Morleigh Limited

Clinton House Nursing Home

Inspection report

75 Truro Road
St Austell
Cornwall
PL25 5JQ
Tel: 01726 63663
Website: www.morleighgroup.co.uk

Date of inspection visit: 16 December 2014
Date of publication: 19/02/2015

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

Clinton House Nursing Home is a care home that provides nursing care for up to 46 older people. On the day of the inspection there were 32 people living in the home. Some of the people at the time of our visit had mental frailty due to a diagnosis of dementia.

The service is required to have a registered manager and at the time of our inspection a registered manager was not in post. However, the manager who was in overall charge of the day-to-day running of the home had started the process to make an application to the Care Quality Commission (CQC) to become the registered manager. A registered manager is a person who has registered with the CQC 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 and associated Regulations about how the service is run.

We carried out this unannounced inspection of Clinton House Nursing Home on 16 December 2014. At this visit we checked what action the provider had taken in relation to concerns raised at our last inspection on 22 April 2014. At that time we found the provider had not

Summary of findings

fully implemented an effective system to regularly assess and monitor the quality of service that people received. At this inspection we found the manager had implemented a quality assurance system to identify areas of the service that required improvement. However, we had concerns about the effectiveness of some of the processes to monitor and assess the service provided at the home. This was because some care plans had not been updated, there was no analysis of learning from monitoring people's behaviour and people did not have sufficient access to meaningful activities. There was no system in place to monitor the quality of the service provided at the provider level by using an auditing process external to the home. You can see what action we told the provider to take at the back of the full version of the report.

On the day of the inspection there was a calm atmosphere in the home and we saw staff interacted with people in a friendly and respectful way. People told us they felt safe living at the home and with the staff who supported them. People told us; "absolutely safe, no verbal or physical abuse", "very good staff, we can talk to them with any worries but we don't suffer from worries" and "all staff are approachable".

Staff had received training in how to recognise and report abuse. They were clear about how to report any concerns and were confident that any allegations made would be fully investigated to help ensure people were protected.

Staff were well trained; there were good opportunities for on-going training and for them to achieve additional qualifications. There were enough skilled and experienced staff to ensure the safety of people who lived at the home.

We observed the support people received during the lunchtime period. People had a choice of eating their meals in the dining room, their bedroom or one of the lounges. On the day of our inspection there was a delay in serving some people's lunches. We were advised that there had been a problem in the kitchen and some meals were not ready at the expected time. There was no evidence to suggest that this situation regularly occurred.

People told us about the food provided; "The food here is excellent, you can't say better than that; we have a choice of two meals mid-day and evening. To stay healthy I get good nutritional food", "I enjoyed my lunch today", "I have a choice at mealtimes" and "I'm happy with the food, we get a choice and plenty".

Staff supported people to be involved in and make decisions about their daily lives. Where people did not have the capacity to make certain decisions the home acted in accordance with legal requirements under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People told us staff treated them with care and compassion. Comments people made included;

"Staff are good with my brother in law, he is treated with dignity", "I am treated with care and compassion by the staff", "Staff are very kind" and "all staff are kind to me, full respect every time". Visitors told us; "home nice and staff seem nice" and "no concerns with the care".

People received care and support that was responsive to their needs because staff had a good knowledge of the people who lived at Clinton House. Staff were able to tell us detailed information about how people liked to be supported and what was important to them. People's privacy was respected. Visitors told us they were always made welcome and were able to visit at any time. People were able to see their visitors in communal areas or in private.

People told us they knew how to complain and would be happy to speak with the manager or nurse in charge if they had any concerns. There were systems in place to seek people's and their families views about the running of the home.

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 safe. People told us they felt safe living at the home and with the staff who supported them.

Staff knew how to recognise and report the signs of abuse. They knew the correct procedures to follow if they thought someone was being abused.

There were sufficient numbers of suitably qualified staff on duty to keep people safe and meet their needs.

Good

Is the service effective?

The service was effective. Staff supported people to maintain a balanced diet appropriate to their dietary needs and preferences.

Staff received on-going training so they had the skills and

knowledge to provide effective care to people.

The manager and staff understood the legal requirements of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards.

Good

Is the service caring?

The service was caring. Staff were kind and compassionate and treated people with dignity and respect.

People told us they were able to choose what time they got up, when they went to bed and how they spent their day.

People's privacy was respected.

Good

Is the service responsive?

The service was not responsive. Some people's care plans had not been updated to accurately reflect how they would like to receive their care and support.

People did not have sufficient access to meaningful activities that met their individual social and emotional needs.

People told us they knew how to complain and would be happy to speak with the manager or nurse in charge if they had any concerns.

Requires Improvement

Is the service well-led?

The service was not well led. We had concerns about the effectiveness of some of the processes to monitor and assess the service provided at the home.

There was no system in place for the quality of the service provided to be monitored at the provider level by an auditing process external to the home.

Requires Improvement

Summary of findings

Staff said they were supported by the management and worked together as a team.	

Clinton House Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 16 December 2014. This was an unannounced inspection which meant the staff and provider did not know we would be visiting. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has experience of using or caring for someone who uses this type of care service.

We reviewed the Provider Information Record (PIR) and previous inspection reports before the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We also reviewed the information we held about the home and notifications of incidents we had received. A notification is information about important events which the service is required to send us by law. .

During the inspection we spoke with, six people who were able to express their views of living in the home, two relatives and a visiting healthcare professional from the Early Intervention Team (EIS). We looked around the premises and observed care practices on the day of our visit. We used the Short Observational Framework Inspection (SOFI) over the lunch time period. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We also spoke with three care staff, the nurse in charge, the cook, and the manager. We looked at six records relating to the care of individuals, four staff recruitment files, staff duty rosters, staff training records and records relating to the running of the home.

Good

Is the service safe?

Our findings

People told us they felt safe living at the home. Comments included; “absolutely safe, no verbal or physical abuse”, “very good staff, we can talk to them with any worries but we don’t suffer from worries”, “we make a life living here; the staff are good, never any fall outs” and “all staff are approachable”.

Staff had received training in safeguarding adults and had a good understanding of what may constitute abuse and how to report it to the manager. All were confident that any allegations would be fully investigated and action would be taken to make sure people were safe. We looked at the provider’s safeguarding policy and noted the section about the actions staff and the manager should take when any suspected abuse occurred was unclear. The policy described how referrals should be made to the local safeguarding team. However, it also stated that in some circumstances the service would carry out an investigation before deciding whether or not to make a referral. This is not in line with Government and local guidance which states that all concerns should be reported to the local safeguarding team who will take the lead in any investigation. We saw safeguarding referrals had been made by the manager and there was no evidence to suggest that in practice the home had not operated in line with Government and local guidance.

Staff encouraged and supported people to maintain their independence. The balance between people’s safety and their freedom was well managed. There were risk assessments in place which identified risks and the control measures in place to minimise risk. For example one person liked to go out independently in the garden most days. We saw how any risks, such as the risk of slipping in wet weather, had been assessed and discussed with the person.

There were enough skilled and experienced staff to ensure the safety of people who lived at the home. Staffing numbers were determined using a dependency tool, and were regularly reviewed. A dependency tool is used to identify the numbers of staff required by assessing the level of people’s needs. The manager told us staffing levels could be adjusted to respond to changing situations, for example, if people became unwell or if the home had a high number of people staying for short periods. We looked at the staff rotas for the current week and the previous three weeks. Records showed the number of staff on duty each day was in line with the dependency levels of people living in the home at that time.

People told us they thought there were enough staff on duty. Comments included; “there are sufficient staff for our needs. I am not kept waiting long in my room”, “we don’t suffer much from shortage of staff” and “there are enough staff here and I am able to talk to them with any problems”.

We saw people received care and support in a timely manner. On the day of our inspection most people were downstairs in the main lounge /dining room. One member of staff was allocated to work in that room all day. This meant people could easily ask for assistance and the staff member was able provide support promptly. One person chose to spend most of their time in the ‘quiet’ lounge, adjacent to the main lounge. We saw staff regularly go into this lounge to check if the person required any assistance. People who chose to stay in their rooms had a call bell to alert staff if they required any assistance. We found the call bells for two people had been placed out of their reach. We advised the staff of the situation and this was rectified during our visit.

During our inspection we looked at the recruitment process in place to ensure staff had the specialist skills, qualifications and knowledge required to provide the care to meet people’s needs. We found references from a previous employer were missing in two staff files. We saw that repeated attempts had been made to obtain both these references. When we discussed this with the manager they told us when a previous employer did not respond to a reference request they would ring the organisation to obtain a verbal reference. There was no record in the two files of any conversation with the previous employers. However, the manager assured us this would have taken place. Other appropriate checks had been completed to help ensure staff were suitable to work with people living in the home.

Medicines were stored and administered safely. All Medication Administration Records (MAR) were completed correctly providing a clear record of when each person’s medicines had been given and the initials of the member of staff who had given them. We observed the nurse in charge giving people their medicines during our inspection. The nurse explained to people what their medicines were for and ensured each person had taken them before signing

Good

Is the service safe?

the MAR chart. For one person we found there had been a delay of 10 days in receiving one of their pain relief medicines. After a discussion with the manager we found the delay was, in part, due to the request going to the wrong doctor from the pharmacist. This medicine was an 'as required' (PRN) medicine and the person had not requested to have this particular medicine since moving into the home two weeks before our visit.

Medicines were securely stored in a portable metal cabinet. Some medicines which required additional secure storage and recording systems were used in the home. These are known as 'controlled drugs'. We saw that these were stored, and records kept in line, with relevant legislation. The stock levels of these medicines were checked by two staff members at least twice each day. We checked some people's stock levels during our inspection and found these tallied with the records completed by staff.

Any incidents and accidents that occurred in the home were recorded and monitored for trends. We found appropriate action had been taken to learn from these individual events to reduce the risk of harm to people.

The environment was overall clean and well maintained. On the day of our inspection there was an unpleasant odour in the corridor to the right of the main entrance. We were advised this had only occurred that day and we saw steps were taken to find the cause of the odour and the smell had improved by the end of our visit. We also found light bulbs in two bathrooms needed to be changed and this was also rectified during our visit. We found there were appropriate fire safety records and maintenance certificates for the premises and equipment. There was a system of health and safety risk assessment of the environment in place, which was annually reviewed.

Good

Is the service effective?

Our findings

Staff demonstrated a good understanding of how they cared for each individual to ensure people received effective care and support. People were satisfied the staff team had the right skills to meet their needs. One person told us, "I think the staff are well trained and we get on well with them".

Staff told us there were good opportunities for on-going training and for achieving additional qualifications. There was a programme in place to help ensure staff received relevant training and refresher training was kept up to date.

Care staff told us they met regularly with a member of the management team for regular one-to-one supervision meetings and yearly appraisals. Records we looked at confirmed there was a programme in place to carry out regular supervision with care and nursing staff.

We spoke with one newly recruited member of staff and they confirmed they had completed an induction when they commenced employment. The care worker told us the induction had been very helpful and they had been supported by other staff into their role. This included working alongside more experienced staff before starting to work on their own.

Care records confirmed people had access to healthcare professionals to meet their specific needs. For example, staff had worked closely with the local dementia liaison nurse for one person who was unsettled and disorientated when they first moved into the home. The dementia liaison nurse supported staff to develop ways of working with the person to understand their needs and how best to meet them. This joint working had resulted in the person becoming more settled and less anxious than when they were first moved into the home. A visiting healthcare professional told us staff had good knowledge of the people they cared for and made appropriate referrals to them when people needed it.

The home monitored people's weight in line with their nutritional assessment. Some people had their food and fluid intake monitored each day. We saw the associated records had been completed regularly by staff. However, the amount of food and fluid intake was not totalled each day and records did not show what was considered to be an adequate intake for individuals over a 24 hour period.

We discussed this with the manager who told us they would review the way food and fluid intake was recorded so it was a more robust way of checking how people's nutritional needs were met.

People were offered drinks throughout our visit and jugs of squash were readily available. The main lounge/dining room had a kitchen area where the member of staff allocated to work in that room could provide people with drinks and snacks whenever they requested them.

We observed the support people received during the lunchtime period. People had a choice of eating their meals in the dining room, their bedroom or one of the lounges. On the day of our inspection there was a delay in serving some people's lunches. People who required assistance to eat and/or had their lunch in their rooms received their lunch in a timely manner. However, 13 people, who were able to eat independently, waited in the dining room for 30 minutes before their meal arrived. Later in the day we were advised that there had been a problem in the kitchen and some meals were not ready at the expected time. Unfortunately this delay had not been communicated to staff so people had been assisted into the dining room at the usual time. There was no evidence to suggest that this situation occurred regularly.

People told us about the food provided; "The food here is excellent, you can't say better than that, we have a choice of 2 meals mid-day and evening. To stay healthy I get good nutritional food", "I enjoyed my lunch today", "I have a choice at mealtimes" and "I'm happy with the food, we get a choice and plenty".

Staff asked people for their verbal consent before they provided care and support. For example before giving people their medicines or assisting people with personal care. The registered manager and staff had a clear understanding of the Mental Capacity Act 2005 (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 MCA provides a legal framework for acting, and making decisions, on behalf of individuals who lack the mental capacity to make particular decisions for themselves. The legislation states it should be assumed that an adult has full capacity to make a decision for themselves unless it can be shown that they have an impairment that affects their decision making.

Good

Is the service effective?

Many people living in the home had a diagnosis of dementia and their ability to make daily decisions could fluctuate. The home had worked with relatives to develop 'my day' documents to understand the choices people would have previously made about their daily lives. Staff had a good understanding of people's needs and used this knowledge to enable people to make their own decisions about their daily lives wherever possible.

Where people did not have the capacity to make certain decisions staff acted in accordance with legal requirements. We saw records of where decisions had been made on a person's behalf; the decision had been made in their 'best interest'. For example best interest meetings had taken place for one person to decide on the use of bedrails and for another person to decide whether or not they should move permanently into the home. Records showed the person's family and appropriate healthcare professionals had been involved in these decisions.

There was evidence the service understood when any restrictions, put in place for people in order to keep them safe, would need to be authorised under the Deprivation of Liberty Safeguards (DoLS). The legislation regarding DoLS is part of the Mental Capacity Act 2005 (MCA) and provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. There have been changes to the legislation following a recent court ruling. This ruling widened the criteria for when someone may be considered to be deprived of their liberty.

The service had not made any recent applications to restrict people's liberty under DoLS. However, it was clear the provider had a good understanding of when an application would need to be made. We saw one person had a DoLS authorisation when they first moved into the home.

Good

Is the service caring?

Our findings

People told us staff treated them with care and compassion. Comments people made included; "Staff are good with my brother in law, he is treated with dignity", "I am treated with care and compassion by the staff", "Staff are very kind" and "all staff are kind to me, full respect every time". Visitors told us; "home nice and staff seem nice" and "no concerns with the care".

We saw people were smartly dressed and looked physically well cared for. A visitor told us, "we are very impressed with my brother in law's overall appearance, he is clean and well groomed".

People were able to make choices about their daily lives. We saw that some people used communal areas of the home and others chose to spend time in their own rooms. People were able to move freely around the home. We saw one person go out into the garden independently several times during our visit and we saw staff assist another person to go out into the garden.

Individual care plans recorded people's choices and preferred routines for assistance with their personal care and daily living. Staff asked people where they wanted to spend their time and what they wanted to eat and drink. We saw a member of staff explaining to one person, who was visually impaired, where the plate guard was positioned and where each type of food was on their plate to enable them to eat their meal independently. People told us, "I can choose what time I get up and go to bed and they bring me tea in bed because I ask", "we can get up and go to bed when we want" and "I'm an early riser, around 6.30 am, I get up when I want and go to bed when I want". Where people were unable to communicate their choices the home had worked with people's families to write details of their known daily routines on their behalf. All care plans we read had detailed life histories and this information was used to understand how people's past life might influence their current needs.

The care we saw provided throughout the inspection was appropriate to people's needs and staff responded to people in a kind and sensitive manner. For example, when staff helped people who needed assistance with eating this was conducted in a respectful and appropriate manner, sitting alongside the person and talking to them. We also saw staff discreetly asking people if they would like an apron to cover their clothes when having their lunch. We observed one person who was anxious because they had lost their spectacles. A member of staff responded swiftly, located the glasses and returned them to the person without any sign of annoyance or sense that they were busy or inconvenienced by this.

People's privacy was respected. All rooms at the home were used for single occupancy. This meant that people were able to spend time in private if they wished to. Bedrooms had been personalised with people's belongings, such as furniture, photographs and ornaments to help people to feel at home. Bedroom, bathroom and toilet doors were always kept closed when people were being supported with personal care. Staff always knocked on bedroom doors and waited for a response before entering.

People were supported to maintain contact with friends and family. Visitors told us they were always made welcome and were able to visit at any time. People were able to see their visitors in communal areas or in their own room.

Requires Improvement

Is the service responsive?

Our findings

We spent six hours observing and speaking with people in the communal areas of the home. On the day of the inspection we did not see any evidence of meaningful activities. The activities co-ordinator was due to work that afternoon but called in sick and the programmed 'life histories' activity did not take place. During most of our observation period there were 16 people in the main lounge and one person sitting in the small 'quiet' lounge. While staff were around to assist people if they needed help we did not see any evidence of staff spending one-to-one time sitting and talking with people. People told us, "they [staff] put the football on for us, which we enjoy, but there are limited activities in the home", "I would like to go out" and "my life would improve if I could have conversations with people, I do get lonely, I just sit alone and read or do jigsaws." A visitor told us, "there's no activity, my sister lies around all day". However, one person was taken out to the shops with a care worker on the day of our visit and another person told us, "I enjoy gardening and I can go out when I want."

There was an activity programme but it had not been designed according to the preferences of people living at the home and would not necessarily cater for everyone's needs. The programme included; bingo, pamper sessions, life histories, craft making and a visiting musical entertainment. In all the care plans we looked at there was some detail about the type of activities people would like to take part in. For example one person's care plan said, "likes to go out for a smoke and watch TV" and another person's said "enjoys time outside in the garden". Records of activities people had taken part in each day referred to activities like; "read paper, went outside in the garden, enjoyed a milkshake and had hair done". However, there were no in-depth assessments of how people's social and emotional needs could be met. We found people did not have access to meaningful activities that met their individual social and emotional needs, especially for people who required assistance from staff for their daily living.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found the level of personalised detail, about each person's specific needs and how they liked to be supported, varied in the care plans we looked at. All care plans were recorded as being reviewed monthly but some had recently been re-written in a more individualised style. The manager advised us they planned to change all care plans into this style. These 'newer' style care plans were informative, easy to follow and accurately reflected the needs of the people we spoke with and observed. For example, one person's care plan explained how staff should "only deliver one instruction at a time and give [person's name] time to process and repeat if necessary". This meant staff had clear instructions to follow to enable them to meet this person's needs.

Three of the six care plans we looked at had not been updated into the more individualised style. These care plans were not personalised to the individual and contained some generic statements that were not informative about the person or relevant to their needs. For example the care plan for one person stated in several sections; "[person's name] has some forgetfulness at times but this is common due to old age". There was no information about how this 'forgetfulness' might present or how staff could support the person. The statement; 'due to old age' was neither respectful nor informative, especially as the person was only in their 60s. This meant that, for some people, there was a lack of clear information for staff to follow to enable their needs to be consistently met.

Some people living in the home could sometimes display behaviour that was challenging for staff. Whenever incidents occurred behaviour charts were completed. Charts we looked at recorded specific incidents but there was no detail about how staff had responded to incidents or if any action had been taken. This meant the opportunity to capture information to update the person's care plan and guide staff about how to deliver care to meet their needs was being missed.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People who wished to move into the home had their needs assessed to help ensure the home was able to meet their needs and expectations. The manager was knowledgeable about people's needs and made decisions about any new admissions by balancing the needs of any new person with the needs of the people already living in the home.

The service had received eight complaints in the last 12 months. We looked at the complaints log and saw that all complaints had been responded to in the agreed timescale

Requires Improvement

Is the service responsive?

and had been resolved to complainant's satisfaction. People told us they knew how to complain and would be happy to speak with the manager or nurse in charge if they had any concerns. One person told us, "yes, we can talk to the manager".

Requires Improvement

Is the service well-led?

Our findings

At our inspection on 22 April 2014 we found the provider had not fully implemented an effective system to regularly assess and monitor the quality of service that people received. We found the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At this inspection we checked if the provider had made the necessary improvements to comply with the regulation. We found the manager had implemented a quality assurance system to identify areas of the service that required improvement. We found there were a range of audits regularly completed to monitor the quality of the care provided. These included: equipment checks, infection control, tissue viability, falls, medication, call bells, staff files and care plans.

However, we had concerns about the effectiveness of some of the processes to monitor and assess the service provision to ensure the care provided met people's individual needs. The systems had not identified areas of the service that required improvement. This was because the system for auditing care plans was not up-to-date and there were no in-depth assessments of how each person's social and emotional needs could be met. When behavioural charts were completed there was no analysis of the key learning from monitoring the behaviour and no evidence of action taken as a result.

There was no system in place to monitor the quality of the service provided at the provider level. There was no external auditing process or any opportunities to share good practice across the organisation. For example a new effective behavioural monitoring chart format had recently been implemented in a sister home but this was not being used at Clinton House. The provider told us standard policies and procedures had started to be developed across all the Morleigh homes, but these were not all in place at the time of this inspection. This meant there were no standard governance arrangements to help ensure a consistent quality of service across the group's homes.

The service is required to have a registered manager and there had not been a registered manager in post for over nine months. The current manager was appointed as manager in March 2014. We were advised that the manager had started the process to make an application to the Care Quality Commission (CQC) to become the registered manager. There had been a delay in this application being submitted because the manager had been working at a different location for a few months and the provider was not sure which service they would permanently manage. However, we were advised that the manager had returned to the service one month before our visit and this was a permanent arrangement.

This was a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

It was clear from our discussions with the manager that, despite our concerns about some monitoring systems, they were committed to continuously improving the quality of the care provided. Staff confirmed that the manager was very visible in the home and regularly worked alongside them. The manager had been pro-active in inviting dementia experts form Cornwall Council into the home to help staff understand more about the needs of people who had dementia. We saw a report from a dementia mapping exercise that had taken place in June 2014 where staff interaction with people was observed over a 5 hour period. The results from this had shown mostly positive interactions and where areas of concern had been identified we saw that the manager had addressed these.

There were systems in place to seek people's and their families views about the running of the home. The provider asked people and their families to complete questionnaires annually and 'residents meetings' were held regularly. People and their families told us they had opportunities to express their views about the home and were very positive about the manager and the staff. Two visitors told us; "Staff couldn't have done enough for my wife, they were brilliant" and "the home is much better than it was, we have more contact from the home with the present manager, they phone me when events are happening. I'll talk to staff with any problems, usually to the office."

Staff told us they enjoyed working in the home and felt supported by the manager, who they said was very approachable and spoke with them each day at handovers. Staff told us they had regular staff meetings and ideas they had about the running of the home were listened to. Comments from staff included; "no problem with the management", "it's a lovely home, I want to carry on working here", "a good staff team", "the home has a lovely atmosphere" and "good to have [manager's name] back".

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 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 Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met: The registered person had not taken proper steps to ensure that each person was protected against the risks of receiving care that was inappropriate or unsafe. Care and treatment was not planned and delivered in such a way as to meet people's individual needs. Regulation 9 (1) (b) (i) and (ii).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers How the regulation was not being met: The registered person did not have an effective system in place to regularly assess and monitor the quality of service provided and identify, assess and manage risks relating to the health, welfare and safety of people who used the service. Regulation 10 (1) (a) & (b)