

A Cox and Mrs Z Cox

Ashleigh Nursing Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Good 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

Ashleigh Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulated both the premises and the care provided, and both were looked at during this inspection.

Ashleigh Nursing Home accommodates 21 people in one adapted building. At the time of our inspection there were 17 people using the service.

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.

This is the third time the service has been rated Requires Improvement.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

We looked around Ashleigh Nursing Home with the registered manager and found improvements were needed. We found many furnishings, including carpets and armchairs in communal rooms and bedrooms to be stained or torn. Paintwork in many bedrooms and corridors was damaged. We found a toilet that had a broken seat and pull cords in bathrooms and toilets to be heavily stained. Bed linen, including duvets and sheets had worn thin. A majority of the shortfalls we found had not been identified by the provider in their audit of the environment.

The registered person and registered manager did not have robust and reliable systems and processes in place to assure themselves as to the quality of the service being provided. This lack of oversight about the quality of the service and the services governance, meant shortfalls and areas for development and improvement had not always been identified. Plans for development in some areas had been identified, however there were no written plans about how and when these would be implemented, who would be responsible for their introduction and the process of how they would be monitored.

There were limited formalised opportunities for the management team, nurses and staff to share information about the quality of the service, share ideas for improvement and address shortfalls and concerns as staff meetings had not taken place.

People using the service and their family members spoke positively about the care they received, which included positive comments about the atmosphere of Ashleigh Nursing Home and the friendliness and approachability of staff.

People's safety was promoted by staff that had the appropriate training to monitor and support people to be safe. Potential risks were identified and action to reduce these was taken. There were sufficient staff to keep people safe and staff were aware of their responsibilities in monitoring people's safety and well-being. People received their medicine and were supported by staff with the appropriate knowledge and skills in the management of medicine.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrict way possible; the policies and systems in the service supported this practice. People were supported by staff that had the necessary training and skills to provide care and support. Staff worked collaboratively with people using the service and health and social care professionals to monitor people's health to maintain and promote people's well-being. People's dietary requirements along with their likes and dislikes with regards to food and drink were recorded. People expressed satisfaction with the meals.

People spoke positively about the caring attitude and approach of staff. Staff promoted people's dignity and all interactions between staff, those using the service and family members were positive to ensure the best outcomes for people.

People were encouraged to make decisions about their care and treatment and people's care plans reflected their opinion about the care they wished to receive, which included any decisions made about end of life care. People received visits from family members and friends who were greeted warmly by staff.

We spoke with a family member who had raised a concern to the registered manager. They told us the registered manager had acted on their comments straight away, and that changes introduced had had a positive impact on their relative.

The registered person and registered manager had upheld their legal responsibility by submitting notifications to the Care Quality Commission (CQC) of events which had taken place in the service. The provider had displayed the CQC rating from the previous inspection within the service and on their website. Staff told us they found the registered manager to be supportive.

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 safe.

People were safeguarded from abuse as robust systems and processes were in place, which included robust staff recruitment practices.

People's safety was monitored, with risk assessments and care plans providing clear information for staff as to how people's safety was to be promoted.

People were supported and cared for by sufficient numbers of staff to ensure their individual needs were met.

People's needs with regards to their medicine were identified within their care plans and medicine management systems were robust.

Good ●

Is the service effective?

The service was not consistently effective.

The provider's monitoring of the premises was ineffectual. The premises and furnishings were not sufficiently maintained, which meant people's living environment was not of a good standard.

People's needs were assessed and were used to develop care plans, which provided information as to their needs, which included guidance on the nutritional needs.

People's health and welfare was promoted as staff liaised effectively with health care professionals.

Staff were aware of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. People using the service, family members and health care professionals were involved in decisions about people's care and support.

Requires Improvement ●

Is the service caring?

The service was caring.

Good ●

People were supported by staff that were kind and caring and who spent time with them providing reassurance, care and support.

Staff respected people's privacy and dignity and independence, which was acknowledged by those using the service and family members.

People's information was stored securely.

Is the service responsive?

Good ●

The service was responsive.

Care plans detailed the care and support people required and were regularly reviewed and evidenced people's changing needs were responded to.

Concerns had not been recorded, however concerns raised had been actioned.

Is the service well-led?

Requires Improvement ●

The service was not consistently well-led.

A registered manager was in post.

The provider's and registered manager's approach towards the monitoring of the quality of the service was haphazard. Audits were not routinely carried out or planned. Therefore, the opportunity to identify shortfalls and implement the required improvements were missed.

The providers' and registered managers' approach to providing and promoting opportunities for staff to comment upon the quality of the service was limited.

There was no written plan in place for the development of the service.

People's responses to questionnaires distributed by the provider identified satisfaction with the care being provided. Family members spoke positively about the service and the care their relatives received. Staff spoke positively of the support provided by the registered manager.

Ashleigh Nursing Home

Detailed findings

Background to this inspection

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

The inspection site visit took place on 27 June 2018 and was unannounced. The inspection team consisted of two inspectors, and a Specialist Professional Advisor.

We used the information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection we reviewed all the information we held about the service. This included concerns received about the service and notifications we had received from the provider. A notification is information about important events and the provider is required to send us this by law. We reviewed the provider's statement of purpose. A statement of purpose is a document that describes the facilities and services, what people can expect to receive and the provider's philosophy of care; visions and values.

We contacted commissioners for health and social care, responsible for funding some of the people that use the service and health care professionals involved in the care of people living at Ashleigh Nursing Home Court and asked for their views. We used this information to inform our inspection judgements.

We spoke with three people who use the service and three family members who were visiting their relatives. We spoke with the registered person, the registered manager, two nurses and three members of care staff.

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 looked at the care records of three people, which included their medicine records, care plans and risk assessments. We looked at the recruitment records for four staff and staff training information. We looked at

a range of documents including meeting minutes, audits and complaints and records relating to how the provider monitored the quality of the service being provided.

Is the service safe?

Our findings

A person told us they felt safe at Ashleigh Nursing Home and why. They told us, "I feel safe, because staff can look after me." Staff had received safeguarding and understood what procedures were to be followed if they suspected or witnessed abuse. This included contacting outside agencies such as the police, The Care Quality Commission (CQC) and local authority safeguarding teams. The registered manager provided information when required, to the local authority and other agencies involved in the investigation of safeguarding concerns.

Risk assessments were undertaken on a range of issues to promote people's physical safety and welfare when they first moved into the service and were regularly reviewed. Risk assessments identified the action to be taken to reduce potential risks. For example, a number of people had been assessed as being at risk of malnutrition. Care plans for people had been developed to encourage them to eat and drink, and where appropriate referrals to dieticians were made who in some instances had prescribed food supplements. We found people's risk assessments were regularly reviewed and people's daily notes recorded the care and support people received to maintain a healthy food and fluid intake.

A number of people were living with dementia had risk assessments in place as their behaviour at times could be challenging to others. The risk assessments were regularly reviewed and were used to develop care plans. People's care plans identified how staff were to support the person using de-escalation techniques, daily notes showed this approach was affective and promoted people's well-being and safely.

Information was held in a central location which could be accessed in an emergency, this included individual personal emergency evacuation plans (PEEPs). The PEEPs provided a brief overview of the person's health, their ability, and the level of assistance required to evacuate in an emergency and details as to any equipment needed.

People who due to their health or personal preference remained in their bedroom had access to a call bell, which they could use when they required assistance. Our observations showed that staff responded to people's request for assistance in a timely manner. One person told us that they found it easy to get staff when they were in their bed.

The provider engaged external contractors to maintain and service equipment, which included electrical and gas systems, the fire system and equipment used to support people in the delivery of their personal care, such as hoists and other mobility aids.

A nurse is on duty at all times along with care staff, staff we spoke with provided mixed views on staffing levels, a majority of staff told us there were sufficient staff to meet people's needs, whilst a minority stated an additional member of staff was needed. The registered manager confirmed they had not recently assessed the needs level of people using the service to determine the staffing level required. The registered manager spoke with the provider about this, saying they would complete the assessment to assure that staffing levels were sufficient. We found that staff responded to people's needs in a timely manner.

People were safeguarded against the risk of being cared for by unsuitable staff through the provider's recruitment procedures. Recruitment files we looked at contained evidence that the necessary employment checks had been completed before staff started to work at the service. These included application forms with a full history of employment, identification documents and a check with the Disclosure and Barring Service (DBS). The DBS carry out criminal record and barring checks on prospective staff who intend to work in care and support services to help employers to make safer recruitment decisions. For nurses, a check of their Nursing and Midwifery Council registration was carried out.

We spoke with a person about their medicine. They told us, "Staff bring me my medicine and sit with me while I take them." They went on to say how staff responded and supported them when required. They told us, "If I get sore skin, out comes the cream."

Where some people had declined to take their medicine, a best interest decision had been made that their medicine was to be administered covertly (without their knowledge), as an assessment had identified the person did not have the capacity to make an informed decision about their medicine. A pharmacist reviewed all the medicine prescribed and identified how the medicine should be administered, for example what food or drink. This was to ensure that any medicine given remained effective.

We found the cleaning of surfaces of equipment and soft furnishings to be hampered due to damage. Staff had undertaken training in infection control and staff wore personal protective equipment, such as aprons and gloves when providing personal care. The provider employed staff to undertake cleaning within the service.

External safety alerts and information received by the service, for example about equipment or medicine, were printed out and reviewed, and had been recorded as no action required and signed by the registered manager.

Is the service effective?

Our findings

We looked around the premises with the registered manager and found a significant number of shortfalls. The registered manager told us they would speak with the registered person and take action. Many of the shortfalls had not been identified by the registered person. Carpets and chairs in people's bedrooms were stained. Carpets in communal areas, including corridors were stained. Armchairs in the blue lounge were damaged, which included stains and torn upholstery. We noted an odour of urine in two bedrooms. There was damage to paintwork in people's bedrooms and communal areas including corridors. The toilet seat of the ground floor toilet was broken and pull cords in bathrooms and toilets were stained. The registered manager informed us that the two bathrooms on the first floor were not used, in part because one was not accessible to people and many of the people on the first floor received their personal care in bed due to their health needs.

Some equipment was also found to be in poor state of repair, for example 'bumpers/buffers' which were in place on bed guards were damaged, the shower chair in the ground floor bathroom under the stairs had rusty wheels. Bedroom storage, including draws and bedside cabinets were damaged on the surface. The curtains in some bedrooms were not hung well, and in some instances, were shorter than the window. We noted pillows on some beds were misshaped and duvets covers and sheets were thin from frequent laundering.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (regulated activities). Regulations 2014. Premises and equipment.

People were involved in identifying the assistance they would like prior to care being provided, which included recognising any needs people had in relation to protected characteristics as defined by the Equality Act 2010. This included areas such as support with their physical and social needs. Assessments. A nurse we spoke with explained to us about their understanding of discrimination and talked about how they did not judge people by their colour, race, gender and how being non-judgemental about people when working with them to develop their care plan.

Assessments of people's needs were undertaken by a commissioner where people's care was funded, and everyone had an assessment of their needs carried out by the registered manager or another member of staff of the service. Assessments identifying people's needs were used to develop care plans, outlining the care and support people required. As part of the assessment process the involvement of health care professionals was incorporated, with copies of their recommendations sent to the service, to ensure continuity of care.

A recently recruited member of staff spoke positively of the support they had received from the registered manager and staff. They told us they had worked alongside experienced staff as part of their induction, which enabled them to learn about the needs and preferences of people. They told us they had that morning received a telephone call from an external company to confirm that the registered manager had secured a placement for them to study a vocational qualification in care.

A nurse spoke to us about how they kept up to date with good practice by accessing information from websites for nurses. They spoke of NICE (The National Institute for Health and Care Excellence) guidance in the use of medication for people living with dementia and the need to try to reduce its use.

Staff told us that having observations and feedback as part of their supervision and appraisals improved their practices. The registered manager provided formal supervisions, through one to one meetings; this provided an opportunity for staff to talk about their role within the service, their training as well as providing an opportunity to share their thoughts and concerns. In addition, staff said they had their work 'observed' by the registered manager, to which feedback was provided. The purpose of observed supervision was to ensure staff delivered people's care consistent with their care plan, so that the provider and registered manager could ensure themselves that people were receiving effective care.

People we spoke with commented on the meals. One person told us, "I have enough food." A second person said, "The food is delicious, breakfast lovely, teal lovely, lunch different all the time, we have a jolly good cook." We spoke with the chef, who told us. "I try to vary food and always on the lookout for new menus."

We spent time in the dining room at lunchtime, people were offered a choice about where they ate their meal, some choosing to remain in their bedroom or a lounge. People were offered a choice of what they wished to eat and drink and were encouraged to eat independently. Meals were served on red plates for those living with dementia, which reflected good practice guidance. Staff aided those who required support on a one to one basis and with sensitivity, sitting and speaking with the person to make the dining experience positive. We saw drinks and snacks were served regularly throughout the day.

People's dietary needs were detailed within their assessments and care plans, and where appropriate people had been referred to a dietician. People who were at risk of poor nutrition had in some instances been prescribed food supplements.

Ashleigh Nursing Home had been awarded a 4 star rating of 'good' from the Food Standards Agency (FSA) when we carried out our inspection. (The ratings go from 0-5 with the top rating of '5' meaning the service was found to have 'very good' hygiene standards).

A 'hospital pack' held information in a central location and was easily accessible should people need to access health care services either in an emergency or a planned admission. The hospital pack included a picture of the person, identification information such as NHS number and their age. In addition the information included a summary of medical conditions, including known infections, prescribed medicines and nutritional requirements. Decisions made by people and health care professionals were also included, for example where advanced decisions had been made about their care.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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 process for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

A nurse told us mental capacity assessments were carried out if staff had reason to believe that a person did not have the capacity to make an informed decision. They told us mental capacity assessments were

recorded within people's records and were used to support applications for a DoLS's, for example where people declined personal care.

We checked whether the service was working within the principles of the MCA and whether any condition on authorisations to deprive a person of their liberty were being met. We found copies of these authorisations were available in people's records with conditions being met. For example, a person's medicine was reviewed consistent with a condition of their DoLS.

Is the service caring?

Our findings

People spoke positively about Ashleigh Nursing Home and shared their views with us. One person described it as a "nice place." One person told us, "The people are lovely here." And a third person told us, "The girls (staff) are very good." A fourth person told us, "I am happy here, I can watch TV." People told us that staff worked together as a team.

We observed staff greeting visitors of people using the service in a friendly manner. People's family members and friends who were visiting shared their views about the staff. One visitor told us, "I have a good relationship with staff." A second visitor said, "Staff are very helpful, they get us chairs so we can sit together, they get us a cup of tea so we can sit and have a cup of tea with [person]".

Staff had developed positive relationships with people and using information they knew of their backgrounds were seen to start conversations with people. Staff were seen to reassure a person when they became anxious and provided reassurance to family members who were visiting. Staff told us they had good working relationships with other team members and the management team, supporting each other which had a positive impact on people they cared for and supported.

A family member described how they were involved in their relative's care plan and had been invited into review it with staff.

Family members had acknowledged the care and support provided to their relatives, with family members sending thank your cards. Cards included family members comments. For example, 'I would like to thank each one of you who contributed to the care of [person's name] over the last...years. You not only provided them with a home but a surrogate family as well. Thank you for your kind words and attention to detail.'

We found the atmosphere at the service to be very relaxed, staff provided support and care at a pace to suit each person. People we spoke with said staff were respectful and they felt their dignity was upheld when they were receiving personal care. We observed staff knocking before entering rooms and doors were closed when staff delivered personal care. People had personalised their bedrooms with photographs and ornaments.

The registered manager was aware of changes to legislation with regards to the storage and accessibility of people's information, covered by The General Data Protection Legislation. Information as to its impact had been shared with staff and family members of people using the service had been contacted.

Is the service responsive?

Our findings

A nurse told us how people's care plans were written from the perspective of the person to ensure their needs reflected their wishes and preferences. The nurse confirmed people's family members and their doctor were also involved, where people using the service were not able to express their wishes.

People's records, including risk assessment, care plans and daily notes were stored electronically. Staff had hand held electronic devices, which meant all interactions with people, which included all aspects of care, were recorded at the time the care was provided. The system also alerted staff when aspects of people's care and support needed to be provided, for example, where the person due to their health remained in bed, it reminded staff to re-position the person to promote good skin integrity and to reduce the risk of the development of pressure areas. This meant staff had access to up to date information which enabled them to provide care and support to meet individual needs.

People's preferences and choices with regards to their wishes in relation to end of life, where appropriate have been discussed and their views recorded within a care plan. Staff had received training in end of life care. For people who do not wish to be resuscitated, Do Not Attempt Cardio Pulmonary Resuscitation. (DNACPR) forms recorded their wishes, and had been signed by the appropriate health care professional.

A person receiving end of life care had medicine prescribed to manage their pain and symptoms, however there was no care plan providing guidance. We spoke with a nurse, who told us a care plan would be put into place. We found their care plan did not contain the correct information to support their needs, which included being cared for in bed where appropriate with an emphasis on ensuring the person was comfortable and regularly reposition to prevent the person's skins from becoming damaged and sore.

Organisations that provide publicly-funded adult social care are legally required to follow the Accessible Information Standard (AIS) which says services should identify record, flag, share and meet information and communication support needs of people with a disability, impairment or sensory loss. We found information about people's communication style to be included within their care plans and within the hospital information packs that accompanied people for planned or emergency visits to hospital.

The environment had some adjustments made to meet the needs of people living with dementia, for example by using décor, signs and symbols to assist people in locating facilities within the home, such as clear pictorial signage on toilet and bathroom doors. The environment had been used to provide points of interest for example, communal areas of the service had been decorated with 'themes' in mind. This included a corridor displaying three-dimensional sports equipment, which included a football, tennis ball and racket.

The side garden and courtyard area had seating, which overlooked a wall which had been painted to represent places of interest for people to look at, which included 'shop fronts', a butchers, green grocers and a post office.

On the day of our visit, those who were not in bed sat in a lounge watching the television. During the day a number of people received visits from family members and friends. In the afternoon staff sat with people, engaging them in conversation, which included comments on the football match people were watching. Opportunities for people to take part in activities were organised, which included visits from a range of performers, including theatre shows and visiting animals and presentations about the animals.

The registered person had not received any formal complaints; however, a family member had raised a concern with the registered manager by telephone. The registered manager told us about the concern, which had not been documented. The concern was considered by the registered manager who responded by informing staff of the required changes in a staff memorandum displayed in the office of the service. We spoke with the family member who had raised the concern and was visiting their family member. They told us the registered manager had acted on their concern straight away, which had improved the experience of their relative. Information about how to raise a complaint was displayed in the service.

Is the service well-led?

Our findings

A registered manager was in post at Ashleigh Nursing Home and the registered person visited the service regularly.

The registered person's and registered manager's approach towards the monitoring of the quality of the service was haphazard. Audits were not routinely carried out or planned. Therefore, the opportunity to identify shortfalls and implement the required improvements were missed.

The monitoring of the premises was ineffectual. An infection control audit had not been undertaken since April 2017. We found areas of improvement were needed to the environment and equipment to enable effective infection control procedures. An audit of the environment had not been carried out since March 2017, however on the day of the inspection the registered person carried out an audit of the environment, which they shared with us. The audit identified improvements were needed to the two lounges, which included decoration, new furnishings and flooring. However, we found the audit was not robust. We looked around the premises with the registered manager and found a significant number of shortfalls and improvements were required.

An audit carried out recently by an external stakeholder in health and safety had found shortfalls. The provider had been given an improvement plan detailing the action required.

Audits of records were not robust or comprehensive. The registered manager had begun an audit of care plans in June 2018, with four care plans being audited. Prior to this the most recent audit of care plans had been carried out in July 2017.

The medicine audit had been carried out in June 2018, it identified that all areas were complaint. However, it contained no information about what records had been reviewed and the tool used to measure compliance in order to reach the conclusion that there were no shortfalls.

Policies and procedures had been reviewed. We found policies and procedures to be limited in their content. For example, the policy for the supervision and appraisal of staff made no mention as to the frequency of supervisions and appraisals or the expectations of staff in relation to their participation and the expected outcome and purpose.

The Provider Information Return (PIR) referred to a range of identified improvements. These included the introduction of 'care champions', the provider states these will raise the quality of the service. Other identified improvements, included raising awareness of mental health through training, and the development of a guide for family members, providing information about the services and how care is delivered, monitored and evaluated. The PIR stated improvements would be made over the next 12 to 18 months. The registered manager confirmed there was no written plan in place detailing how identified improvements would be introduced, by who and how they would be implemented or monitored.

We spoke with the registered manager about the shortfalls we had identified in quality assurance and governance. They told us they had a meeting planned with a representative of an external organisation that provided quality assurance documents and guidance, supported by policies and procedures. The registered manager said the meeting was to find out whether the service provided by the external organisation would meet the needs of the service in monitoring the quality of the Ashleigh Nursing Home.

The PIR reflected that staff from Ashleigh Nursing Home liaised with a range of health care professionals, with a view to sharing good practice and meeting the needs of people with specific needs, which included dementia and End of Life Care.

The registered persons' and registered managers' approach to providing opportunities for staff to comment upon the quality of the service being provided and share ideas was limited. Staff meetings were not routinely held, the most recent staff meeting had taken place in November 2016. There were no staff meetings planned. Staff received supervision on a one to one basis, and through observed practice. However, supervisions were not planned in advance and happened when initiated by the supervisor.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (regulated activities). Regulations 2014. Good governance.

Staff told us they were supported by the registered manager. One member of staff said, "I'm well supported, I can approach management with anything." A second staff member said, "I have been more supported here in 3 weeks (recently employed) than I did at my last job." Staff members commented on the atmosphere of the service. A member of staff said, "What's very good here is the relaxed atmosphere, I feel included in everything, if you need help they (staff) help you, nothings rushed." A second staff member told us, "Staff are welcoming, I feel part of the team."

Family members visiting relatives on the day of our visit were complimentary about the relaxed atmosphere of Ashleigh Nursing Home and the staff friendliness. One family member said, "I'm always welcome." A second family member told us, "Always welcome here when I come."

People's views and that of their family members had been sought in May 2017, we found the completed surveys to be complimentary about the service and in some instances, had made specific reference to individual members of staff, singling them out for praise. The registered manager told us information gathered from surveys would be analysed and shared.

The registered manager confirmed that with the support of the registered person and the nurse employed at the service, they had reduced the number of days which they provided nursing care to people. They told us this meant they had additional days to focus on the day to day running and management of the service.

The registered person and registered manager had upheld their legal responsibility by submitting notifications to the Care Quality Commission (CQC) of events which had taken place in the service, such accidents or incidents and deaths. Consistent with their legal responsibilities the provider had displayed the CQC rating from the previous inspection within the service and on their website.

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 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to ensure fixtures and fittings within the service were of a good standard of repair and well-maintained.
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to implement effective systems to monitor the quality of the service and to put plans in place to bring about improvement. The provider had failed to provide sufficient opportunities to consult with staff on the quality of the service being provided to drive improvement.