Miltas Limited

Newbridge Towers

Inspection report

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Date of inspection visit:
05 April 2018
06 April 2018

Date of publication:
16 May 2018

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 5 and 6 April 2018 and was unannounced.

Newbridge Towers 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.

Newbridge Towers accommodates up to 20 people in one adapted building across four floors. At the time of our inspection there were 18 people living at the service. There were gardens to the back and sides of the building which were being landscaped and a paved are in front of the premises.

A manager was in post at the time of our inspection. They were undertaking the registration process to be the registered manager of the home. 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.

Risks to people's safety had not always been identified, rectified or reduced. Radiators were not covered to prevent the risk of burns and other risks did not have effective plans to reduce the risk to people. People's individual risks were not always identified and staff had not developed plans to manage these. For example risks to people's skin and mental health.

Staff had not always learnt from accidents, for example when one person had sustained falls staff did not develop a care plan to keep them safe and reduce the risk of further falls.

Staff had not received regular and effective supervision to support them to carry out their work.

Care plans were minimal and generic and did not contain full information about people's care needs. Care plans did not contain information about how people liked their care to be delivered. One person's care records were not completed but the provider's systems had not identified the records were missing.

The provider did not have an effective system in place to monitor the quality and safety of the service. Regular quality assurance checks had been conducted but did not identify or address the shortfalls we found during our inspection.

Everyone we spoke with at Newbridge Towers told us they felt safe living there or that they felt their relatives were safe living there.

People were supported to eat and drink enough and were very complimentary about the food. The introduction of breakfast in the dining room rather than people's bedrooms had increased people's weight

and food intake.

Staff liaised with health professionals as needed and outcomes of visits were recorded in people's care files. However, care plans were not updated to contain any changes to people's care to guide staff.

Staff had a clear understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected.

People were complimentary about the staff and we observed staff spoke about people warmly. Staff were friendly in their manner towards people.

Medicines were managed safely. The provider had ensured all equipment at the home was regularly serviced and safe to use.

Safeguarding procedures had mostly been followed; however we found one incident which had not been reported to the local authority safeguarding team and the Care quality Commission.

There were sufficient numbers of suitably qualified staff at the service who had undergone checks before employment. The provider addressed staff performance problems and took suitable action.

The manager had a vision for the service and had begun to make some changes. The service was now fully staffed.

Staff morale was good and they were positive about the manager.

We found four 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The provider had not always identified environmental risks to people's safety.

Individual people's risks had not always been assessed.

There were sufficient staff who had been recruited safely.

Medicines were managed safely.

Staff knew how to identify and report abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Assessments were completed but were not always used to inform people's care needs.

Supervision of staff had not been delivered regularly for a long time and records were of poor quality.

The food was of a good standard and improvements had been made to breakfast. However there was a lack of available menus for people.

The service communicated well with health care professionals.

Is the service caring?

Good

The service was caring.

People were treated with respect and kindness.

Staff always knocked on people's doors.

Staff respected people's wishes in how they liked to spend their time.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were of poor quality and did not contain information about people's preferences.

There was limited information about people's care needs.

Social opportunities and activities were limited in the service.

Is the service well-led?

Requires Improvement

The service was not well led.

The quality and governance framework had not always identified shortfalls in the quality and effectiveness of the service.

Health and safety audits and other systems to monitor the safety of the service had not been carried out for over three months.

Staff were complimentary about the manager and had good morale.

Newbridge Towers

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 was the first inspection under the new provider and was unannounced. However the current provider took over the operation of the service in August 2016 following the death of the service provider. The personal representative of the deceased service provider, where that provider is an individual, may continue to provide the regulated activity, accommodation with personal care, for a specified period.

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

Before the inspection we reviewed information we had about the service including statutory notifications. Notifications are information about specific events that the service is legally required to send us.

Some people at the service were not able to tell us about their experiences. We used a number of different methods such as undertaking observations to help us understand people's experiences of the home. As part of our observations we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the needs of people who could not speak with us.

During the inspection we spoke with nine people living at the home, two relatives and seven staff members, this included senior staff, and the manager. We also spoke with a visiting health professional. We looked at medicine records, three people's care and support records and four staff files. We also looked at records relating to the management of the service such as incident and accident records, meeting minutes, supervision and training records, policies, audits and complaints.

Requires Improvement

Is the service safe?

Our findings

Risks to people's safety had not always been identified, rectified or reduced. The provider had two health and safety audits which identified a lack of covers on radiators. Every radiator in the home was uncovered. People living in the home were vulnerable to risks from hot surfaces and may not be able to react quickly enough to prevent injury. This was a risk that people may fall against the radiator and be burnt. People with a cognitive impairment may sit touching the radiator and not realise they could be burnt. The quality assessor for the provider had identified the lack of radiator covers in November 2017. Their recommended safety measure was to set all radiators at a lower setting. However, this was not an adequate measure as settings could be easily changed. The risk assessment did not recommend the fitting of covers. There were no individual risk assessments for people who may be at higher risk from this. We raised this with the manager at the inspection.

Other risk assessments did not identify risks to people clearly and contain measures to reduce risk. For example a therapy dog visited the home. Risks identified were, 'disruption, noise and trip risk'. The assessment did not identify possible allergies or a person being frightened of dogs. There was no clear plan about who was responsible for the dog, where it would go in the home and how people who did not like dogs would be supported.

People's care records did not always contain comprehensive risk assessments and management plans. One person suffered from an ongoing skin complaint. They required consistent staff support with continence to help manage this condition. There was no information in care files to alert staff to this risk or guidance on how to manage it. This person had also developed sore skin following incorrectly completed personal care. There was no body map or information to alert staff to this risk. We asked the manager about this person and were told one member of staff knew them and their care needs very well. However, the service had been using high numbers of agency staff until recently and had also recruited a number of new staff. This meant staff new to the service may not be fully are of their support needs.

The same person had fallen five times earlier in the year. Staff had not completed a falls risk assessment to identify when and why the falls were occurring. Records showed the majority of falls happened at night, in their bedroom. We asked about potential risk reduction measures and were told the person had an infection and that is why they had fallen. The provider had not considered putting a temporary plan in place until the risk of falls had decreased.

A second person was assessed as at high risk of falls but there was no plan in place to help reduce the risk of falls. This person was assessed as at high risk of pressure damage to their skin. Their management plan for this was, "support me with the monitoring of my skin, particularly my legs". There was no guidance for staff on how to identify an emerging problem or what action to take. Staff recorded in daily notes on 1 January "[Name] sore bottom has returned". Daily records on 12 January 2018 suggested the person may have pressure damage but there was no plan to monitor or support this. We did not see any further entries about this in daily records, for example a body map, however staff told us they monitored this.

A third person had a history of mental health problems. Staff had not completed a risk assessment or management plan to guide staff on how to identify deteriorating mental health and any risks. The management plan was, "I ask the staff to monitor my mental health status and should there be any concerns that staff contact the appropriate mental health service provider".

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not all areas of the home were suitably clean. The majority of bedrooms and communal areas within the service were bright and free from odour. However, in one person's room there was a strong smell of urine and we saw a continence pad on the floor behind their chair. The kitchen had not been thoroughly cleaned. We saw a collection of grease staining cupboard doors and the floor was not clean. The cooker and freezer had visible debris to the sides and underneath.

Communal toilets in the home had tiled floors and the grouting between the tiles was stained and dirty. Toilet floors should have an impermeable cover to ensure they can be cleaned thoroughly.

Prior to the lunch observation on the first day of our inspection staff brought a person into the dining room and seated them without noticing they had a large wet patch on the back of their clothing and smelt very strongly of urine. We pointed this out to staff and the person was immediately supported to go and get changed. The chair was not suitably cleaned before they came back and used the chair.

One person's bed headboard was loose and hanging off. The manager arranged for this to be fixed immediately.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Fire equipment was tested and maintained and fire drills had been carried out according to the provider's policy. Records showed fire alarm checks were completed regularly. People had emergency evacuation plans to guide emergency services on people's needs. However, these plans did not contain sufficient detail.

Everyone we spoke with at Newbridge Towers told us they felt safe living there or their relatives were safe living there. People told us, "Definitely I feel safe, they are very easy going" and "Staff help me feel safe. I never have any worries." Comments from relatives included, "[Name] loves it here they feel safe, has no cares" and, "It was sheer luck we came here and [Name] loves it"

Staff we spoke with understood how to identify and report abuse. Staff told us they had received training in safeguarding adults and told us, "If I see any abuse I would report it to the manager" and "I'd go straight to my manager." We looked at safeguarding records at the service and saw that when a concern was raised the manager took immediate action. They notified both Care Quality Commission and the local safeguarding team. However, there was a second allegation on the same day about the same member of staff which had not been reported as a safeguarding concern. The provider's quality assurance systems had not identified this during the check of accidents and incidents.

There were sufficient numbers of suitably qualified staff at the service. Staff files showed the provider had carried out checks before employing new members of staff. All contained a Disclosure and Barring number (DBS) this is a check that is made to ensure potential staff are safe to work with vulnerable people. Staff files also contained proof of identity, an application form, a contract right to work details and references. The

manager told us since they started in January 2018 they had focussed on recruitment as the service had sometimes used over 100 hours of agency staff a week. Agency use was now minimal. Staff told us they felt there were enough of them to deliver people's care. The manager acted appropriately when concerns were raised about staff conduct. The service policies and procedures were followed and actions recorded.

Medicines were managed safely. There was an effective system in place to order and dispose of people's medicines. Medicines were stored in locked cupboards with medicines that required storage in accordance with legal requirements stored in a separate locked cabinet. People's medicines were delivered from the pharmacy monthly in blister packs. The service had a good working relationship with the pharmacy. If a person's medicines were changed by the GP the pharmacy would collect the person's current medicines and update the medicines in the blister pack. Non-used or refused medicines were recorded in a disposal book and returned to the pharmacy. Some medicines which required extra security were administered and signed for by two members of staff. Where people had pain relief patches staff completed a body map and both signed and dated the patch.

People's medicines administration records (MARs) had photographs and details about how they liked to take their medicines. For example if they liked them put into their hand, a pot or on a spoon.

When a person was admitted and brought their medicines from home staff checked with the GP to confirm which medicines were current to avoid giving any discontinued medicines or omitting any. One relative we spoke with said, "Medication is handled effectively." People confirmed they got their medication on time and that it was given appropriately.

The provider had ensured that regular maintenance and checks were carried out for gas, electricity and appliances within the service. The service did not have any hoists or stand aids. Access between floors was via a stairlift, which was regularly maintained.

Requires Improvement

Is the service effective?

Our findings

Staff carried out assessments for people on their care needs but had not developed meaningful plans to support their needs. People were assessed for nutrition, weight, mobility and dexterity and falls. However, these assessments did not inform staff how to meet people's care needs.
Staff kept records of visits by health professionals and these were recorded in people's care files. However, people's daily progress notes did not mention visits by health professionals and advice was not added to people's care plans. This meant there was a risk that information would not be passed on and recommendations implemented. Three people's care plans contained statements about, "refer to relevant health professional" but care plans did not contain the information of who that was or under what circumstances a referral should be made.
Staff had not received regular and effective supervision to support them to carry out their work. The new manager had now met all staff for a face to face meeting, however there was no evidence of meetings having taken place regularly. We looked at three sets of supervision records. Supervision records were brief and had a list of topics which had been ticked,; there was no written evidence of any meaningful discussion of staff needs or actions to be taken. Staff appraisals were in a one page format. Not every section was completed. For one member of staff, their appraisal goals were identified as 'none'. This meant the provider had not ensured staff had the opportunity to discuss any learning needs or to reflect on their practice.

People had a document in place which identified their resuscitation status for emergency services should they need emergency treatment and be unable to communicate their wishes. This document had been completed in a person's best interests where they were deemed unable to make the decision independently. However, one person's document recorded that the resuscitation decision had been taken by the person's family and GP. The person had the capacity to make the decision for themselves but had not been included in the decision.
There was no menu available for lunch which affected people's mealtime experience. We observed people eating lunch on the first day of our inspection. People were unsure about what they were having and were not aware of the choices available. People told us, "We don't know what we're having until it arrives" and another said;," I think it's lamb but they couldn't tell me if it's roasted". Plates of food were brought one table at a time. The first table was told it was lamb stew but subsequent tables were not told. People discussed amongst themselves; "Is it Lamb stew?" , " I believe so ", " Lamb stew is it ? It looks nice ", "I've had cauliflower cheese the last three days." This person was given what looked like a vegetarian burger but not told what it was. Everyone was served a pudding but not everybody was told what it was.
People were supported to eat and drink enough and were very complimentary about the food, however not everyone was supported in a personalised way. We observed one member of staff assist a person to finish their main course. They remained standing throughout and fed the person. The member of staff did not make eye contact or conversation but stood over the person and appeared impatient to finish.
The provider had recently employed a new chef. The food was of good quality, freshly cooked each day. People told us, "The food is really good and really nice. We have a great variety of choice. We get cakes and sponges everyday" and "There is always enough to eat it is very good." Another person told us, "I do like the food here. I prefer to eat on my own."
All the staff we spoke with confirmed there were enough staff to meet people's needs. Staff received

induction and training to ensure they had the skills needed to care for people. People told us, "They're [staff] lovely. They're all well trained" and "I think they're well trained. I think they're alright – they'll pass". We saw that staff had signed induction books to confirm they had received an induction.

The new manager had an aim to make it feel more of a 'hotel' atmosphere and had introduced a breakfast served in the dining room. There was a laminated menu for breakfast and people could choose from this. Cereals, juice and fruit were available in the corner of the dining room. The manager told us people were pleased with the change and it had increased people's food intake. People could still choose to have breakfast in their room if they wished. There was a four weekly menu but this was only displayed in the kitchen and accessible to people living in the home.
Lunch was a hot meal and the evening meal was a lighter meal, such as soup or sandwiches. The new chef had begun serving afternoon tea with homemade cakes attractively displayed on cake stands. This was popular with people.

Staff completed a handover form at the end of their shift to ensure that information was passed between the day and night staff. One member of staff told us, "The handover is minimal".

Staff had a clear understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Eight people had DoLS authorisations in place, but with no conditions attached.

Good

Is the service caring?

Our findings

People were complimentary about the staff. One person said, "Staff are lovely, I feel relaxed. They're generous too". Another person told us, "They are very kind and good." Other comments included, "Staff are great, they are kind to me" and, "They were so pleased when I came back from hospital, they made me feel really welcome."

Staff interacted with residents in a friendly manner. They used first names when addressing people and knew everyone well. Staff were polite to people but did not always initiate interactions. Some staff we observed we observed were chatty and helpful to people. However, at times the atmosphere was not dynamic due to the lack of staff engagement. For example, there was not much laughter or humour. This was particularly observed in the morning and after lunch when people were in front of the TV.

People told us, "I shower every other morning- I'm pampered! The hairdresser comes too". Another person said, "I have never been rushed. There is always someone with me when I shower". All the people we spoke with looked well cared for with clean hair and manicured fingernails. They were wearing clean clothes and were smart and appropriately dressed. People had spectacles and hearing aids as required. Ladies were wearing jewellery they had chosen.

Staff spoke warmly about people, and were able to describe how they protected people's privacy and dignity. Staff always knocked on people's doors before entering their rooms. Staff told us they enjoyed getting to know people, "You have to gain their trust and let them know you're there to help, You're trying to make them feel at home and comfortable." Another member of staff said, "I love interacting with the residents".

Staff told us, "You get to know them, their likes and dislikes, family and past". We were told, "[Name] has got a great sense of humour". Another member of staff said, "You talk to them and listen, it is really interesting" and, "You're trying to make them feel at home and comfortable".

All the staff we spoke with had a good understanding of equality and diversity. They said, "They are human beings and have a right to do what they want. It is equality for all of them". Staff said, "It's different nowadays, difference is part of life". Two people at the home were vegetarian and always had vegetarian food available. All of the staff we spoke with were very clear about choice and explained to us that nobody had to do anything they did not want to.

People were supported to maintain contact with their friends and family. Visitors were welcome at any time with no restrictions. One person had attended a local church but recently had not wanted to attend. Whilst we were visiting we saw one person go out for a walk, staff said they really enjoyed this.

Requires Improvement

Is the service responsive?

Our findings

The manager had introduced a new system to support people. People were organised into two 'care groups' and assigned to specific staff. This was so staff could get to know people and their needs and preferences well. Each staff member was responsible for delivering the care their group needed during their shift. Staff were given a worksheet with the names of people which contained brief notes about each person such as, "replace commode pan", "apply creams", "manage continence". Whilst these plans are intended to improve care there is the risk people could become a list of tasks to be completed, particularly as care plans did not contain any information about people's preferences.

Care plans were minimal and generic and did not accurately reflect people's needs and preferences. Several of the care plans contained similar statements, failed to identify individual needs and preferences and had no guidance for staff on how to meet people's assessed needs.

One person was living with dementia and needed support from staff as they were not always able to communicate their wishes. There was insufficient information about how they should be supported. The person's daily records documented they had been aggressive. There was nothing in any of their care plans to alert staff about what might cause aggression, how this was displayed, or guidance on how to reassure and support the person.

People's care plans contained contradictory information. One person's plan for 'communication, sight and hearing' stated, "I have no verbal communication issue or hearing. I have macular degeneration". This person was living with a specific type of dementia but the care plan did not inform staff of how this might affect their communication. A different care plan told staff, "I have hearing loss in both ears". The guidance for staff was, "I ask the staff to support me on a daily basis by understanding the problems I face with my hearing loss". There was no guidance to staff on the problems this caused for the person and what this support should consist of.

A second person's care records contained incorrect information about family contact. Information in their care records implied they did not want to see a particular family member. A member of staff had confirmed this when we spoke with them. We asked the manager about this who told us the person really wanted to see this relative. This contradicted the information in the person's care plan. We were told that staff had tried to contact the family member but had been unsuccessful. We asked them to correct the family information immediately.

A third person had Asperger's syndrome'. There was no information about what Asperger's was or how to provide support. For people with Asperger's it is important that staff understand what this means for the person and how to provide support in a way that does not cause distress. Staff need to understand what the person's preferred routines and interests are in order to ensure their needs are met.
Other people's care plans contained more detailed information. One person had a detailed plan to guide staff on how to provide their personal care and included their preferences. However, other areas of this person's care plan were less detailed to guide staff appropriately.

The manager told us they had increased staff awareness of continence support by introducing the care group system and verbally reminding staff, and that this had improved. However, care plans did not reflect this as they did not contain sufficient information about people's continence needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person's records had the majority of their daily records missing. Daily records should be consecutive and provide a record of care delivered each day to monitor people's care. We found that there were large gaps in this person's records between August 2017 and the day of our inspection. There were no daily notes at all between 4 March 2018 and 3 April 2018.

People had limited access to activities opportunities that reflected their interests. People's social interests and hobbies were not recorded in their care records. On the two days of our inspection people were either in their bedrooms or watching the TV in the lounge. We carried out observations and saw limited interaction with staff. The majority of interactions consisted of offering drinks. One member of staff spent a few minutes chatting to people but another sat for a few minutes in the lounge and did not speak to anyone. We observed staff sat in people's rooms chatting to them. The service had engaged two students to offer activities to people. They were kind and enthusiastic, however their English was limited and impacted on the activities they were able to deliver. The programme was repetitive. This comprised mainly of Hoopla but due to language difficulties the students did not interact well with people. The provider had organised outside entertainers to come to the service but this was not on a regular basis. People told us, "A lady comes and sings and we play Hoopla," and, "I don't like them [the activities]. They have exercises and games and a lady comes to sing. I might go in the garden. I use the stairs myself, that's exercise". The service had records for one resident meeting which took place in August 2017. People discussed what trips out they would like. One person wanted to go to the Arboretum and two others to a pantomime. Neither of these trips took place. The manager had advertised a post for an activity person.

The service had recorded two complaints and seven compliments in the last year. One complaint had been raised by a person using the service regarding their treatment by a staff member. This had been resolved through the disciplinary policy. The manager told us other concerns were dealt with immediately but not recorded.

One relative had contacted the home to thank them for end of life care. They said, "At the end [Name] was as pain-free, comfortable and peaceful as was possible". Due to the lack of a lift and hoists people generally needed to move from the home if they lost mobility which meant that the service did not often provide end of life care.

Requires Improvement

Is the service well-led?

Our findings

Systems in place to monitor the quality and safety of the service had not identified the shortfalls we found at the service. The provider had a quality assurance system in place but this had either failed to identify issues or had not enabled the development of effective improvements. For example; uncovered radiators had been identified in the health and safety audit but effective action had not been taken to reduce the risk of harm to people.

Audits of care files had failed to identify the lack of personalisation and the lack of clear plans to manage risks to people's health and well-being. Quality assurance checks had not identified that the majority of one person's daily records were missing. Regular safety checks on water temperatures and call bells had not been completed since December 2017. A nutrition audit had been completed in September 2017 which stated meals were discussed at 'resident' meetings. The last meeting was held in August 2017 and this did not discuss meals. People were not given opportunities to feedback on the service provided.
Checks on accidents and incidents had failed to identify a safeguarding concern which had not been notified to the relevant people.
Staff received training and an induction, however quality audits had not identified shortfalls in the frequency and quality of supervision.
The pharmacy which supplied medicines to the service carried out regular audits. We asked to see the most recent audit but it was not available.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
The service did not have a registered manager and one had not been in place since before the operation of the service had transferred in 2016. During this period the management arrangements had changed. Currently a manager is in post and intends submitted an application to register. They are supported by an external consultant who assists with auditing.

The manager had been in post since January 2018 and had developed a clear idea about the direction of the service. They wanted to create a more independent and relaxed atmosphere and had introduced breakfast and changes to the dining room. A member of staff said, "At the moment the home is in a good place. It will be better in the future". Another member of staff said, "the new manager is a bit stricter but it is better. They always come and say 'thank you' at the end of the shift. I know if I need to ask anything they will explain in a way I can understand".

The provider had a service improvement plan in place. Shortfalls identified during the inspection and discussed with the manager were added to this following the inspection.

Staff morale was good. Staff told us they enjoyed their work. They said the manager was supportive and they had confidence in the direction they planned to take the service. Staff told us "It's good working with [Manager] they are very approachable, any problems at home or at work I can go to her." Another member of staff told us, "The manager is good, they look after us."

The manager had now met with all staff individually and planned to improve the frequency and regularity of supervision meetings.

The last staff meeting had been held in November 2017. The manager told us a staff meeting was planned for April 2018.

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 9 HSCA RA Regulations 2014 Person-centred care People's care plans did not reflect their preferences for care. People's care plans did not always contain sufficient information about their care needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not always have risks to their health and safety assessed and mitigated. Infection control procedures were not always followed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had not ensured all areas of the premises were clean.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to monitor the effectiveness and safety of the service were not effective Accurate contemporaneous records of people's care were not always kept.