

# Hillcrest House Limited

# Hillcrest House

## Inspection report

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## Ratings

### Overall rating for this service

Requires improvement



Is the service safe?

Requires improvement



Is the service effective?

Requires improvement



Is the service caring?

Requires improvement



Is the service responsive?

Requires improvement



Is the service well-led?

Requires improvement



## Overall summary

The inspection took place on 29 and 30 September 2015 and was unannounced.

Hillcrest House provides residential and nursing care for up to 88 older people. Some people may be living with dementia, or may have physical and mental health needs. On the days of our inspection 66 people were living at the care home. Hillcrest House is separated into two different areas, each specialising in different levels of care and support for people. These included a residential and nursing area and a nursing dementia area. The home was on two floors, with access to the upper floor via stairs

or a passenger lift. Bedrooms have en-suite facilities. There are shared bathrooms, shower facilities and toilets. Communal areas include four lounge/dining rooms, a main dining room, a reading room/music room, a large grassed garden and an outside patio and seating area.

The service had three registered managers in post. One of the registered managers was the owner of the home and the other two registered managers had specific responsibilities. One of the registered managers managed the care of people who lived in the nursing and residential area whereas the other registered manager

# Summary of findings

took responsibility for the management of dementia care. 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.

People told us they felt safe. People were protected by safe recruitment procedures as all employees were subject to necessary checks which determined they were suitable to work with vulnerable people. Staff understood how to recognise abuse and knew what their responsibilities were.

People told us staff were kind to them. Staff knew people well and spoke of them in affectionate terms. However staff were often too busy carrying out essential tasks to stop and talk with people. There were not always enough staff deployed to meet people's needs, particularly those living with dementia. People's dignity and privacy were respected. Conversations between staff about people were not always held in private; however the registered manager took immediate action to address this.

People were protected by effective infection control procedures and staff had received training. The environment generally smelt fresh and clean, however, in the area which cared for people with dementia, communal areas, some bedrooms and bathrooms had a malodour of urine. Following our inspection, the provider responded quickly and informed us flooring was being replaced, and this had made a difference.

Staff told us they felt well supported by the registered managers. Staff received training and supervision to carry out their role.

People had risk assessments in place to help provide guidance and direction to staff about how to minimise risks associated with people's care. Staff were trained in moving and handling, however, correct moving and handling techniques were not always used to help ensure people were supported safely.

The registered managers understood how the Mental Capacity Act 2005 (MCA) and deprivation of liberty safeguards (DoLS) protected people to ensure their freedom to make decisions and choices was supported

and respected. However, although staff supporting people living with dementia received training, they had a limited understanding of the legislation, which meant their human rights may not always be respected.

People liked the meals provided. People living with dementia experienced a disorganised approach at lunch time, and were not always involved in decisions about what they wanted to eat or drink or supported effectively.

People had care plans in place to address their individual health and social care needs. People's care plans provided guidance and direction to staff about how to meet people's care needs. People's changing care needs were communicated amongst the staff team, which meant referrals to relevant health services were made in a timely manner. People's wishes and preferences were not always known because people had not always been involved in the review of their care plan.

People living with dementia were not always socially stimulated and were not always given opportunities to participate in activities. Staff were busy carrying out their duties and they did not always have time to spend socially with people. The provider was taking action at the time of our inspection to make improvements to the environment, in line with dementia research and consultation with people, their families and staff.

People's end of life wishes were documented and communicated to staff. People received their medicine safely. However, when people required medicines as required, such as paracetamol, their care plans did not always guide and direct staff, to help ensure a consistent approach.

People and those who mattered to them, were encouraged to provide feedback about the service they received. People were able to raise concerns and the registered managers investigated and learnt from complaints to make improvements. The registered managers worked well with external agencies to help support joined up care, and drive improvements.

Prompt action was not always taken to ensure improvements were made, because the processes and systems used to assess and monitor the quality of care people received, and to determine if people's needs were being met were not effective.

# Summary of findings

We found 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.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not always safe.

There were not always enough staff deployed at the right times, to meet people's needs.

People received their medicine safely. However, people's care plans did not always guide and direct staff about when to administer as required medicine, such as paracetamol.

People had risk assessments in place to help provide guidance and direction to staff about how to minimise risks associated with people's care.

People told us they felt safe.

People were protected by infection control practices.

Staff knew what action they would take if they suspected abuse was taking place.

Safe recruitment practices were in place.

**Requires improvement**



### Is the service effective?

The service was not always effective.

People liked the meals provided. However, people living with dementia were not always involved in decisions about what they wanted to eat or drink or supported effectively at lunch time.

People were protected by the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) as the registered managers understood the legislative framework. Staff received training, however, some staff who supported people with dementia, had a limited knowledge which meant people's human rights may not always be protected.

Staff had the necessary knowledge, skills and training to meet people's needs.

People had their health needs met. People's changing care needs were referred to relevant health services in a timely manner.

**Requires improvement**



### Is the service caring?

The service was not always caring.

Staff were kind, caring, knew people well and spoke of them in affectionate terms. However staff were often too busy carrying out essential tasks to stop and talk with people.

People told us staff were kind.

**Requires improvement**



# Summary of findings

People were respectfully cared for at the end of their life. Nursing staff had good links with GPs to help ensure people's care was effectively co-ordinated.

## Is the service responsive?

The service was not always responsive.

People were not always supported to follow their interests and take part in social activities, which meant people had very little to occupy their time.

People's care plans were individualised and provided guidance and direction to staff about how to meet people's care needs.

People felt confident to raise concerns or complaints and knew who to speak with.

**Requires improvement**



## Is the service well-led?

The service was not always well led.

People did not receive a high standard of quality care because the systems and processes for quality monitoring were ineffective in ensuring people's needs were met.

People and staff were encouraged to provide feedback about the running of the service.

There was a management structure in place and staff told us they felt well supported by the registered managers.

The registered managers and staff worked well with external agencies to help support joined up care, and drive improvements.

**Requires improvement**



# Hillcrest House

## 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.

We visited the home unannounced on 29 and 30 September 2015. The inspection team consisted of three inspectors, a pharmacy inspector, a specialist advisor of older people's mental health, and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed information we held about the home. We reviewed notifications of incidents that the provider had sent us since the last inspection and previous inspection reports. A notification is information about important events, which the service is required to send us by law. One of the registered managers had completed and submitted a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We also contacted the local authority service improvement team, a continuing health care nurse, and Healthwatch Cornwall for their views.

We spoke with 20 people living at the service and three relatives/visitors. We also spoke with 11 members of care

staff, a laundry assistant, two nurses, the activities co-ordinator, a care ambassador, the catering manager, the admissions co-ordinator, a care plan assessor and reviewer, a trainer, an audit and maintenance assessor, the receptionist, two administrators, and the registered managers.

We carried out a Short Observational Framework Inspection (SOFI). SOFI is a way of observing

care to help us understand the experience of people who could not talk with us. We observed how people living with dementia were supported and watched how staff engaged and communicated.

We observed care and support in communal areas, and watched how people were supported during lunch. We spoke with people in private and looked at 12 care plans and associated care documentation. We participated in the staff handover and pathway tracked four people who lived at the home. Pathway tracking is where we follow a person's route through the service and capture information about how they receive care and treatment. We also looked at 20 medicine administration records (MARS), as well as documentation relating to the management of the service. These included policies and procedures, audits, staffing rotas, 11 staff recruitment files, training records and quality assurance and monitoring paperwork. We assessed and reviewed the safety and cleanliness of the environment.

After our inspection we received feedback from relatives who had completed comment cards and requested feedback from a GP practice.

# Is the service safe?

## Our findings

People living with dementia were not cared for by sufficient numbers of staff. This impacted negatively on people's daily routines, contributed to a lack of social stimulation and resulted in people not always being supported at lunchtime. During our inspection people spent the whole day sitting in chairs with the TV on in the background. For one person their day was spent walking up and down a corridor with little interaction from staff. During lunch time, in one dining room, there were two members of staff supporting and assisting 14 people. This included the collection and serving of food, as well as prompting and assisting people to eat. People unable to eat their food independently had to wait until staff were available which meant their meal was going cold.

People living with dementia did not have their individual needs met because there were not sufficient numbers of staff deployed. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other people benefited from staffing levels which met their needs. One person told us, "I think there are enough from what I see" and a relative commented, "There is always plenty of staff, I don't see any difference whenever I visit".

People had care plans to provide guidance and direction to staff about how to meet their moving and handling needs safely and staff received training. However, we saw one person assisted by one member of staff, without any equipment. The person was seen to be supported by a variety of techniques, such as holding the person under their arm and lifting them which was potentially unsafe. We spoke with one of the registered managers about this, who confirmed this was not how the person should have been moved, nor how the member of staff had been trained. They told us action would be taken to ensure the member of staff knew how to support the person correctly.

People received their medicine safely. There were systems in the home to order, store and administer medicines safely. However, there was a lack of clarity in people's care plans about when they should receive "when required" medicines and variable doses of medicines. This meant there could be an inconsistent approach between staff. The medicines management audit which helped to identify poor practice had not highlighted the lack of clarity in

people's care plans. We spoke with the registered managers about this, who told us action would be taken to ensure the audit covered all areas of the management of medicines.

People were protected by effective infection control procedures. Staff had received training and had been provided with personal protective equipment (PPE), such as gloves, aprons and hand gel. Bathrooms had paper towels, and soap available for people and staff. The registered manager had a contract in place to dispose of clinical waste. The environment generally smelt fresh and clean, however, in the area which cared for people with dementia, communal areas, some bedrooms and bathrooms had a malodour of urine. Staff also confirmed this to be unpleasant. One of the registered managers explained the carpet had recently been replaced and there was a rigorous schedule of cleaning for the home. Following our inspection, the provider responded quickly and informed us flooring was being replaced, and this had made a difference.

People told us they felt safe, one person replied, "yes, I feel very safe" another person told us,

"I always feel safe because I always get a good night's sleep. It's like a home from home".

People had risk assessments in place covering aspect of potential harm they could experience, for example falls and skin integrity. The risk assessment detailed the risk, how the risk could present itself and the action staff were to take to reduce the likelihood of people coming to harm. People's risk assessments were regularly reviewed and were linked to their care plan.

People's falls, accidents and incidents were recorded and information was used to identify themes and necessary action which may be required. For example, for one person who had been falling frequently, a record of their falls had been used to show when staff were not present, the likelihood of them falling was increased. This information had been used to provide one to one support and since this support, the person had not been falling.

People were protected by staff trained and knowledgeable about how to protect them from abuse and harm. Information about how to report concerns was displayed. Staff felt confident the registered managers would take

## Is the service safe?

action, but were also aware of other agencies they could contact. There was a whistle blowing policy in place to protect staff should they have to report poor practice or professional conduct.

People were supported by suitable staff who were recruited safely. Robust recruitment practices were in place and records showed checks were undertaken to help ensure the right staff were employed to keep people safe. The provider had a disciplinary policy and procedure in place which had been used to deal with employee misconduct.

The provider had systems in place to monitor the safety of the premises and to help keep people safe, some of which included fire equipment checks, water temperatures, legionnaire's checks and testing of portable electrical appliances to ensure they were safe to use in the home.

People had personal emergency evacuation plans (PEEPS) in place which meant, in an evacuation emergency services would know what level of care and support people may need.



# Is the service effective?

## Our findings

People living with dementia were not always effectively supported at lunch time and involved in decisions about what they would like to eat and drink. People who required assistance were not always given it. For example, staff were trying to assist people, and at the same time trying to stop others from eating from their plate. Another person had been waiting to be assisted, but by the time they were supported, their liquidised meal had cooled and congealed. Staff did not ask the person if the temperature or consistency of the meal was to their liking, and continued to give the person their lunch.

The atmosphere at lunch time in one dining area was disorganised and a lack of staffing meant some people were not adequately supported. For example, some people did not know what to eat or how to use their cutlery. Some people got up and left their meal. One person returned later to someone else's meal and tried to eat it instead.

People living with dementia were not always given a choice for their lunch. Staff told us when people were unable to make a choice, they were given the same food as others. During our inspection, everyone living with dementia had the same meal. One member of staff told us they had some issues regarding the menu choices for some people. They explained they had discussed this with one of the registered managers and were waiting for the outcome.

People living with dementia were not appropriately supported to ensure their dining experience met their individual needs. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Those living without dementia were given a variety of choices from a menu but were also able to request alternatives. People were asked the day before what they would like to eat. For people living with dementia, this process may not be suited to meeting people's needs, as people may forget what they have ordered. One person told us, "I choose all my meals the day before, but I always forget what I've picked. It's always a nice surprise". Residents meetings helped to ensure the menu was to people's liking, for example liver and onions had been re-introduced following feedback.

People told us the food was nice, comments included "Food is excellent and they know I don't like rice pudding",

"There's choice and plenty of it", and "I'm well fed, there's plenty, it's nice and there is choice". People were able to choose where they wanted to have their lunch, one relative told us, "My mum eats all her meals in her room; it's just what she wants to do". People had access to drinks and were regularly offered drinks.

People had care plans in place in respect of eating and drinking and these helped staff ensure people were being supported in the way they wanted to be. An external health professional told us they could recall Pimms being offered to people, and because one person had swallowing difficulties, the care staff had put thickener in the drink, so the person could enjoy a glass. Care plans detailed when professional advice was to be followed, for example guidance from speech and language therapists. People's weights were recorded and when people had lost weight action had been taken, for example supplements had been given as prescribed.

People were not supported to make decisions by effective means of communication, for example for one person it was evident they could not engage in verbal communication so their views could not be obtained by talking with them. We did not see staff attempt to try and engage the person in other ways, such as picture charts.

People had consented to their care, by signing their care plans and staff asked people prior to supporting them. For people who did not have the mental capacity to do this, decisions had been made in their best interests.

People had their mental capacity assessed when required. People's human rights were supported as registered managers understood their responsibilities in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people were assessed as not having the capacity to make a decision, a best interest decision was made involving people who know the person well and other professionals, where relevant. The registered managers had made DoLS applications to the supervisory body when required. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. However, staff who supported people living with dementia had a limited knowledge about the legal frameworks, which meant

## Is the service effective?

people's human rights may not always be protected when staff assisted them. Staff received training, but one of the registered managers expressed staff may have been feeling anxious when asked.

People had their health needs met. People's changing care needs were referred to relevant health services. People's care records demonstrated a variety of health care professionals were contacted as necessary, for example, community nurses, opticians, chiropodists, and speech and language therapists. A GP visited weekly to help with people's continuity of care. An external health professional told us communication was good and staff always acted on advice given.

People received care and support from staff who received training applicable to their role, for example dementia training. Staff received supervision and annual appraisals to discuss their role and ongoing development. Staff confirmed they felt well supported.

There was an induction programme for new staff. The registered managers were aware of the new care certificate and told us this had been incorporated into the induction. The care certificate is a national induction tool which providers are required to implement, to help ensure staff work to the desired standards expected within the health and social care sector.

The provider was taking action to ensure people living with dementia were supported and empowered by their environment. The provider had a refurbishment plan in place and told us dementia research would be used, along with consultation with people and their families.

# Is the service caring?

## Our findings

Staff were kind, caring, knew people well and spoke of them in affectionate terms. However staff were often too busy carrying out essential tasks to stop and talk with people. People also confirmed this, comments included, “They don't come and talk to me socially” and, “staff come and talk to me if they have time, I reckon there aren't enough staff”.

People living with dementia were cared for by staff who did not always have the time to develop positive relationships and provide reassurance. For example, we observed one person was confused and distressed. They kept asking “Why am I here? What am I doing?” A member of staff brought a colouring book and felt-tip pens. They took time to encourage the person to colour in the pink bits, and replied to the person in a kind manner, “as it matches your cardigan”. However, after a couple of minutes the staff member had to leave the person, to deal with something else. As a result of this, the person forgot what they were doing and became distressed again. Another person walked along the corridor “asking for work”. Staff would lead the person away, but then left them thereafter, offering no stimulation or engagement. These actions were repeated throughout the day.

Overall people's confidentiality was respected, however we overheard two members of staff speaking openly about people's needs in front of other people, however the registered manager took immediate action to address this.

People's comments about staff included, “the staff are very nice”, “staff are very very kind” and “I've been here 21 years so that tells a story. I love it here” and “My visitors are always offered a cup of tea”. One relative told us, “I can always talk to staff about my relative and they always tell me if there is a problem or they ring me up”. Another relative told us, “The staff have been wonderful at helping

me through these past months when I visit, as I have found this development in my X condition very upsetting”. Health and social care professionals all told us, staff were kind towards people, and had not seen anything of concern.

People's care plans had a short summary of who they were, and detailed information about their past history. This helped staff get to know each person and understand what was important to them. However, this information was not being effectively used to help ensure people were actively involved in their care, particularly those living with dementia, because staff did not use this information to create meaningful, purposeful days for people. People's care reviews were helping to ensure people's care plans were reflective of their care they wished for.

Residents meetings were held to obtain people's feedback and a comments box was available in reception for people's friends and families to use. The registered managers had introduced a Care Ambassador for people who lived in the nursing and residential area. The role of the Care Ambassador was to help ensure people's views about their care were heard and fed back to the provider. They told us, “it is important people feel valued, we take an interest in their lives”.

People's end of life wishes were recorded so staff knew what people's wishes were at the end of their lives. Nursing staff worked closely with GPs when people were at the end of their life, to help ensure a co-ordinated approach was taken. A weekly meeting was also held with the registered manager and nursing staff to help ensure everything was in place. The provider, although not accredited at this time, adopted the philosophy of the Gold Standard Framework for end of life care. The Gold Standard framework is a national tool which ensures people receive the highest standards of care at the end of their life.

We recommend the provider considers research and published guidance in relation to the care of people living with dementia.

# Is the service responsive?

## Our findings

People living with dementia were not always socially stimulated and were not always given opportunities to participate in activities. Staff were busy carrying out their duties and they did not always have time to spend socially with people. We saw people sitting in chairs for the majority of the day, walking up and down corridors or trying to get out a locked door. A member of staff told us, what we had observed, was the same most days.

The provider explained, dementia research showed walking or sitting should not be seen as a lack of stimulation but, connected with the person's illness. Too much stimulation could cause increased anxiety if a person was in the late stages of a dementia. People's care plans did not make reference to this, but made reference to the importance of social care; which was not always being incorporated into people's lives.

People living with dementia were not always provided with opportunities for social stimulation, which met with their individual needs, preferences and wishes. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

For other people, they were able to spend their day as they chose to. People told us there were social activities available, but staff respected their choice if they did not want to attend. The registered managers recognised people's reluctance to participate in activities, and were taking steps to try and encourage people. For example, there was a part time activities co-ordinator who worked in both areas of the home and an invitation had been given to the 'University of the Third Age' to use Hillcrest House as a meeting venue, so people could attend. Photograph albums and newsletters showed social activities did take place and on the day of our inspection, people were having their hair cut, their nails painted and there was a Pets at Therapy (PAT) dog visiting people.

People were positive about the personalised care they received and felt that it was responsive to their needs, one person told us, "I'm happy with the way I'm looked after".

One relative was complimentary of how they were kept informed of their loved ones health and changing care needs and described the staff as "diligent". The registered managers had a pre-assessment process which helped to determine if they could meet people's needs prior to them moving to Hillcrest House. People's care plans provided staff with guidance and direction about how to meet their individual needs. Care plans addressed their health and nursing care needs. People had summary care plans, which contained a coloured photograph of the person, a summary of who the person was and what their needs were, including medical needs in place. This was useful in supporting new and agency staff. People's care plans were reviewed as necessary with the person and or their family.

People had supporting care records when they had a specific care need, for example charts were in place to monitor people's skin conditions and record how often they should be re-positioned and dressings changed. This helped to ensure people's skin did not become vulnerable to unnecessary damage.

People had care plans in place for if they went into hospital to ensure continuity of their care. The care plan gave important information in a simplified way so hospital staff were aware of how to effectively support the person. One of these care plans had recently been updated with important information about changes to the person's communication needs.

People's changing care needs were discussed at daily handovers as well as management meetings to help ensure the care being provided was responsive to people's needs.

The service had a complaints policy in place which was made available to people and their relatives. People felt comfortable raising concerns. They explained if they wanted to complain they would speak to staff, comments included, "I always have questions to ask, but not complaints" and, "I would talk to the duty manager or the nurse in charge". Records showed the registered managers and provider responded to complaints. For example they had responded to a complaint; this had involved arranging a meeting with the person to find a solution.

# Is the service well-led?

## Our findings

People did not always receive a high standard of quality care because the provider did not have effective systems and processes in place to help ensure people living with dementia had their individual needs met. The provider's auditing tools had failed to identify whether there were enough staff to meet people's needs as demonstrated by the poor dining experience of some people, the lack of social stimulation for some people, and the impact of the environment on people's individual needs. It has also failed to ensure people were protected from risks associated with their care.

The systems in place to monitor the quality of service people received were not effective. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was receptive to our feedback and following our inspection contacted us to inform us about some of the immediate actions which had been taken, such as an increase in staffing, a change of flooring and ideas in respect of dementia training and research.

There was a clear management structure in place, and people and staff knew who to speak with. The provider who was also a registered manager was knowledgeable about people, their families and the staff. One of the registered managers told us the ethos was for Hillcrest House to be a family run service and stressed they were not a corporate establishment, and maintaining a family ethos was important to them. There were another two registered managers; each had specific managerial responsibilities. One registered manager was responsible for the care of people who lived in the nursing and residential area; whereas the other registered manager took responsibility for the management of dementia care.

Management, staff meetings and departmental meetings, were held to help with effective communication and to assist with the monitoring of the service. The registered managers received supervision to help with reflection, support and provide opportunities for ongoing training and development. The registered managers met formally on a weekly basis and a management report was also used to provide an overview of what was happening in each department.

The registered managers were available throughout our inspection and people and staff approached them with ease. Staff told us management were available to speak with at any time and listened to their views. One member of staff told us, "The management are approachable, [...] is very approachable; I normally go to him first", and "It's nice to come to work, when you enjoy your work". Another member of staff said, "Everyone supports each other and we are a good team." They went on to say, the registered managers called staff meetings as required and provided feedback through supervision.

The registered managers were aware of their responsibilities under the Duty of Candour and had recently created a new policy. The Duty of Candour means that a service must act in an open and transparent way in relation to care and treatment provided when things go wrong.

People completed an annual survey to help the registered managers establish if people were satisfied with the care and service they were receiving. The results of the survey had been collated and shared. The information was used to improve aspects of the service. For example, one person's en-suite door was too difficult to open. The registered managers had taken action to address this and had fitted a curtain instead. Departmental meetings had also been introduced following comments made in relation to the laundry service.

The registered managers were pro-active in making changes when she felt they would benefit people and staff. For example, new staffing roles had been introduced to help when someone moved in. This member of staff was able to spend quality time with the person, as well as completing the necessary paperwork. Another member of staff had been employed to assist with the review and updating of care plans, so nursing staff were not taken away from their day to day duties.

The registered managers were open and transparent when working with external professionals. They listened to advice and implemented changes as required. They had been responsive in replying to the Commission when we had received whistleblowing information. Concerns were always taken seriously, robust investigations were carried out and the registered managers always took any necessary action.

## Is the service well-led?

The registered managers had notified the Commission of significant events which had occurred in line with their legal obligations. For example, expected and/or unexpected deaths.

The service was underpinned by a number of policies and procedures, made available to staff. Policies were reviewed in line with changing regulations. There was a whistleblowing policy in place which protected staff should they make a disclosure about poor practice.

This section is primarily information for the provider

## Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care  <b>Regulation 9 (1) (a) (b) (c) (2) (3) (i) (5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</b>  People living with dementia were not appropriately supported to ensure their dining experience met their individual needs. People living with dementia were not always provided with opportunities for social stimulation, which met with their individual needs, preference's and wishes.
Regulated activity	Regulation
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  <b>Regulation 17(1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</b>  The systems in place to monitor the quality of service people received were not effective.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing  <b>Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</b>  People living with dementia did not have their individual needs met because there were not sufficient numbers of staff deployed.