Bradwell Hall Nursing Home Limited

Bradwell Hall Nursing Home

Inspection report

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Date of inspection visit:
25 June 2019
26 June 2019
27 June 2019

Date of publication:
14 November 2019

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

About the service
Bradwell Hall is a nursing home that provides personal and nursing care for up to 187 people. Bradwell Hall accommodates people in seven units across five different wings, each of which has separate adapted facilities. At the time of our inspection, there were 167 people using the service.

People's experience of using this service and what we found
People were not always protected from the risk of harm as staff did not always have or follow the correct guidance to help them manage people's risks and health conditions. Environmental risks were not always assessed and managed. The provider did not consistently ensure that infection control and prevention measures were in place.

There was a lack of governance because the provider and the registered manager did not consistently have a clear oversight of the day-to-day running of the service. The systems that were in place to assess the quality and safety of the service were not always effective.

Staff were not always deployed effectively around the home which meant people did not always receive person-centred care.

Staff knew how to identify and report safeguarding concerns and the policies and systems in the service largely supported the principles of the Mental Capacity Act. The provider supported people's end of life wishes and these were recorded in line with people's preferences. We observed some caring interactions between staff and the people they were supporting.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Requires Improvement (published 19 October 2018). At this inspection enough improvements had not been made and the provider was in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating.

The inspection was prompted in part due to our continual monitoring of the service and concerns we received, and we needed to ensure that improvements had been made following our focussed inspection in August 2018. We have found evidence that the provider needs to make further improvements. You can see what action we have asked the provider to take at the end of this full report.

Enforcement
At this inspection, we have identified breaches in relation to Regulation 9 of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014 (Person centred care), Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe Care and Treatment), Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good Governance) and Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Staffing).

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Bradwell Hall Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by three inspectors, a pharmacy inspector, two assistant inspectors, a nurse specialist advisor and two Experts 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.

Service and service type
Bradwell Hall is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. This information helps support our inspections. We used all this information to plan our inspection.

During the inspection
We spoke with 25 people who used the service and 12 relatives about their experience of the care provided. We spoke with 45 members of staff including the provider, registered manager, deputy managers, senior care workers, care workers, activity coordinators and the head of maintenance. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.
We reviewed a range of records. This included twenty-one people's care records and multiple medication records. We looked at variety of records relating to the management of the service, including training data, audits and policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Preventing and controlling infection

- People who required support to manage skin wounds did not always have clear and effective plans in place. Information contained in people's care plans was not always followed meaning that people received inconsistent care that posed a risk to their health and well-being.
- Guidance for staff to follow for people's specific health conditions, was not always available putting people at risk of harm through inconsistent care interventions.
- The environment was not always maintained in a safe way. For example, we observed hazards such as exposed hot water pipes without the appropriate risk assessments in place.
- In some parts of the home, equipment and furniture was not always maintained to a satisfactory standard and therefore could not be cleaned effectively.

We found no evidence that people had been harmed, however people's individual risks were not always assessed, monitored or managed in a way that maintained their safety. The measures that were in place to control and prevent the risk of the spread of infection were not always effective. This is a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- The provider had systems in place to ensure there were sufficient numbers of staff across the home. However, we found that staff were not always deployed effectively across each unit and as a result, people were occasionally left waiting to receive care and support.
- There was a high usage of agency nurse staff and some staff told us that they did not always have the opportunity or time to read people's care records. This meant that people did not always receive consistent care and support. People who required 1:1 support did not always receive personalised support because of the high turnover of agency staff.
- One person told us, "I am concerned there are lots of agency staff particularly nurses. Some agency nurses try to give me my medication orally and I have to explain that I cannot take medicines this way. The agency staff don't know really know my needs. I am treated well but this place is short-staffed most of the time."
- The registered manager told us that they did not meet with the unit managers to undertake formal, 1:1 supervision. This meant that senior members of staff did not always receive the appropriate support, development and appraisal necessary to enable them to carry out their duties.

There were not always sufficient numbers of experienced staff deployed to meet people's needs and wishes. Staff did not always receive on-going or periodic clinical and/or professional supervision to ensure their

competence was maintained. This is a breach of Regulation 18 (Staffing) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

● In one wing of the home, the provider had changed the way staff were deployed to support people as a way of assessing if people received a better of quality of care. The provider told us this was being monitored and if successful, they would look at deploying all staff across each unit in this way.
● The provider had a recruitment policy in place and staff were subject to a Disclosure and Barring Service check prior to commencing their employment. A DBS helps employers make safer recruitment decisions.

Using medicines safely
● Not all medicines on were managed in a safe or a timely way. For example, one person's blood sugar level was not checked, or their morning dose of insulin offered to them, until lunchtime. Some people's medicines were crushed or mixed with yogurt against the manufacturer's instructions. People had plans of care in place stating their medicines could be administered covertly (hidden in food without the person knowing) but we could not tell from the available records when and if this had happened as records were not always clear.
● Protocols for the use of medicines prescribed 'when required' had recently been reviewed to make sure they described people's current needs. However, two people had a protocol for a medicine to relieve anxiety that was not listed on their medication administration record (MAR). We could not tell from the records whether this 'when required' medicine was still prescribed.
● We found a surplus of three tablets when we counted one person's anti-psychotic medicine, implying that staff had signed the record on three occasions without giving the tablet. This meant that people were put at risk of receiving the wrong medicine or the incorrect dosage. We brought these issues to the attention of the Unit Manager, so they could be rectified without delay.
● The registered manager told us that they had introduced red 'Do Not Disturb' tabards for staff to wear to reduce interruptions when administering medicines thus reducing risk of error. During our three-day inspection, we observed several medication rounds and we only saw one nurse on one occasion wearing the tabard. The registered manager had not recognised that this new process was not being followed by care staff; we alerted them to our observations.
● The medicine manage practices across the home on the different units varied. Whilst we identified areas of good practice on some units this was variable.

Learning lessons when things go wrong
● The registered manager had changed certain practices within the service and developed new policies and procedures as part of on-going learning from previous incidents and concerns.
● The registered manager held meetings each morning with the unit managers from across the home to discuss any matters arising from the previous evening and for the day ahead. These meetings were designed to discuss any changes in people's care needs so that plans of care could be developed and implemented to reflect these changes in need. However, we found that this was not always an effective process as information was not always passed on to senior members of staff to relay back to the registered manager. The registered manager told us they would address the communication shortfalls with care staff and senior members of staff to alleviate the risk of important information not being shared.

Systems and processes to safeguard people from the risk of abuse
● Staff could tell us about the actions they took to safeguard people and knew how to identify and report and safeguarding concerns.
● People we spoke with told us that they felt safe living at Bradwell Hall. Comments we received included, "Yes, I do feel safe living here", and "I have no concerns about my safety."

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement: This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

- Where people lacked the capacity to consent, assessments were completed to evidence that people had been given the support required to make decisions about their own care. However, not all the assessments we saw were 'decision specific'.
- Most staff we spoke with understood their responsibilities in relation to supporting people in line with the MCA. However, some members of staff were unable to tell us about the legislation and how they adhered to this to care for people. We brought this to the registered manager's attention who stated that they would look at the MCA training for staff and offer refreshment training for staff as necessary.
- Where people were being deprived of their liberty, applications to the local authority had been made to ensure people were being deprived of their liberty lawfully and relevant parties had been involved in discussions about people's care needs.

Staff support: induction, training, skills and experience

- Some staff had not received up-to-date Clinical Intervention training. Some people with different conditions may need to be supported through physical intervention or restraint. We identified that a number of staff had not received their annual refresher training which meant they may have been using intervention techniques for people that were not suitable or out-of-date. We brought this to the registered manager's attention who informed us that they had liaised with the training team to immediately rectify this shortfall.
- Staff had received all other necessary training and we could see that this was current and relevant for the care and support that was being provided to people.
- Staff we spoke with told us that they had received a detailed induction before they were able to work independently at Bradwell Hall.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People had their needs assessed and documented within their own plan of care. However, not all staff knew about people's needs which demonstrated that care staff did not always follow people's care plans. For example, we observed one member of staff attempting to support one person to transfer out of a chair without using the correct equipment.

● The registered manager had recently introduced a 'resident of the day' on each unit. This meant that all staff would be particularly responsive in reading the resident's care plan documentation to ensure that the care delivered was reflective of the person's needs. This was still being implemented and we could not yet assess whether this approach had been successful.

Supporting people to eat and drink enough to maintain a balanced diet

● Mealtimes were not always a positive experience for people. On some occasions throughout our inspection, we observed some people having to wait to receive their meal. Some people who required support to eat were not always offered help in a timely or dignified way. For example, people were not engaged in discussion or conversation when receiving support. We observed one staff member attempting to support someone to eat whilst they were still asleep in bed. We brought this to the attention of the registered manager who stated that they would take action to address our observations.

● People we spoke with gave us a mixed response about the quality of the food they received. Some people spoke highly of the food telling it was nutritious and plentiful. Other people said the choice was limited and it was not of a good quality. The registered manager had recently adapted the menu for people to include greater choice for people particularly at tea time because of negative feedback they received. The registered manager stated that they would continue to seek feedback to make the required improvements.

● People with specific dietary requirements received support to ensure they received a balanced diet in line with their care needs.

● The registered manager introduced a hydration champion who had the responsibility of ensuring people were receiving the correct amount of daily fluid that was appropriate for them. The registered manager told us, "We did this as an extra measure to push fluids and hydration for people."

Adapting service, design, decoration to meet people's needs

● Some units of the home needed redecoration and people and staff we spoke with reiterated the need for this.

● Some of the units were cluttered and untidy. We observed that some equipment had been stored inappropriately blocking fire exits and stairwells. We raised this with the unit managers and the equipment was moved. We asked the head of maintenance for an action plan of improvements and we were told that the improvement plan for one unit was due to commence the week after our inspection. We will follow this up on our next inspection to check that the required improvements have been made.

● However, other units of the home were decorated in light colours that enhanced the natural light. There was appropriate signage on the walls. People's bedroom doors were decorated with their own pictures or were painted in specific colours. This supported the needs of people living with dementia because the environment enabled people to continue to live safely and in the way that they chose.

● There was a large garden area to the front of the building and we observed people enjoying this space for recreation.

● One unit had recently had their garden area improved with funds that were raised and donated by a local organisation. We saw pictures of people using the new facilities in the warmer weather.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● The provider had been working with the Clinical Commissioning Group to provide accommodation and

support to people leaving hospital to prevent unnecessary and lengthy hospital stays. During our inspection, we observed occupational and physiotherapy staff working with people throughout the home with the aim of rehabilitating people for them to return to their own homes.

- People had accessed other professionals such as chiropodists, opticians and dentists as they required.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement: This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People were not always cared for and supported appropriately. Throughout our inspection we observed a mixture of interactions between staff and people.
- Some people were responded to as soon as it was observed that they required support. However, some people were left waiting for extended periods of time before any members of staff gave them any attention. For example, we observed a person shouting out for someone to help them. The inspection team alerted staff to this as there was no response from any of the staff. The person was very distressed and sitting in an uncomfortable position. The person did not have access to a call bell.
- Some staff were 'task orientated' and placed less of an emphasis on supporting people. For example, we saw one person being supported to eat. There was very limited interaction with the person and the person had their eyes shut whilst the member of staff spooned food into their mouth.
- Several people throughout the home required 1:1 support. This meant staff were supporting people on an individual basis. Some people we saw did not have positive 1:1 interactions with the staff member who was supporting them. For example, one staff member told us they did not know the name of the person they were caring for. Another staff member was observed not to make any conversation with a person and sat by the person's side without attempting to provide any stimulus for the person. We raised these issues with the registered manager.
- People and their relatives told us they felt cared for living at Bradwell Hall. One person told us, "I am looked after very well, I have no complaints." Another person said, "Staff are good; they treat me well and are caring."
- Relative's comments included, "Some staff are very good, some are fairly good. They are always there for [relative's name] whenever they need them" and "I consider many of the staff as friends."
- We observed some positive and caring interactions throughout the inspection. For example, a member of staff was observed kneeling to be at the same level as a person whilst they spoke with them asking them how they were feeling. We observed people being offered drinks and people being asked if they needed any support in a polite and courteous way.
- The provider did not always consider people's protected characteristics such as race and religion under the Equality Act 2010 and this was recorded in people's care plans. We discussed this with the registered manager who stated that they were looking at making further improvements in this area to become a more inclusive service.

Supporting people to express their views and be involved in making decisions about their care

- We observed various practices across the different units during our inspection. Some people were

consulted about their care needs whilst we observed, and were told, that others were not.

● Some people were not consulted about things that were happening. For example, some staff were seen to move people in the chairs in which they were sitting without any discussion about if they were happy to move or where about they were being moved to. Other people were supported to eat and drink but were not spoken to or told what was being given to them as a drink or a meal.

● One person told us, "I've been asked for feedback a couple of times, but I have lived here [Bradwell hall] for many years. I am not aware of changes that happen."

● However, across other units, people were asked if they would like support and were spoken to in a way that encouraged conversation. People were given options of drinks, snacks and meals and staff were seen to be actively giving choices to people about what they would like to do. We discussed the inconsistency in practices with the registered manager.

● On some units, we observed posters on the walls telling people when resident meetings were to be held. People told us that these meetings did go ahead although they were not always largely attended.

Respecting and promoting people's privacy, dignity and independence

● People told us staff respected their privacy and dignity by knocking on doors before they entered people's rooms and closing doors and curtains when they were being supported with tasks of a personal nature. One person said, "I get a wash every day but if I don't want one then I tell the staff and they respect my wishes." Another person said, "I feel valued and respected." We largely observed staff demonstrating what people had told us.

● People were observed spending time in their own rooms as per their own wishes and staff respected this.

● People told us that their visitors were able to visit at any time of the day or night and we saw people spending time with visitors throughout our inspection.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement: This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were not always involved in the planning of their care. Some records we viewed stated that people had received a review of their care needs but we did not see any evidence this had been discussed with people or their relatives in a formalised way. Some people told us that they did not receive a review of their care needs and were not asked about changes in their needs. This meant care was not always reflective of people's needs.
- Care plans were not consistently personalised for people. Some records contained lots of detail and others lacked significant and important information for people such as likes and dislikes and life histories. The provider was in the process of changing the electronic care planning system so documentation varied across each unit. Some staff were unable to access information when we requested it.
- Staff did not always know the needs of the people they were supporting. We observed people waiting for support for extended periods of time. This meant people did not always receive appropriate and timely care and support.
- Some units did not provide meaningful activities for people. We observed, and, some people told us that there were not enough things for them to do and to keep them occupied. Comments we received included, "There isn't a lot for us to do" and "We could do with a lot more activities."

People did not always receive care that met their needs and reflected their preferences. People were not receiving consistently personalised care. This is a breach of Regulation 9 (Person Centred Care) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

- Some units in the home were more proactive about organising activities for people however, this practice was variable throughout the home. We observed activities on certain units that were inclusive for people who were not able to mobilise or communicate but were still encouraged to take part with support from staff.
- The activity coordinators for these units demonstrated to us their commitment and dedication for providing a good quality of life for people. One activity coordinator told us, "I found out people's likes and dislikes by speaking to people and families and by gauging people's reactions to activity. The challenge is for people who don't have the capacity, they will rarely join the activity, but I try to get everyone involved. I plan the activities week by week and write them down on the board."

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to

follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● The registered manager, when asked was not sure of their responsibilities under the AIS. However, we observed, and people and, staff told us that the service was meeting the standard. For example, one person said, "I have a hearing aid and the staff ensure that I can always hear and understand what is going on." Staff shared examples of good practice with us, for example where picture aids and communication boards had been used and how the positive impact this had on people.

Improving care quality in response to complaints or concerns

● There was a complaints process in place. The registered manager evidenced to us how they addressed complaints in line with the policy.

● People told us that they knew how to complain and would feel comfortable in doing so.

End of life care and support

● People had their end of life care wishes recorded.

● The registered manager was working with a local hospice to improve the end of life care planning process for people.

● The registered manager had nominated nursing staff to attend further clinical training as part of the on-going improvements in this area.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- There was a lack of consistent person-centred care across the service and therefore people did not always have good outcomes. The registered manager was aware that the service needed further improvement and told us, "Our challenge is how we get beyond the things that we are not doing. We are set up to improve and there is enough people and we have the right calibre of people, but we need to get there."
- The provider was not identifying opportunities to learn and improve because governance systems were not effective. For example, audits that were completed were not reviewed and did not have action plans that addressed how shortfalls would be managed and risks mitigated.
- The management team did not have a full oversight of the service and there was a lack of accountability when things went wrong. For example, we identified that an incident had occurred, and this had not been reported through the formal process. This meant the registered manager was unaware of the incident and therefore could not take immediate and appropriate measures to prevent reoccurrence.
- Quality assurance systems had failed to identify that some equipment was not fit for purpose due to rusting and extensive wear and tear. This also meant that equipment was not cleaned effectively which audits also failed to action.
- The registered manager had not formally supervised the unit managers for an extended period. Morning meetings were held with the all the unit managers however this process did not measure staff development, progress and competence of the unit managers. This meant staff were not always aware of quality performance and risks as already highlighted and evidenced throughout this report.
- The provider had been working with the Local Authority, attending performance Improvement meetings to improve quality and care. However, the provider failed to recognise the areas that we identified during our inspection.

Governance systems in place were not operated effectively to continually assesses, monitor and improve the quality and safety of the services provided. This is a breach of Regulation 17 (Good Governance) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager told us of best practice initiatives they used to try to keep up to date with changes in the health and social care sector and recognised this was an on-going process.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager was aware of their responsibilities under the duty of candour. The registered manager told us, "We will respond to people when something goes wrong and let people know what are doing about it. We say sorry to people if we need to; we always give an apology."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People had received questionnaires as a mechanism as obtaining feedback. We saw that some of the feedback had been used to develop new menus for people and we saw actions taken recorded in a 'you said we did' format on display within the service.

● Staff told us that they did receive supervision from the unit managers and had team meetings which they felt this was beneficial to developing their skills for practice and keeping up-to-date with changes within the service.

Working in partnership with others

● The provider had developed working relationships and links with agencies and organisations to improve outcomes for people. For example, the local nursery and schools visited the service to promote inter-generational work between people using the service and the young children.

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 Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always sufficient numbers of experienced staff deployed to meet people's needs and wishes. Staff did not always receive on-going or periodic clinical and/or professional supervision to ensure their competence was maintained.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	People did not always receive care that met their needs and reflected their preferences People were not receiving consistently personalised care.

The enforcement action we took:

Impose a condition- Action Plan and Provider Meeting

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	People's individual risks were not always assessed, monitored or managed in a way that maintained their safety. The measures that were in place to control and prevent the risk of the spread of infection were not always effective.

The enforcement action we took:

Impose a condition- action plan and provider Meeting

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Governance systems in place were not operated effectively to continually assesses, monitor and improve the quality and safety of the services provided.

The enforcement action we took:

Impose a condition- Action Plan and Provider Meeting