the provider was able to check whether or not the care needs of the person could be met and managed at the home. Following the assessment all risk assessments, care records and support plans were developed with the person and their representative where appropriate.

There was a lack of consistent visual or tactile items to engage people living with dementia. Pictorial signs to support people with communication needs were in place in some areas but not others. Doors to bathrooms

were not coloured to identify them as bathrooms. Picture menus which contained photographs of different meals were in use to support people in their decision making.

People were supported to maintain a balanced diet and to have enough to eat and drink. We observed lunch time during our inspection. There were enough staff to support people to eat but people were not encouraged to choose where they ate their meals. Each unit had a lounge/dining room which varied in size. On one unit the lounge/dining room had limited dining space but there was a larger dining room along the corridor. We noted that people's access to the larger dining room was restricted due to keypad operated doors. On the second day of inspection these doors were opened at lunch time and people were supported to the larger dining room if they preferred to eat there. People told us the larger dining room and adjacent lounge were rarely used despite them being a decent size and pleasant.

The meal time experience was not always enjoyable. Despite two different cold drinks being available we saw a staff member giving people a drink without asking them which flavour they preferred, or if they wanted a hot drink instead. This meant people's choices were not always sought and respected. The dining tables had table cloths, flowers and placemats, but no cutlery or condiments. One person was given their meal but had no cutlery to eat it with until the kitchen staff brought some. On the first day of inspection lunch was a choice of sandwiches, crisps, and fresh fruit; on the second day of inspection lunch was a choice of fish and chips or quiche and chips. People said they liked the food and it had improved recently due to some menu changes. One person said, "That was lovely I really enjoyed it." Another person told us, "I had the fish and it was nice." People's dietary needs and preferences were recorded in their care plans and kept in a file in the kitchen for staff to refer to.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found that DoLS applications had been made to the relevant local authorities. Records showed decisions had been made in people's best interests regarding medicines and accommodation. Staff told us how they involved people to make their own decisions where possible, for example when choosing how to spend their time or what to wear. During our inspection, we observed that staff sought people's consent before carrying out care tasks. This meant the service was meeting the requirements of the MCA.

People were supported to access appointments with healthcare professionals such as ophthalmology, the mental health team, dietician and speech and language therapy.

Requires Improvement

Is the service caring?

Our findings

People and relatives gave us mixed feedback about whether the service was caring. One person said, "Staff are kind and caring." Another person told us, "There is a lack of care. Some staff are excellent but others aren't so nice." Several people and relatives spoke positively about permanent staff but not so positively about agency staff. One person said, "Staff are kind to me but the agency staff are poor."

People received a service that was not consistently caring. Staff were mainly supportive and respectful but there were occasions when some staff were task-focused rather than concentrating on the individual being supported. For example, when supporting people to transfer from one area to another some staff hardly interacted with the person, whilst others explained what they were doing, made general conversation and provided reassurance. Some staff did not reassure people when they needed it or diverted people when they became anxious or upset.

Some people needed to spend significant periods of time in bed due to their health needs. Whilst people had their physical needs met such as support to wash, dress and eat, this took up the majority of staff time. This meant that once people had received personal care there was very limited interaction with staff until they required support with another task.

People were mostly treated with respect. We observed most staff interacting with people in a kind and encouraging manner. For example, we heard a staff member say to one person whilst supporting them to move to another room, "Just take your time, it's not a race, I`m here." However, there were occasions when staff did not respect a person's abilities to make choices for themselves, for example at mealtimes.

People had limited information about the service. A residents' guide (an information booklet on key aspects of the service) was not available. Some people we spoke with said they had been given verbal information about the service before they moved in and afterwards.

Some people who used the service had an advocate to support them as and when needed. An advocate is someone who represents and acts on a person's behalf, and helps them make decisions. Information about advocacy support from external agencies was not available, should people have needed it. When we mentioned this to the provider's head of care delivery they said they would make sure such information was readily available.

An electronic care records system was in place. These and paper records were kept securely and could be located when needed. This meant only care and management staff had access to them, ensuring the confidentiality of people's personal information as they could only be viewed by those who were authorised to look at records.

Requires Improvement

Is the service responsive?

Our findings

Some of the information in people's care records was unclear or not up to date. In one person's diabetes support plan there was a description of high and low blood sugar levels, but no guidance for staff on what to do should this happen. There was no detail as to what the person's usual blood sugar levels were or what was a high or low reading. By reading the care plan alone staff would not have been able to identify when the person's blood sugar levels were too low or too high. Staff we spoke with told us how they supported this person with their diabetes, but this had not been included in their care records.

One person's wound assessment and treatment plan had only started on 13 September 2018, despite the tissue viability nurse having visited on 15 June 2018 and recommending one was started immediately. The wound assessment and treatment plan stated that the dressing should be changed every five days, which contradicted what the tissue viability nurse had recommended, which was that it should be changed twice a week. Whilst there was no evidence that this person had been adversely affected the lack of adequate care records had placed this person at risk.

One person's catheter care and support plan gave staff limited guidance in terms of infection prevention and control. A catheter is a thin flexible tube used to drain urine from the bladder. It is important that appropriate infection control measures are in place for people who have a catheter as the risk of infection is increased.

Care records were not reviewed regularly. One person's care records stated that they liked to cook and they had started a job as a volunteer. However, when we discussed this with staff they told us this was no longer the case. We could not be sure people's care records always reflected their current needs.

People's individual care records were mostly personalised but some could be improved. For example, one person's communication support plan was generic and not personalised specifically for the individual's communication needs. Most staff could tell us about this person's communication needs but the support plan did not fully reflect this.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care records had not always been signed by the person concerned when they were able to do so. Most people we spoke with said they did not know what was in their care plans. This meant we could not be sure people had been fully involved in their care planning. One person told us, "I don't know what's in my care plan. It means nothing as I get told one thing and then something else transpires." Most relatives we spoke with felt they were involved in their family member's care planning.

Care records we viewed contained mostly person-centred information about how people wanted and needed to be supported. Person-centred planning is a way of helping someone to plan their life and support by focusing on what is important to the person such as how they like to spend their time and what they like

to eat. Care plans detailed people's needs and preferences across a range of areas such as diet, general health, pain management and communication. Care plans also contained risk assessments which were detailed and specific to the person.

We saw that there were arrangements in place for people and relatives to be involved in making decisions about end of life wishes. Where people had been consulted and had expressed preferences, these were recorded in their care plans for staff to refer to.

Relatives had mixed views whether staff responded to changes in people's needs promptly. For example, one relative told us, ""I'm not 100% happy with the care provided. My [family member] has been here a few months and needed to go into hospital due to nursing staff not responding quickly enough in my opinion. However, I didn't want to submit a formal complaint, I just don't want it happening again or to anyone else. I'm generally happy with the staff now." Another relative said, "[Name of nurse] always keeps me up to date and rings the GP when necessary."

People and relatives told us there was a lack of activities. We found that although people appeared settled there were no meaningful activities to engage people, particularly those living with a dementia. People tended to sit in the lounge or their bedrooms watching the television or just sitting or sleeping. Despite an activities schedule being on display, no activities happened as advertised. People who received one to one support through the day visited local shops and attractions, but these were in the minority. NICE guidance states, 'It is important that people with dementia can take part in leisure activities during their day that are meaningful to them.'

There was a hydrotherapy pool at the service but people and staff told us this was never used. Staff told us they had not received any training on how to use this safely and that people's suitability to use such a facility had not been assessed yet.

The provider's head of care delivery and behaviour lead acknowledged activities was an area for improvement. The provider's behavioural lead told us, "We've got an activities co-ordinator from another home and one of our occupational therapists coming in to arrange activities. We've got a charity coffee morning arranged for next week and hope to offer more activities and entertainment. We've also got an activities champion here now."

The provider had a complaints procedure in place and most people told us they knew how to make a complaint if necessary. People said they would speak with one of the nurses or members of care staff should they have any concerns. People and relatives who had complained had mixed views whether their concerns had been responded to appropriately.

Several people and relatives told us there were problems with the laundry. A relative said, "The laundry really needs improving as clothes are always going missing." The provider did not have dedicated laundry staff; care staff did the laundry. The provider's head of care delivery told us dedicated laundry staff would be recruited when occupancy at the home increased. Three people we spoke with said they were fearful of being asked to leave if they complained, but confirmed that no staff member had ever said this to them.

Requires Improvement

Is the service well-led?

Our findings

The provider had a quality monitoring or audit system in place to review areas such as medicines, care plans, complaints and health and safety. These were not always effective in identifying and generating improvements within the service. Whilst recent audits had identified some issues relating to staff supervisions and training, the provider had not identified all the areas for improvement we found during this inspection such as: a lack of guidance for staff in relation to 'when required' medicines; care records being unclear and not up to date; care records not being reviewed often enough; and a lack of consistent visual or tactile items to engage people living with dementia.

Whilst staff could describe people's needs and preferences, care records were inaccurate, contradictory and incomplete which placed people at risk.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's head of care delivery told us they were doing more frequent and more in-depth audits to address the issues they had identified. They gave us a copy of an action plan they were currently working on.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service in the form of a 'notification'. The provider had not always made timely notifications to the CQC in relation to significant events that had occurred in the home.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The provider's head of care delivery identified this and made immediate notifications to the CQC. We are dealing with this outside of the inspection process.

The service had had three managers since it first opened in October 2017. The most recent manager left the service in August 2018. The provider was in the process of recruiting a new manager. The provider's head of care delivery, who was overseeing the home in the absence of a manager, assisted us throughout the inspection.

People told us the service was not well-led due to issues retaining a manager and permanent care staff. One person told us, "The managers just walk out and the staff turnover is high. The atmosphere here is difficult and frustrating. It just makes you want to give up."

Feedback from people and relatives had been sought via resident and relatives' meetings, but these had not happened regularly due to management changes. We noted that the next resident and relatives' meeting was scheduled for October 2018. Feedback via an annual provider survey was due to be conducted in October 2018 after the service had been open for a year.

Staff we spoke with said there had been "teething problems" since the service opened. All the staff members we spoke with mentioned the need for a permanent manager and a stable staff team. One staff member said, "We knew it would be tough opening from scratch. Once we get the staffing sorted we can work on putting everything else right. The building is new and the facilities are excellent here. If we could get a good manager who wants to stay it would be great." Another staff member told us, "We need more permanent staff rather than agency and consistency in the management team."

Staff meetings were held but these varied in frequency due to management changes. Staff told us they did not always have enough opportunities to provide feedback about the service as supervisions were behind and managers did not stay at the service for long. Most staff we spoke with said they felt if there was a good manager they were confident they could make improvements to the service for the benefit of people who lived there. A staff member told us, "This is a brand new purpose-built building. There's so much potential here."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems to assess, monitor and improve the quality and safety of the service. The provider did not have accurate and complete records for each service user.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not completed training relevant to service users' individual care needs. Staff had not received regular supervisions to enable them to carry out their duties.