HC-One Limited

Victoria Mews

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**

Overall summary

This inspection took place on 18 and 19 August 2015. It was an unannounced inspection.

Victoria Mews provides accommodation with personal care for up to 30 people. There were 27 people living in the home at the time of our inspection. Everyone living at Victoria Mews was living with dementia.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider determined the staffing levels on the number of people living in the home instead of on an assessment of people's needs. On the first day of our visit we found that most of the staff on duty were not permanent members of staff and had limited knowledge

Summary of findings

about people's care and support needs. Staff were rushed; people's needs were not always met in a timely manner and staff were not always following plans to manage identified risks to people's health and wellbeing.

Staff understood what constituted abuse or poor practice. There were systems and processes in place to protect people from the risk of harm. Most medicines were managed safely and in accordance with good practice. However, improvements needed to be made in the management and storage of topical medicines that were applied directly to the skin.

Staff received training to meet the needs of people living in the home, but we found staff were not always implementing the training effectively into their practice. Staff supervision, which may have identified areas where staff needed further support to develop their skills, were not consistently taking place.

The manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). We were told some people lacked capacity in certain areas but capacity assessments had not been completed to show how people were supported to make those decisions.

People received food and drink that met their nutritional needs and were referred to other healthcare professionals to maintain their health and wellbeing.

Staff were caring in their approach, but the main interaction with people was focussed on offering support or completing a care task. Permanent staff we spoke with had a good understanding of people's support needs, but had limited knowledge of their backgrounds. This meant people were defined by what support they needed rather than who they were.

People felt confident they could raise any concerns with the registered manager. There were processes in place for people to express their views and opinions about the home.

There were systems in place to monitor the quality of the service. This was through feedback from people who used the service, their relatives, staff and a programme of audits. The provider played an active role in quality assurance to ensure areas of poor practice could be identified so the service could improve. Quality monitoring visits had not identified some of the areas of concerns we found during our inspection visits.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

People's needs and the skills and knowledge of the staff available to meet those needs, were not taken into consideration when staffing levels were determined. Plans in place to manage and minimise identified risks to people's safety, were not consistently followed. There was a thorough staff recruitment procedure to check staff were safe to work with people in the home.

Requires improvement

Is the service effective?
The service was mostly effective.

Staff had completed training but were not always putting it into practice when delivering care. Where people lacked capacity, assessments were not always completed so decisions could be made in their best interests. People were provided with a good choice of food which they enjoyed. People were referred to healthcare professionals when required.

Requires improvement

Is the service caring?
The service was not consistently caring.

Staff were caring in their approach, but the main interaction with people was focussed on offering support or completing a care task. Records relating to people's personal needs were not stored securely to ensure they remained confidential.

Requires improvement

Is the service responsive?
The service was mostly responsive.

Care plans provided staff with the information they needed to respond to people's support needs. The environment provided limited sensory stimulation to promote engagement for people living with dementia. Complaints were responded to in line with the provider's complaints policy and in good time.

Requires improvement

Is the service well-led?
The service was mainly well led.

Staff and people spoke positively about the approachability of the registered manager. There were quality assurance systems in place, but action had not always been taken to manage issues identified. Staff and people were encouraged to give feedback about the quality of service within the home.

Requires improvement

Victoria Mews

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 19 August 2015. The first day was unannounced and the second day announced.

The inspection team consisted of two inspectors and an expert by experience. An expert-by-experience is a person who has experience of using or caring for someone who uses this type of care service.

We reviewed the information we held about the service. We looked at information received from agencies involved in people's care. We analysed information on statutory notifications received from the provider. A statutory notification is information about important events which the provider is required to send us by law. These can include safeguarding referrals, notifications of deaths, accidents and serious injuries. We considered this information when planning our inspection of the home. We looked specifically at four care plans, but also viewed other care documentation such as people's daily records, weight charts, food and fluid charts and medication records. We looked at the complaints file, accidents and incident records and records of safeguarding incidents in the home. We completed observations during the day including over mealtimes in both the dining room and the lounge to see what people's experiences of the home were like.

We spent time observing how staff interacted with people in the home. We also used the Short Observational Framework for Inspection (SOFI). This is a specific way of observing care to help us understand the experience of people who were not able to talk with us.

We spoke with six people who used the service, eight visitors to the home, the registered manager, the assistant operations director and eight members of staff which included six care staff.

Requires improvement

Is the service safe?

Our findings

People who lived at Victoria Mews were living with dementia which meant they could not always respond in detail to the questions we asked about their care. We asked people if they felt safe living in the home. One person responded, "I feel safe." Relatives we spoke with confirmed that they thought people were safe. Comments included: "[Person] is safe." "I think they are well treated." "I do think he is safe here."

We found that not all staff knew about people's needs and did not know the routine of the home. Although staff numbers had been maintained, not all staff working were permanent staff members which resulted in a lack of cohesion among the staff team. At times people had to wait for assistance and did not receive the care or support they needed which could have put them at increased risk. For example, one person at risk of skin breakdown sat in the lounge all day without being assisted to the bathroom. Another person was given the wrong textured meal before a staff member realised their mistake and gave them the pureed meal they required because they were at high risk of choking.

People we spoke with told us they thought there were enough staff on duty to meet people's needs. One relative told us, "Generally yes, but it is holiday season so it is a bit stretched at the moment." A member of staff told us, "We're short today. It's usually OK for staff, but at the moment it's a holiday period."

We were told by the assistant operations director that staffing levels were based on the number of people living in the home rather than an assessment of people's needs. We were concerned this did not accurately reflect the number of staff required to keep people safe because of the layout of the home and the fact some people required close observation and supervision. It also did not take into account the competence, skills and knowledge staff had of the individual needs of people living in the home. A high number of staff on duty on the days of our inspection visits were from other homes within the provider group or from the provider's staff 'bank'. Some had not worked in the home before. One staff member told us, "I've just come on shift. I came here from another HC-One home. I came to help out this afternoon. I didn't know I was coming until this morning. I have been here before, but only for training. I don't know the residents."

On the first day of our inspection the registered manager was acting as the senior on duty. As there was no administrative member of staff or deputy manager on duty, the registered manager struggled to cover their responsibilities as the senior working on the floor and their managerial tasks. We were concerned about holding conversations with the manager or staff because we felt it would have a detrimental impact on the level of care provided within the home.

On the second day of our inspection there were three members of permanent care staff including a senior. The other two care staff were 'bank staff'. The registered manager was able to concentrate on the managerial aspects of their role and an administrator had been brought in to provide support in the office. Staff appeared more relaxed and responsive to people's requests for support.

Risk assessments were in place to identify risks, but staff were not always following the plans to manage the identified risks. For example, one person who was mobile with a walking aid was identified as being at risk of falls. Their risk management plan stated that staff must ensure their walking aid was nearby in case they needed it. We saw the person sat in the lounge with their walking aid clearly out of reach. This person was very anxious and constantly tried to stand. There was no staff presence in the lounge for several minutes at a time when the person was trying to mobilise.

The same person was at high risk of skin breakdown. The person was resistant to sitting on a pressure relieving cushion, but their risk management plan stated that staff should regularly encourage them to do so. The person was not sitting on a pressure relieving cushion and throughout the morning we did not see staff make any attempts to encourage them to sit on one. At 3.10pm the person complained they were uncomfortable and a member of staff gave them a pressure relieving cushion to sit on.

We observed staff assisted one person to move using an inappropriate manual handling technique. The person's mobility care plan stated that the person was immobile and required staff to use a hoist and stand aid when supporting them to transfer. Care staff told us nobody in the home required equipment when transferring. However, the senior member of staff on duty told us that the person

Is the service safe?

required staff to use a stand aid when they were being transferred. This meant the person was at risk of injury because staff were not aware of the correct equipment to use.

Some people could display behaviours that could cause concern or impact on the safety of other people. Plans to manage behavioural risks were not always followed. For example, on some days people who needed to be observed every 30 minutes were only observed every 60 minutes. A couple of days before our visit a person who required regular supervision had been involved in an incident with another person living in the home. This person had become involved in a second incident 45 minutes later. This suggested that when the person was demonstrating agitation, they had not received appropriate supervision and support to prevent the second incident happening.

We found this was a breach of Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

Staff understood how to recognise the different types of abuse and told us they had regular training in safeguarding and whistleblowing procedures. One staff member told us, "If you get a resident up and they don't want to, that is abuse." Staff told us they would raise any safeguarding concerns with the registered manager or senior members of staff and were confident the registered manager would look into reported concerns. There were a number of posters around the home with a helpline number for staff to use if they had any whistleblowing concerns. One staff member told us, "I know how to report safeguarding concerns. I know the whistleblowing procedure. I'm confident the manager would sort things out if there were any concerns." The registered manager was aware of their responsibilities to report safeguarding issues to us and the local authority.

There were processes to keep people safe in the event of an emergency. Each person had an emergency evacuation plan which detailed the equipment staff or the emergency services needed to use to evacuate them safely. There were a range of checks in place to ensure the premises and equipment within the home were safe and fit for purpose.

There was a system in place to make sure checks were carried out when care staff were recruited to ensure they were safe to work with people who used the service. The provider took disciplinary action when concerns around poor practice had been identified.

Medicines were stored safely and we observed staff administer these as prescribed during the day. They went to each person and asked discreetly if they were in pain and if they required pain relief to manage this. Each person had a printed Medicine Administration Record (MAR) which had been signed by staff to show they had administered the medicines.

There were protocols for medicines that were administered on an "as required" basis. These included the non-verbal signs people may display if they had limited communication. Staff kept accurate records of why and when these medicines had been administered. This meant the next member of staff giving medicines could check there was an appropriate gap between the medicines to prevent an overdose.

We found the management of topical medicines that were applied directly to the skin required improvement. Such medicines were applied by care staff, but the directions for their application were not always clear. Records did not demonstrate that these medicines were being applied as directed. Some of these medicines were kept in people's bedrooms and accessible to people who had a diagnosis of dementia which presented a risk.

Staff who administered medicines had received training and their competency had been assessed by the registered manager. Due to a staff vacancy for a senior member of staff at night, there had been some nights when there was no suitably qualified member of staff to give medicines. We were told that medicines were given by the day staff late in the evening so they did not need to be given at night. However, this did not take into account if people required pain relief. The registered manager accepted there was a gap on some night shifts and confirmed the newly recruited senior staff member would receive medication training so they could give medicines as required. In the meantime there was an on-call system and a member of the management team would attend the home if a person required pain relief

Requires improvement

Is the service safe?

There were a series of regular checks and audits so any errors when medicines were given could be identified quickly and action taken.

Requires improvement

Is the service effective?

Our findings

Staff had access to a range of training essential to support them in their role. Most training was delivered though e-learning on the computer. Staff completed an assessment to test their understanding of the training at the end of each module. Although staff had completed this training and told us they found it useful, it was evident they were not always putting their learning into practice. For example, we observed two staff members transfer a person from a chair into their wheelchair using an underarm lift. Use of this manual handling technique can result in discomfort or injury to the person.

The provider offered staff formal supervision twice a year. Supervision meetings provide staff with an opportunity to discuss their personal development and any training requirements. They also provide the registered manager with an opportunity to discuss staff performance, what they are doing well and any areas of their practice that require improvement. One senior member of staff told us they observed staff practice as part of the supervision process, but these observations were not recorded. At the time of our inspection only 11 of the 30 staff employed at Victoria Mews had received supervision in 2015. More regular supervision may have identified some of the areas where we saw staff needed support to develop their skills.

New staff received induction training and supervision from more experienced staff to support them in their roles.

We asked the manager about their responsibilities under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission is required by law to monitor the operation of the MCA and DoLS and to report on what we find. The MCA ensures the rights of people who lack mental capacity are protected when making particular decisions. DoLS referrals are made when decisions about depriving people of their liberty are required to make sure people get the care and treatment they need in the least restrictive way.

The manager and staff demonstrated some understanding of the legislation, particularly around seeking people's consent before delivering care and support. However, we were told there were people in the home who lacked capacity to make certain decisions. Capacity assessments had not been completed to show how people were supported to make those decisions. Records showed one person who was at high risk of skin breakdown only received a bath or shower once every month. We were told this person consistently refused to have a bath or shower, although these refusals had not been documented. This person's decisions about their personal care had a potential effect on their health and wellbeing and we were told they did not have the capacity to understand the consequences of refusing personal care. There had been no discussion with relevant healthcare professionals or family members about how this should be managed in the person's best interest. A referral for an MCA assessment and best interest meeting had not been considered.

Where restrictions on people's liberty to leave the home had been identified, capacity assessments had been completed and the manager had submitted DoLS applications to the local authority as required. At the time of our visit nobody had a current DoLS in place as they were in the process of being assessed by the authority.

At lunch time three people sat in one of the lounges to eat. All three needed assistance or encouragement to eat, but there was only one member of staff in the lounge. The staff member did not have time to sit with one person from the start to the finish of their meal. Instead we saw them start to support one person, then move to another person and then return to the person they had initially started to help. This meant the meal time was not a relaxing experience for those people.

People we spoke with told us they were satisfied with the food served in the home. One relative told us, "The food is okay, yes I have tried it and could not fault it. There are two choices." Another said, "[Person] is fussy. He has not lost weight and he certainly looks well." When we arrived for our visit, some people were still in the dining room eating their breakfast. People had a choice of cereals and porridge and one person told us they had enjoyed a cooked breakfast of eggs on toast. At lunch time there was a choice of fish in lemon and dill sauce or sweet and sour pork. Both options were plated up and shown to people to assist them in making their choice which was supportive of people living with dementia. In the dining room, most people were able to eat independently, but staff were available to assist people if they needed support. One person took a long time to eat and a member of staff sat with them throughout

Requires improvement

Is the service effective?

the lunch time meal supporting at a relaxed pace that suited the person. Staff were aware of people who were able to eat independently, but required encouragement and prompting to eat.

Care plans contained information about people's nutritional needs. Where risks had been identified, a nutrition care plan was in place to minimise the risk. For example, people who had difficulty swallowing received pureed food and thickeners in their drinks. Staff we spoke with demonstrated a good knowledge of those people's nutritional needs. One staff member told us, "[Person] likes a cup of tea and chocolates. Now they can't have them because they can't swallow. They are on puree now and drinks have to have thickener."

Some people who were at risk of not eating or drinking had food and fluid charts completed so that their intake could be monitored. When we looked at food and fluid charts, these had not been completed sufficiently or consistently to be sure people had eaten and drank enough to maintain their health. For example, sometimes staff had indicated people had eaten all their meal, but it was not clear what the full meal consisted of. The senior member of staff on duty at night was delegated to total the amount of fluid people had taken that day to identify those people at risk of dehydration. They could then inform staff coming on shift to prompt and encourage those people to drink more, however, this was not always being done. Information recorded on the food and fluid charts was not always being monitored to ensure risks associated with people's nutritional health were managed.

People were weighed regularly and an analysis of the weights had identified a number of people within the home had experienced some weight loss. The provider had carried out a "weight loss support visit" to the home and assessed the dining experience for people who lived there. Following the visit, the catering team had been given an action plan. This included actions to be followed in respect of people with a loss of appetite and further training in supporting people who required specialised diets. The registered manager told us the provider would continue to review weight charts to ensure the action plan was being fully implemented.

Care records showed that people were referred to health and social care professionals when a need was identified and supported to attend regular health checks. These included the district nurse, the speech and language team (SALT) and psychiatric services. A weekly GP surgery meant people received consistent support for their medical needs.

Staff told us 'handover' meetings held at the beginning of each shift enabled them to communicate any areas of concern so they could be followed up if needed. Written records of the handover meetings showed whether any GP or other healthcare professional visits were planned for the day, any medicine or prescription queries and any issues of concern for each person so they could be monitored.

Requires improvement

Is the service caring?

Our findings

People and relatives were positive in their comments about the staff. They told us, “They are friendly and you can approach them,” and, “The carers could not be nicer.”

We saw staff were caring in their approach, but the main interaction with people was focussed on when they offered support or completed a care task. On the first day of our inspection, staff appeared rushed and unable to spend time talking with people. Some staff did not always take the time to engage and communicate with people when they had the opportunity. For example, one member of staff walked into a lounge where two people were sitting. They spent five minutes in the lounge selecting some care records before walking out again. At no time did they acknowledge or speak to the people sitting there. Staff spent long periods of time in the lounges completing records rather than talking to or engaging with people.

Where staff did spend time with people, it was clear people enjoyed the engagement. For example, we observed one member of staff who spoke Polish took time to speak to a person whose first language was Polish. Another person had recently moved into the home and was finding it difficult to settle. The registered manager reassured the person and encouraged them to help with the mid-afternoon drinks rather than sit in their room by themselves. On the second day of our visit the person sat with the registered manager in her office while she completed some managerial tasks. This one to one support helped to alleviate the person’s anxiety. Another member of staff sat with a person and gave them physical reassurance by stroking their hand. A member of staff told us, “Mornings are busier than afternoons. You can interact with service users more in the afternoons.”

People were offered choices about what they wanted to eat and drink and most people were able to choose where they wanted to spend their time. People who were independently mobile were able to move around the home at their own will and use any of the lounges or dining areas.

There were occasions though when staff took decisions without asking people. For example, one member of staff put a DVD on, but did not ask the people in the room what they wanted to watch.

We noticed that clocks and calendars were not maintained to ensure they showed the correct date and time to promote people’s independence and dignity. For example, we visited on Tuesday but calendars showed it was Sunday. Clocks in communal areas had stopped. A Christmas tree in a box was in the corner of the activities room. This can be disorientating to a person with a diagnosis of dementia.

We found inconsistency in the promotion of people’s dignity and personal sense of wellbeing. On the first day of our inspection we saw three occasions when people were walking around with wet trousers because they had not been assisted with appropriate continence care. When staff became aware of these people’s needs for personal care, they discretely approached the person and led them to their bedrooms so they could provide the assistance they needed in privacy. Another person was in the lounge and had food on their face after eating their lunch. As the person walked through the lounge a member of staff held them by the shoulder and wiped their face in front of visitors and other people. One person told us they did feel staff respected them and said, “They do maintain my dignity, give privacy and I like to stay on my own. I am well looked after.”

Daily records were kept in chests in the lounge areas. These were not locked and were accessible to anyone in the lounges. Care plans were kept in the care office. This was not always locked and the cabinet where the care plans were stored was also not locked. This meant personal information was not always kept securely and confidential.

People were encouraged to maintain relationships with those who were important to them. Throughout our inspection we saw relatives coming to the home to visit their family members. Visitors were able to choose whether to see people in private or sit with them in the communal areas. There were no restrictions on people visiting.

Requires improvement

Is the service responsive?

Our findings

People told us there were some activities and entertainment within the home which met their social needs. One relative told us, "They are taken to the pub for beer and the garden centre in the minibus. Yes there is entertainment, but not activities, apart from skittles and playing with blown up balloons." Another relative told us, "People come out to talk about old wars, do western music and a lady sings old songs."

There was an activities co-ordinator who supported the activities and entertainments in the home. One staff member told us, "There are arranged activities, but these usually only take place about three days out of seven." On the first day of our inspection we did not see any activities in the morning, but in the afternoon some people joined in a game of bingo. On the second day there was more going on to engage people's interests. Some people enjoyed listening to a singer in one lounge while in the other lounge people took part in a horse racing game.

Whilst some people clearly enjoyed these group activities, there was little evidence of person centred activities which related to interests that were important to people in the past or that were important to them now. We found there were long periods of inactivity in the lounge areas when people were sleeping because there was little to interest them or provide activity and occupation that was meaningful to them. There were missed opportunities to engage people with daily tasks or interests and to maintain life skills.

We looked at a selection of care records. These covered all aspects of people's individual care needs, the support they needed and how these were met. The records contained information about how people preferred their care and support to be delivered. Permanent staff we spoke with had a good understanding of people's support needs, but limited knowledge of their backgrounds so they were unable to engage people in conversations that were meaningful to them. This meant people were defined by what support they needed rather than who they were.

At our last inspection in September 2014, the provider had developed the environment to make it more friendly and responsive for people living with dementia. Items had been introduced to provide sensory stimulation and to promote engagement of people with dementia care needs. Rummage drawers in lounge areas contained objects of different shapes and textures to provide sensory stimulation. Items of interest had been introduced to corridors to engage people as they explored their home. At this inspection we found these items had been removed and placed into the "activities room". This room was locked and not accessible to the people who lived in the home. There were no pictures of interest in communal areas and no tactile or scented objects within easy read to stimulate people's interests or senses or promote spontaneous conversations.

Should anyone wish to make a complaint, there was a copy of the provider's complaints policy and procedure in the hallway for people to read. There was also information about external organisations people could approach if they were not happy with how their complaint had been responded to. We looked at the complaints file maintained by the registered manager. The complaints log confirmed that any complaints received had been responded to promptly and in accordance with the complaints policy.

People we spoke with told us they had never had cause to make a complaint but would talk to a member of the management team if they did have any concerns. One relative told us, "Firstly, I would come in and see Lyndsey (the registered manager) and if it wasn't sorted out to my satisfaction, I would have to investigate who I should see."

Requires improvement

Is the service well-led?

Our findings

The registered manager had been in post for six months. People told us the home was well managed and the registered manager was available. One relative said, "Lyndsey, (registered manager) you can approach her and speak to her about anything." Another relative told us, "The manager is approachable and she is nice."

Staff also spoke positively about the registered manager and told us she took time to listen to them. One staff member told us, "I can approach the manager, she's good. It's teamwork. The manager is good at listening to staff. We work well together." Another said, "If you are unhappy with anything you can go and talk to the manager."

The registered manager told us they spent time in the home observing the care being provided. This was confirmed by staff who told us, "She does come out and do a walk around." However, we found some staff did not work in line with the provider's training for safe moving and handling of people. We also found the environment provided limited stimulation for people with dementia care needs. The registered manager had not identified either of these concerns during their 'walk around' or observations of staff practice. We also found a high level of annual leave and sick leave at the time of our visit impacted on the continuity and consistency of care.

Staff told us they enjoyed working in the home. One staff member told us, "I'm happy here, it's a lovely place to work. They are a good company." The provider had a process of recognising individual staff member's commitment with "Kindness in Care" awards. Staff who received the award were presented with a certificate and gift vouchers and their photograph was displayed on the noticeboard in the entrance hall.

The provider had recently introduced a new engagement programme called "Have your Say." This was a new initiative encouraging people, relatives, care professionals and staff to provide feedback through a computer tablet in the entrance hall. The registered manager explained that the programme would provide people with an opportunity to provide instant feedback about the care provided.

People were asked to attend regular meetings so they could make suggestions about how the home was run. A "You said, we did" board demonstrated some of the improvements that had taken place as a result of comments made. For example, family and visitors had asked for more information about what activities were planned each month. We saw a four weekly rota of activities was displayed by the dining room. People had asked to go out on more outings and a minibus was now available to take people out once a week. The provider was in the process of refurbishing the dining room. They were using a design book that was dementia specific so people living in the home could make decisions about what they wanted the new dining room to look like.

Staff attended regular staff meetings and told us they felt confident to raise concerns. Looking at the minutes of the last couple of meetings we found the provider had identified some of the concerns we found during our visit. For example at the meeting in May, there had been a discussion about staff not completing topical medicine records correctly. We found this was still an issue and had not been fully addressed.

Staff were also invited to complete a staff survey. We looked at the survey completed in June 2015. We saw that 29% of staff said there was insufficient time and resources to offer activities for people, 28% said they did not regularly discuss their development needs and 21% said they did not receive regular supervision. These were all areas where we identified that improvements were required.

Records we looked at showed that staff recorded when an accident or incident occurred. Incident records were reviewed to identify patterns or trends, for example any falls people had or where falls had occurred. We saw appropriate action had been taken following incidents to minimise further risk and to avoid re-occurrence.

The registered manager was responsible for providing quality monitoring information about all aspects of the business to the provider. This meant the provider played an active role in quality assurance and ensured the service continuously improved. The provider made regular quality monitoring visits to the home and identified any actions that needed to be taken to maintain the quality of the service provided. These visits had not identified some of the areas where we found improvements were 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 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services were at risk of unsafe care because staff did not always have the experience or understanding to follow management plans to mitigate identified risks. Regulation 12 (2)(c)