



**Jersey Care  
Commission**

## **INSPECTION REPORT**

**Clairvale Road Recovery Unit**

**Care Home Service**

**Government of Jersey – Health and  
Community Services  
19-21 Broad Street  
St Helier, JE2 3RR**

**8 June 2021**

## THE JERSEY CARE COMMISSION

Under the Regulation of Care (Jersey) Law 2014, all providers of care homes, home care and adult day care services must be registered with the Jersey Care Commission ('the Commission').

This inspection was carried out in accordance with Regulation 32 of the Regulation of Care (Standards and Requirements) (Jersey) Regulations 2018 to monitor compliance with the Law and Regulations, to review and evaluate the effectiveness of the regulated activity and to encourage improvement.

## ABOUT THE SERVICE

This is a report of the inspection of Clairvale Road Recovery Unit. The service is based at a property which is situated on the outskirts of town in a quiet residential area of St Helier. The service became registered with the Commission on 26 February 2021 and provides accommodation for care receivers requiring support for mental ill health and their ongoing recovery.

Regulated Activity	Care Home
Conditions of Registration	<p><u>Mandatory</u></p> <p>Type of care: Personal support</p> <p>Category of care: Mental Health</p> <p>Maximum number of care receivers: Ten</p> <p>Maximum number in receipt of personal care / personal support: Ten</p> <p>Age range of care receivers: 18 and over</p> <p>Maximum number of care receivers that can be accommodated in the following rooms: Bedroom 1-10: One person</p> <p><b>Discretionary Condition</b></p> <p>John Clark registered as manager of 16 Clairvale Road Recovery Unit Care Home must complete a Level 5 Diploma in Leadership in Health and Social Care by 22 February 2024</p>
Date of Inspection	8 June 2021
Time of Inspection	9:30am – 1.30pm

Type of Inspection	Announced
Number of areas for improvement	Three
Number of care receivers accommodated on the day of the inspection	Seven

Clairvale Road Recovery Unit is operated by Government of Jersey – Health and Community Services and the registered manager is John Clark.

This is the first inspection since the care home was registered on 26 February 2021.

## SUMMARY OF INSPECTION FINDINGS

The following is a summary of what was found during this inspection. Further information is contained in the main body of this report.

Staff are recruited safely and provided with opportunities for training, supervision and development. There is an induction plan provided which aims to equip staff with the knowledge and skills associated with their role. The home is always operated with two staff. It was apparent from discussions with staff members that the team has a wealth of experience and knowledge in supporting care receivers experiencing enduring mental ill health. It was noted that there are some gaps in the training log which require review and evaluation. This is an area for improvement.

As recorded in the homes Statement of Purpose (SOP), it is the aim of the home to provide support by enabling individuals with enduring mental ill health through the provision of a recovery-based approach to their care. Therapeutic approaches and activities were seen in action. This was further confirmed from discussions with some care receivers, their significant others and other agencies engaged in supporting care receivers to achieve their goals. Examples included supporting care receivers to return to work or in securing independent accommodation.

A review of existing care plans highlighted that some were devised by case coordinators, such as Community Mental Health Nurses (CMHN). Although this may have been appropriate at the outset, this creates a difficulty in that the care coordinator may not either be based in the home or actively engaged in direct care throughout the duration of the care receiver's stay. Similarly, these care plans may also derive from in-patient settings, which is the primary referral pathway into the home. It was apparent that there was an absence of clear review and evaluation of some of these care plans and that a collaborative approach, which would be expected as part of the recovery model of care, was not consistently demonstrated. This represents an anomaly and is an area for improvement.

The home environment was found to be in good order with facilities which promote the acquisition of skills (such as in relation to cooking and other domestic tasks), where this is an identified need. It was noted on day of the inspection that there was a shortage of key equipment in three bedrooms and that this was preventing the

home from operating to its full capacity. This had been the case for more than six months and was therefore identified as an area for improvement.

The provider has a quality monitoring process in place which involves a peer review of the services and which is undertaken on a monthly basis.

## INSPECTION PROCESS

This inspection was announced, to ensure the manager would be available to participate in this first inspection of the service. This was also necessary to promote best practice for infection control and the management of visitors to the home.

The Care Home Standards were referenced throughout the inspection.<sup>1</sup>

This inspection focussed on the following lines of enquiry:

- **Staff recruitment, training and development**
- **Approaches to care and welfare of care receivers**
- **Staff competence relating to categories of care provided**
- **Care home environment**
- **Management of services**
- **Choice, preferences and lifestyle**

Prior to the inspection visit, all the information held by the Commission about this service was reviewed including the Statement of Purpose.

The Regulation Officer observed persons who use the service going about their morning routines and noted the interactions and interventions carried out by staff in support of this. It was also noted that an associate service (Clinic) is run from the same building but is separate from the residential area, that service is provided for two days of the week.

The manager provided information pertinent to the inspection process in discussions with the Regulation Officer and in ensuring that policy documents, the training log and care plans were available for review. In addition, the experience of the care team was established from their direct involvement and contribution to the inspection process and which was actively encouraged by the registered manager.

This inspection included a review of the premises, with consideration given to the registration and expected occupancy levels of the home at time of inspection.

Limited recruitment of staff has occurred since the home's registration, but the newest member of the team was contacted to ascertain what induction and support

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<sup>1</sup> The Care Home and all other Care Standards can be accessed on the Commission's website at <https://carecommission.je/Standards/>

was provided when they were first introduced into the home. Although there weren't any recent recruitment records to be viewed since the service became registered, reference was made to the providers approach to safe recruitment. This took place separately to the inspection visit in consultation with the Human Resources department.

Four members of staff were spoken with, to ascertain their views of the service and of how they are supported. Two were able to speak with the Regulation Officer during the visit and the other two were consulted by telephone after the inspection visit. Two of the care receivers' representatives were contacted by telephone following the visit also. A discussion also took place with personnel from an external agency who provide support to care receivers and staff members in respect of recovery work.

At the conclusion of the inspection, the Regulation Officer provided feedback to the registered manager.

This report sets out the findings of the inspection and includes areas of good practice which were identified during the inspection. Where areas for improvement have been identified, these are described in the report and an action plan is attached at the end of the report.

## **INSPECTION FINDINGS**

### **Staff recruitment, training and development**

Reference was made to Standard 3 of the Care Home Standards which states: "You will be cared for and helped by the right people with the right values, attitudes, understanding and training."

The manager confirmed that all staff are recruited in accordance with the Government of Jersey's safe recruitment policy and the recruitment process is managed by a Human Resources team. All staff are required to complete an application form with details of previous employment history, details of referees, a statement of personal qualities, proof of identity and proof of right to employment. The applicant is also required to declare that they are not disqualified from working with vulnerable adults due to previous offences. Enhanced criminal records certificates are obtained and reviewed prior to employment which provides further evidence of safe recruitment.

From a discussion with one of the newest members of the team, they reported receiving "the best induction", (and that they) "learnt so much in the first four weeks". It was highlighted by them, that there exists a positive and supportive team culture, and that this was very encouraging for them as they progressed through their induction. They also highlighted that they had opportunities to enhance their learning and to acquire new skills in enabling them to competently support care receivers. Another member of the team, who was more experienced, spoke of the

team and managerial support in very positive terms. It was evident from the information which they freely provided, that they had a good level of experience and knowledge in respect of their role and responsibilities, and in appropriately supporting care receivers in their recovery.

It was confirmed by other staff, as to the opportunity and encouragement which is given to them in gaining clinical supervision from supervisors of their choosing. The Regulation Officer viewed this as representing a positive approach in promoting staff training and development. The provision of managerial oversight and supervision was evidently consistent and of a good quality. It was also very encouraging that staff members had the opportunity to source clinical supervision from external practitioners, based outside of the service. This represented an example of best practice.

During the inspection visit the Regulation Officer was provided with information which was readily provided or volunteered by two members of the team on duty. It was well evidenced their being very experienced and competent support workers, having worked in the home for some time. This relating to not only operational matters as to how the home functions, but also invaluable knowledge about individuals and their personalities and unique care needs. Such experience and understanding of the recovery focus which is needed to best support individual and person-centred care approaches was well demonstrated from the information and observations shared during discussions with these staff. It was apparent from a discussion with two staff members that they had a solid working knowledge of the operation of the home and of the needs of the care receivers.

Mandatory training and mental health focussed topics include Maybo (training to reduce risk and promote positive and safer outcomes where conflict or distressed behaviours may require support). Alongside this, other training relating to lone working and adult safeguarding is provided. Training is also provided in-house within the context of reflective approaches to meeting individual care needs and is often incorporated within daily handovers or monthly team meetings. As part of recovery-based approaches, resident meetings are convened but due to restrictions in place for gathering of groups of people within enclosed spaces, these have been less frequent in recent months.

From a review of the training log, there were gaps for some of the mandatory topics. While it may be acknowledged that there had been challenges in accessing some training over the course of the previous year this did not apply in all of the cases noted. One member of staff had not received the necessary update in safeguarding for example and it was apparent that this need predated the onset of the pandemic. It was also not evident from a review of the training log that training in subjects including Capacity and Self Determination, equality, diversity and human rights, data protection, food hygiene, each of which are requirements to meet Standards for training (Appendix 7 Care Home Standards), had been provided/completed. While there were no concerns about practice or competency of the experienced staff team, some action is indicated from this review of the training log, both with reference to number of outstanding training updates and for any of those subjects not incorporated in the training log. This is an area for improvement.

The shift patterns as discussed with the staff members on duty indicated an appropriate roster system with hours of work not excessive or likely to lead to fatigue. Staff confirmed a very good level of managerial support that includes a 24 hour on-call facility. This ensures that appropriate professional advice can be sourced about any operational or care related matters by staff who are on duty.

### **Approaches to care and welfare of care receivers**

Reference was made to Standard 5 of the Care Home Standards which states: "You will be supported to make your own decisions and you will receive care and support which respects your lifestyle, wishes and preferences."

Staff and care receivers who were involved in the inspection process, provided positive accounts for how care and welfare is promoted and accommodated. It was clear from the information provided and with anecdotal accounts to support this, how the home works within a recovery- based model of care that aims to positively engage with care receivers to aid their recovery from sometimes chronic and enduring mental ill health. It was noted from some of the examples provided that different approaches are utilised depending upon the care receiver's unique presentation, their own stated objectives and the time that is needed to support them in meeting these goals. In practice, care receivers may reside in the home for up to 12 months but with their planned discharge is a focus from the point of admission.

There is a clearly defined written referral and admission process. The process of coordinating the discharge from hospital and admission to the home is always undertaken by two staff members based at the home. The proposed admission is discussed in a team meeting and where agreement is confirmed for this being an appropriate admission into the home. There is a focus on recovery throughout the admission process. This depends upon a therapeutic alliance being formed between the service and the care receiver which includes ensuring that the care receiver thoroughly understands relevant policy and procedure relating to receiving support from the service and is committed to the programme of care delivery. It is acknowledged that the environment may still be relatively restrictive by comparison to independent living, and it is therefore crucial that care receivers agree to receiving a service within the context of these restrictions.

It was noted from some of the records which were reviewed, that there was sometimes an absence of a recovery-focussed narrative, with emphasis being placed on containment and management. This appeared to be at odds with the home environment, the Statement of Purpose and the reported activity and type of engagement that is promoted within the home. From a discussion with the registered manager, it was established that some of the initial care plans derive from the hospital stay and therefore have a more clinical-based focus which tends to be relatively prescriptive in nature. The conflict of approaches between clinical and recovery- based care planning, appeared to be unhelpful and at odds with the reality of how support is provided in practice, as stated by staff and further evidenced in the observations made during the inspection.

The Regulation Officer examined some of the entries on the care recording system which related to care plans. Some of the entries had a negative focus which did not clearly accord with individual care receivers' needs or presentation. This was viewed as an anomaly to the good practice and recovery-focussed interventions and interactions which were observed during the inspection and reported by some of the care receivers, family and staff. It was also noted that number of care plans did not evidence systematic or periodic review dates i.e. monthly or three-monthly. For example, there was no evidence that a care plan which dated from January 2021 had been reviewed or evaluated since that time.

The registered manager however provided some helpful examples of what a good system of review and evaluation may look like if consistently implemented. The principles for RECAP (risk, engagement, care plan, additional information, and patient perspective), represented a very good model for recovery-focussed approach that places the care receiver at the heart of their own care-planning process. However, this model appeared to be used sporadically and inconsistently in that not every element of RECAP was recorded when it was utilised. There was also a lack of a defined timeline or schedule of review and it was not always apparent that minimum data was consistently recorded. This is an area for improvement.

Positive feedback was received from four care receivers and relatives. Individual staff members were identified by relatives and referred to in positive terms. It was evident from this that supportive therapeutic relationships were being fostered and that the approach taken by the staff team in providing support to care receivers was well-received.

A range of allied services and professionals provide support to care receivers as part of their recovery such as in respect of transitioning back to independent living or in sourcing employment. It was established that there were some useful links in place. Often it was the case that community mental health nurses coordinated much of this work. Whilst this was in accordance with their role as care receivers' keyworkers, community mental health nurses were less likely to be involved in the provision of day to day support in the home. However, it was also evident that some closer or more direct coordination with staff working in the home could be useful in developing these alliances and in promoting care receivers' overall recovery. This was discussed with the Registered Manager as part of the inspection feedback for their further consideration

### **Staff competence relating to categories of care provided**

Reference was made to Standard 6 of the Care Home Standards which states: "Your care will be provided with consistency by competent care and support workers who have the necessary training and qualifications to meet your needs."
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Staffing levels and skill mixes were in order with a good standard for induction reported by staff who were spoken to about this matter. The training log did not evidence all the expected and required topics. However, the staff group is made up of experienced staff with QCF level 2 and/or 3 qualifications and it was evidenced that key staff take on other roles and undertake training opportunities as or when



required to support the operational needs of the service. This was noted from the engagement which one member of the team has with broader reviews of services alongside senior practitioners with a focus on mental health.

It was evident that appropriate links are established on behalf of care receivers and their families with relevant independent service or charities which have a mental health focus. For example, links had been established with patient advocacy services, a carers trust and other sources of support which are likely to be helpful to care receivers and/or their families. Staff were clear that they do not involve themselves directly with such matters in accordance with expectations associated with independence and confidentiality.

All staff who might administer medication must complete appropriate training and it was established that this happens, and that staff had the necessary degree of competency and skill to oversee the management of medication. However, it was noted during the inspection that the care receivers who were receiving a service at that point were able to manage their own medication with a degree of independence, and this was being promoted. It was apparent that staff provided prompts and observations in respect of medication management. Medication was stored in the main office.

There is an acknowledged reliance on care staff to oversee operational matters daily in the absence of the registered manager and for all night duties. From discussion with staff it was very well demonstrated their understanding of roles and responsibilities and which there is a robust on-call system for them to utilise if necessary. As noted previously, the level of knowledge and experience of majority of staff working in the home ensures that the care provided in the home is undertaken by competent support workers with the necessary training and skills.

The registered manager was also able to convey their confidence and comfort with any delegated tasks that may need to be allocated to colleagues as or when necessary if they are off site. The Regulation Officer was able to note the seamless transition between manager and support workers in this regard which was reflective of a confident and competent staff group.

This impression of staff competency was further reinforced by feedback from some care receivers and their relatives who reported the staff being "great" and the home being "lovely and well run". Staff who were spoken with, were able to convey very good knowledge and understanding of care receivers' needs, presentation and recovery-focused initiatives. It was clear that this had been established as a result of long-standing and positive working relationships. Rapport between staff and care receivers was seen to be relaxed and good humoured, with respectful and appreciative comments made by care receivers about such support and engagement.

Where necessary, staff record relevant incidents in care records. In addition, this information is generated on the electronic system and Datix (notification of incidents) and comes to the attention of the manager for their further review and if indicated, investigation. There is an expectation therefore, for recording principles to be in place and followed by all staff in the absence of the manager, and this was evident

from discussions with staff and the registered manager. There have been no notifiable incidents submitted to the Commission since registration, but it is encouraging that the registered manager has had discussions with the Commission as to what constitutes best practice in communicating relevant information.

### Care home environment

Reference was made to Standard 7 of the Care Home Standards which states: "The environment will enhance your quality of life and the accommodation will be a pleasant place to live or stay."

The home environment is domestic in nature and has communal spaces that can be freely utilised by care receivers. The level of supervision and monitoring by staff is kept to an appropriate minimum and independence and autonomy is promoted as part of the recovery-based approach. The provision of support is therefore not unduly invasive or interfering in the privacy or independence of the care receivers. However, welfare checks are undertaken as necessary, throughout the day. Care receivers are encouraged to socialise with others and to undertake meaningful activity.

The Regulation Officer was able to observe an open and non-restrictive homely environment, but it was also apparent that there is some potential for an overlap of the home's use by another service. The Community Mental Health Team (CMHT) provide a service in an adjacent area of the building. This was not an area of concern., however, this arrangement should be monitored routinely for care receivers residing in the home. This to ensure that their views are sourced and that it is confirmed that there is no encroachment of this service into the privacy and comfort of care receivers.

The home is a building with all the expected utilities in line with the Statement of Purpose. It is adequate in size and scope and the maximum tenancy period if for no more than one year. The kitchen facilitates some independence and there is ready access to stores and refrigerated goods. It also provides a safe working area, where limited staff and care receiver number may work together in preparing and cooking meals. The home's general furnishing and décor was found in good order.

The home benefits from an easily accessible garden to the rear. A number of residents were making use of this space during the inspection visit. They were relaxed in their presentation, deriving some pleasure from this pleasant and relatively quiet environment.

There are systems in place for maintenance schedules and fire safety, which were being carried out diligently and consistently although there was an administrative oversight for recording of the fire drills carried out routinely for all staff. This related to ensuring the drills were more accurately recorded within the required logbook This was acknowledged and action taken to rectify this matter immediately as stated by staff overseeing this matter

The homes registration records 10 rooms to provide accommodation. However, it was noted that for the past six months, the home has not been fully furnished to facilitate full occupancy. This was despite a requisition order made the previous year for additional (new) beds to be situated in the registered rooms. It was unclear as to the reason for such a delay. This is unacceptable as it has resulted in the home being unable to meet the basic conditions of its registration. An area for improvement was highlighted to the registered manager for their immediate attention, although it is acknowledged that the manager has already made considerable efforts in seeking to resolve this matter.

There are no SROL (Significant Restriction on Liberty) authorisations in place that may prevent care receivers freely exiting the building. However, the home may accommodate some care receivers who remain subject to Article 24 Mental Health (Jersey) Law 2016 restrictions and who have been granted authorised leave of absence from hospital as part of a gradual transition from hospital to the community. It was clarified that as a principle, it would not be anticipated that any SROLs would be in place on account of this not being in accordance with the promotion of the recovery model and the relatively low risks associated with care receivers accommodated in the service. Similarly, the application of SROLs would be at odds with the Statement of Purpose, staffing levels, competencies and resources provided by the service. The continuum of treatment orders under the Article 24 Mental Health (Jersey) Law, while understandable, for practical and relapse prevention reasons, are expected to be few in number or short in duration.

From a discussion with the registered manager and members of the team, there was a clear understanding and recognition of the limitations of what support can be provided within the home environment. It was evident that care is provided in a way which is both safe and conducive to the provision of recovery-based interventions. It was also recognised that for periods of a 24-hour period there will be necessary restrictions on free entry to the building, which is made through a gated entrance. The gate is locked after the hours of darkness, for reasons of security and safety.

Throughout the visit, the care receivers present around the home environment appeared relaxed and comfortable, both in their own company or when in the presence of other care receivers or members of staff.

## **Management of services**

Reference was made to Standard 11 of the Care Home Standards which states: "The care service will be well managed."
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It was explained that there are systems of support in place for staff on duty, in the absence of the manager. This provides helpful tiers of monitoring. This includes the provision of a 24 hour on-call system through which advice from senior managers' in the CMHT or clinicians as Doctors and CMHNS, may be sought as required. It was however clarified and confirmed, that care receivers residing in the home would not be expected to require as high a level of support as this. However, relapse monitoring and relapse prevention is a key focus of the support is provided. These extra tiers of consultation and advice, which are readily available, are considered

integral to how the service can operate effectively, being able to promptly source and provide necessary support to the benefit of care receivers.

The registered manager was clear about their role and responsibilities. They maintain a regular presence in the home but also have another role in supporting an associated service off-site. The staff team will therefore act in their absence to oversee day to day activities, with an on-call facility being available as required. It was very evident that staff have the required experience and skills to undertake this role and this was demonstrated during the inspection process in engagement with staff.

The registered manager analyses the quality of service provision by receiving support from a peer (a registered manager for another service), who compiles a monthly report for their review. This promotes a good system of audit for the Standards to be met. Internal reviews by the provider are carried out with reference to these.

The home is always staffed by two people. The shift pattern is: 8am - 9pm; 8am - 12pm; 8am - 4 pm, and night duty between 9pm - 8am. Within the duty roster planner, there are some variations to accommodate staff supporting clinics, which are provided on-site adjacent to the home. In addition, there are staff identified who provide support to another service for which the registered manager is also accountable. However, for both situations there is no impact on the minimal staffing levels in the home, and the integrated duty roster ensures this standard is adequately maintained and monitored by the registered manager.

As noted earlier in this report, care plans in place in the service and referenced by staff, are not always authored by staff working in the home and on occasion, have been generated by nurses overseeing care within an in-patient hospital setting. This is recorded on the electronic care recording system (Care Partner) and has the potential to detract from some of the recovery-focussed approaches which are promoted in the home.

The registered manager is responsible and accountable for all care-related matters in the home. It was discussed with the registered manager, that some review and refinements to care planning processes may be indicated. Often, community mental health nurses retain the role of keyworker for care receivers accommodated in the home. However, it is important that roles and accountabilities relating to care planning be more precisely defined. This evident from some irregularity in the accountability or reviews of care plans that take place by staff group who are directly supporting the care receiver in the home. In this matter an area for improvement is indicated, this to review the current system in use which incorporates Care Partner and care planning process, but which lacks systematic or clear review and evaluations being recorded.

It was to be noted however the principles being followed to best support identified care needs within recovery- based approaches was seen in practice by the interventions, knowledge, and skills of staff.

One significant issue of concern as discussed with the registered manager was their pending departure from this post. It is clear that this will leave a significant gap in the management structure. While notice of this had been submitted by them in a timely fashion, the Commission had not at the time of inspection received any further information or update from the provider of plans for any replacement.

### **Choice, preference and lifestyle**

Reference was made to Standard 9 of the Care Home Standards which states: "You won't have to give up activities you enjoy when you live or stay in a care setting. There will be a range of things to do which will reflect your preferences and lifestyle".
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A variety of documents was provided at inspection by the team, that demonstrated some of the approaches which are followed to engage and support care receivers. The role of the mental health support worker for supporting those who may experience a range of mental health difficulties is recorded on a document made available to care receivers. Within this document, some actions and specific approaches to manage distressing symptoms and/or situations relating to their mental health is highlighted in Wellness Recovery Action Plans (WRAPS).

Within this framework, there are different stages recognised which by design, promote collaborative working and understanding for both the care receiver and worker. The framework enables there to be a flexibility in the approach adopted by the worker, depending upon the individual needs of each care receiver. Some of the stages focus on triggers for relapse and early warning signs as well as some crisis plan. These areas will be worked through as part of the process in supporting care receivers from the point of assessment onwards. With a relatively small team in place and small resident number, there is no key worker allocation, all staff will support the care planning process and care receiver as and when required.

During the time in the home, care receivers are encouraged to fully participate in a range of activities of their choosing which will include leisure and health-related recovery subjects. These include arts and crafts, smoking cessation, reading group, relaxation, jobs and housing support group, communal cooking events and activities in the community. Within these structured activities, respect and consideration is given to individual preferences, independence and autonomy and which sensitivity to mental well-being and symptom monitoring remain a focus of observation and support from staff.

## IMPROVEMENT PLAN

There were three areas for improvement identified during this inspection. The table below is the registered provider's response to the inspection findings.

<p><b>Area for Improvement 1</b></p> <p><b>Ref:</b> Standard 5</p> <p><b>To be completed by:</b> 3 August 2021</p>	<p>The registered provider must ensure that care plans are systematically reviewed with a clear audit trail demonstrating this is undertaken routinely. Some consideration and attention to how this is best achieved within the recovery focussed approach is also indicated.</p> <hr/> <p><b>Response by registered provider:</b></p> <p>Care Coordinators have been allocated to each service user and a deadline of Tuesday 24th August has been issued to complete a Continuing Care – Recovery Care Plan.</p> <p>Moving forward training to develop Clairvale staff to be able to devise Care Plans is being considered with a recovery focused approach.</p> <p>The care planning process and review will be subject to internal audit and assurance by the registered manager on a 3 monthly basis.</p>
<p><b>Area for Improvement 2</b></p> <p><b>Ref:</b> Standard 6</p> <p><b>To be completed by:</b> 3 August 2021</p>	<p>The content of training log should be reviewed, and action taken to address any shortfalls in the mandatory topics which should be provided to all staff. Outstanding updates should also be addressed</p> <hr/> <p><b>Response by registered provider:</b></p> <p>A training log has been devised and updated. A review of mandatory training has been completed by Interim Registered Manager. Staff have been issued an email requiring them to provide dates when training booked and completed. Completion dates for training information requests set for 31st August.</p>

<p><b>Area for Improvement 3</b></p> <p><b>Ref:</b> Standard 5</p> <p><b>To be completed by:</b> With immediate effect</p>	<p>The registered provider must ensure that all accommodation is fit for occupancy as set out in the mandatory conditions – procurement of beds should be prioritised to meet this requirement</p>
	<p><b>Response by registered provider:</b></p> <p>All bedrooms are now full equipped with beds and furniture. Empty rooms have been inspected and recent decoration has been completed.</p>

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of the Care Commission during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, Standards and best practice.



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