Countryview (Warkton) Limited

Country View Nursing Home

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?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Country View Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Country View Nursing Home is located in a small village in Northamptonshire and is registered to provide accommodation and personal care to older people who may or may not have nursing care needs. They provide care for older people and people with a physical disability. The provider can accommodate up to 29 people at the home in 10 double bedrooms and 9 single bedrooms. When we visited there were 29 people living at the home.

At our last inspection in June 2016, this service was rated overall as good. At this inspection, we found that the service had deteriorated and has been rated as requires improvement.

The inspection took place on the 17 September 2018 and was unannounced.

A registered manager was in post. 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 were treated with warmth and kindness by the staff and management team, and by staff that had taken time to get to know them. People had choice and control over their lives and could access a range of activities tailored to meet their individual needs. People's privacy and dignity was protected and promoted and they received personalised and compassionate care at the end of their lives.

People were assisted to maintain relationships with their families, people's relatives could visit them at the home at any time.

People told us they felt safe. Staff understood their roles and responsibilities to safeguard people from the risk of harm and risk assessments were in place. There was sufficient staff available to meet people's needs.

People using the service and their relatives knew how to raise a concern or make a complaint and felt confident that these would be addressed.

People were supported to access relevant health and social care professionals and there were systems in place to manage medicines safely. People received their medicines as prescribed.

The provider did not have an effective quality assurance system in place to identify areas of concern and to improve and innovate. Safe recruitment processes were not always followed and the provider did not

prioritise maintenance work required to the décor.

People were not always supported by staff that had the skills and knowledge to meet their needs. Staff had not received effective and regular supervisions or appraisals to enable them to carry out their roles effectively.

The provider had not always consistently submitted legally required notifications for incidents such as abuse and those involving the police.

At this inspection, we found the service to be in breach of one regulation of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. The actions we have taken are detailed at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The provider did not always follow safe recruitment processes.

People were not always protected from risks associated with fire.

Staffing numbers were sufficient to meet people's needs and people told us they felt safe.

Is the service effective?

Requires Improvement

The service was not always effective.

People's needs were not always met by the adaptation, design and decoration of the premises.

People were not always supported by staff that had received regular supervision and appraisals.

People were supported to eat enough to maintain a balanced diet and their health needs were met.

Is the service caring?

Good

The service was caring.

People were supported by staff that treated people with warmth and kindness.

People were assisted to maintain relationships with their families.

People told us that their privacy and dignity was respected and being promoted.

Is the service responsive?

Good

The service was responsive.

People received care at the time they needed it.

People received personalised support at the end of their lives.

People's had access to a choice of activities tailored to meet their individual needs.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service had not always submitted statutory notifications.

The provider did not have a robust quality assurance system in place.

The management team were committed to ensure people's emotional and wellbeing needs were met.

Country View 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.

The inspection team consisted of one inspector, an inspection manager and an 'expert by experience'. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this instance their area of expertise was in people living with dementia, older people and long-term health conditions.

Before the inspection, we asked the provider to complete 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 planned to make. We considered the information provided within the PIR in making our inspection judgements.

We reviewed other information we held about the service. This included notifications regarding important events which the provider must tell us about. Notifications are changes, events or incidents the provider is legally required to tell us about within required timescales.

We contacted commissioners of the service and asked them for their views of the service. Commissioners are people who work to find appropriate care and support services for people. We also contacted Healthwatch Northamptonshire, an independent consumer champion for people who use health and social care services, to obtain their views about the care provided at the service.

During this inspection we spoke with four people who used the service and the relatives of three people. We spent time observing people's care and how staff interacted with them. We also spoke with seven members of staff including the registered manager, one nurse, two senior care staff, one activities co-ordinator, one administrator and the chef. We spoke to one visiting health professional, one social care professional, one holistic therapist and the provider.

We reviewed six people's care records to ensure they were reflective of their needs, six staff recruitment files, and other documents relating to the management of the service such as maintenance records, feedback from people using the service and their relatives, and meeting minutes.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in June 2016 'safe' was rated as good. At this inspection we found that the service had deteriorated and there were areas that required improvement.

People were at risk of being supported by staff that had not received the appropriate recruitment checks before commencing employment. Some staff recruitment files we looked at did not contain all the relevant information to demonstrate that staff had the appropriate checks in place. For example, one staff file did not contain two references, a health declaration or confirmation that a Disclosure and Barring Service (DBS) check had been received and checked by the provider. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

Another staff file documented that prior to employment, the staff member did not have a DBS and there was no evidence of one being requested by the provider. The staff member had not completed the personal declaration regarding criminal convictions and only one character reference had been received. When we asked the registered manager why this information was absent, it was reported that the provider had difficulties in gaining references for new staff. The management team told us during the inspection that they had planned to review all staff files to ensure they had a written record of DBS certificate numbers and the clearance date.

We also found that where references had not been obtained by the provider, that they had not undertaken a risk assessment to determine the possible implications of employing the person prior to proceeding with employment as detailed in their recruitment policy.

Risk assessments had been completed to ensure staff knew how to support people in the event of a fire. However, we found that these risk assessments did not provide enough information. For example, one person living on the first floor was unable to mobilise. The risk assessment did not detail how staff should support them in the event of a fire. There was no documentation available for the fire service that would assist them to safely evacuate the people living at the home in the event of a fire. We brought this to the providers attention and following the inspection they told us they had put in place personal emergency evacuation plans for each person living at the home and a summary evacuation plan for use by the fire service.

People told us they felt safe. One person told us, "They [care staff] make me feel safe. I have never felt unsafe or worried." Another person told us, "It's the staff and nurses that make me feel safe." The staff we spoke with all had a good understanding of safeguarding procedures and could describe what to do if they suspected or witnessed any form of abuse. One staff member said, "I would report to the nurse on duty, and if nothing happened, the manager." One staff member told us that they had raised a concern with the nurse on duty and that the registered manager was informed and action was taken. However, we saw that not all staff were trained in safeguarding procedures. One staff member told us, "I can't remember when I had training, not recently." The provider had identified there were 10 members of staff that required

safeguarding training and had taken action to co-ordinate the training.

People's risks were assessed and reviewed regularly. For example, their risk of falls, development of pressure ulcers and of not eating and drinking enough. These risk assessments reflected people's current needs and people's care plans provided staff with clear instructions on how to reduce the known risks. For example, one person's risk assessment for prevention of developing pressure ulcers detailed what pressure their relieving mattress needed to be set at, that it needed to be checked daily and how frequently their position needed changing. We saw that the persons pressure mattress had been checked and they were receiving position changes as per the risk assessment and care plan.

People could be assured that equipment used for moving and handling was serviced to ensure people were supported safely. For example, we saw that the mobile hoists and bath lifts had been serviced. Staff told us that they check equipment before using it. One staff member told us, "I check slings before using and report if the stitching is broken."

Staffing numbers were sufficient to meet people's needs. During our inspection we saw that people had the support they needed from care staff and nurses, who were available for people promptly when called. There were enough staff on shift to make sure people were safe. The management team coordinated additional staff to meet the changing needs of people that lived at the home when required. One person told us "I think there are enough staff generally."

People had access to call bells should they require assistance when in their bedrooms, one person told us "I have a bell in my room. I asked them to change it from right to left and they did. I have used it, they come in minutes." We saw that staff responded promptly when people used their call bells.

People received their medicines as prescribed and on time. There were appropriate arrangements in place for the management of medicines. Medicines were administered by the qualified nursing staff. The provider used Medication Administration Records (MAR) to record when people received their medicines. One person told us, "I take medication three times a day, it is usually on time and they give me pain relief when I ask". We observed that people received their medicines as prescribed and staff recorded accurately when they had administered them. Prescribed medicines had been regularly reviewed by the GP and medicines were ordered, transported, stored, and disposed of safely and securely in ways that meet current and relevant legislation and guidance.

People were protected by the prevention and control of infection. The provider had arrangements in place arrangements for keeping the premises clean and hygienic so that people are protected from infections. One person told us My room is nice and clean." Staff had a good understanding of their role and responsibility in relation to infection control and hygiene. People told us "They [Staff] always wash their hands or wear gloves." We saw that personal protective equipment (PPE) was available in every bedroom and communal area and was being used appropriately by staff.

People were supported by staff that knew how to report and record accidents and incidents. We saw that accident forms were completed by staff and that the provider identified and made improvements to the safety of care people were receiving following incidents. For example, following reports of a suspected prowler the provider had installed additional external lighting and had made alterations to the internal door to improve the safety and security of the home.

Requires Improvement

Is the service effective?

Our findings

At the last inspection in June 2016 'effective' was rated as good. At this inspection we found that the service had deteriorated and there were areas that required improvement.

People were not always supported by staff that had received effective and regular supervisions or appraisals to enable them to carry out their roles effectively. One staff member told us, "We don't have regular supervisions." Another staff member told us "I have not had an appraisal for four years." Nurses clinical skills were not formally reviewed to ensure they remained competent with undertaking clinical tasks. Staff told us they felt able to approach the nurse on duty or the registered manager if they needed support or had any concerns. Since the inspection the provider has booked supervisions and appraisals to ensure they are compliant with their supervision policy and has started undertaking competency assessments of qualified nursing staff.

People did not always receive care from staff that had the skills and knowledge to meet their needs. We saw that not all staff were up to date with the provider's mandatory training. For example, 13 staff members had not undertaken Mental Capacity Act (MCA) training, this was a third of the staff team. One staff member told us "I have not had MCA training, but would like to." Following the inspection, the provider confirmed that training for Safeguarding, MCA, Equality and Diversity, Health and Safety training and Infection Control would be undertaken within 6 weeks for staff that had not previously undertaken this training or required a refresher. The provider told us that they were committed to supporting staff to access additional training that would benefit the people living at the home and had booked additional training such as "End of life care practical skills and knowledge." Staff told us that new staff shadowed senior carers for two weeks as part of their induction until they were confident in undertaking their role, this enabled them to get to know people's individual needs.

People's individual needs were not always met by the decoration of the premises. We found that the décor was damaged in places and in need of refurbishment. For example, in one bedroom and the hallway, we saw that holes in the décor had been patched up but had not been redecorated. The provider had failed to act promptly to address a large area of mould visible in a ground floor hallway that had been caused by a leaking water pipe. Following the inspection, the provider submitted a maintenance schedule which addressed the areas of concern raised. People could personalise their bedrooms with their own belongings and we saw that people sharing bedrooms had their own personal belongings in their part of their bedroom.

The provider had systems in place to assess people and identify the support they required before receiving care from Country View Nursing Home. The provider worked with staff, teams and services across organisations to ensure that people received person centred care when they were referred to the service, or moved to different services if their needs could not be met.

The provider collated information about people's life history, likes and dislikes to inform the care plans and to shape activities to meet their individual needs. People's care plans were reviewed monthly or as their needs changed to ensure they accurately reflected their current needs.

People were supported to eat enough to maintain a balanced diet. The chef was aware of the requirement for food to be prepared to meet people's individual needs. For example, for one person that required a gluten free diet, the chef ensured that a gluten free main meal could be cooked and that gluten free products such as bread and cakes were available. Staff were deployed effectively at mealtimes to ensure that people received adequate nutrition and people's nutritional intake was monitored where there were concerns. People told us, "The food is very good, they offer three choices," and "It's good honest food. If you are not ready they put it to one side for you." One staff member told us "Everyone has a weekly diet chart when they come in, if someone doesn't eat we can raise concerns at handover and it gets followed up." We observed lunch to be a relaxing and sociable occasion with care staff sitting with people, chatting to them and encouraging them to eat.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the provider was working within the principles of the MCA, and found that they were. People's mental capacity had been assessed and people were empowered to be as independent as possible. However, we found that the provider had not evidenced that they had consulted people and their relatives when making decisions about care and treatment in people's best interests.

The registered manager and staff understood their roles in assessing people's capacity to make decisions. People looked happy and contented in the company of staff and we saw staff took care to ask permission before assisting people. One staff member told us, "I ask people questions and give them choices, we talk to relatives. If people are not able to tell us themselves and find out people's likes and dislikes and stick to them as much as we can."

People's health needs were met. The provider had a good relationship with the GP surgery and co-ordinated weekly visits. They also liaised with the GP upon identifying any concerns to ensure people's health needs were promptly responded to. We saw from care records that people had been referred to health and social care professionals and staff followed their guidance and advice. One person told us "The doctor comes when I need him, they take me to the dentist. I have a lady chiropodist." The management team told us that they have access to a vehicle and take people to health appointments if their relatives are unable to take them.

People and their relatives told us that they enjoyed accessing the outdoor areas in the good weather. We saw that there was adequate access to appropriate space for people to access activities as a group or individually, to spend time alone with visitors or to access the well-tended outdoor grounds.

Good

Is the service caring?

Our findings

People were supported by staff that treated people with warmth and kindness and staff interacted with people in a polite and respectful manner. Care was carried out in a dignified and person-centred way. One person told us, "They are all very kind, a lovely lot of staff." A relative told us, "From what I've seen the staff are kind and caring."

The staff and management we spoke with all spoke positively of the people living at the home, and were knowledgeable about people's needs and preferences. We saw feedback from relatives that included comments such as, "Thank you for all your never-ending kindness", "For the first time in a long time, we can relax knowing [name] is being given the care and attention they need" and "You treated my family with kindness and nothing was too much trouble."
People had formed a good relationship with the staff. One person said "They [Staff] regularly come around and chat with people. They are pretty good like that. I think they know me." A staff member told us, "Seeing the smiles on people's faces every day makes my day. I am here to make them all happier."

People's individual communication needs were met. The provider told us they would arrange for an interpreter if required for those people whose first language was not English, however this was not needed at this current time as any people requiring an interpreter were being supported by their family. The provider was aware that they could access advocacy services if required. At the time of the inspection nobody required the use of an advocate as all people were supported by their family members.

People were supported to maintain relationships with their families. One person told us, "My [relative] can come when they want." People told us that staff were respectful towards them. One person told us, "They always treat me respectfully when doing my care." Relatives and visitors were encouraged to visit the home and they could visit at any time.

People told us that their privacy and dignity was respected and being promoted. One person said, "They are quite respectful. If I want them to leave me in the bath for ten minutes they will go away and come back." Staff told us, and we saw that dignity screens were being used in the double bedrooms to ensure people's privacy and dignity was respected. However, we saw that staff did not always knock on the door before entering people's bedrooms. This did not give people the opportunity to refuse or agree to staff entering their bedroom.

We saw that people's records were accurate, complete, legible, up-to-date, securely stored and available to relevant staff to comply with data protection requirements. Information about people was shared on a need to know basis. Handovers of information took place in private and staff spoke about people in a respectful manner.

Good

Is the service responsive?

Our findings

People's assessments and care plans considered people's values, beliefs, hobbies and interests. People, and where appropriate their relatives were involved in developing their care plans. The care plans were person centred, identifying people's background, preferences, communication and support needs.

People's care plans had been reviewed regularly or as their needs changed. Daily records were maintained to demonstrate the care provided to people. People told us they received their care as planned. One person told us, "I think they did a care plan with me and my daughters." Another person told us, "They asked me a lot of questions when I came in, they asked what I liked and needed." Staff were made aware of any changes to people's needs during handover at the beginning of their shift, this enabled staff to make adjustments to the care delivered to ensure people's individual needs were met. All staff we spoke with told us they valued this handover. One staff member told us "Handover is 10-30 minutes and is very detailed, so we know what is happening each day."

People's communication needs were recognised. The provider had implemented picture cards to enable one person to express their basic needs. One staff member told us, "[Name] brings their phrase book down and teaches us phrases, I am trying to learn them." The registered manager was aware of the need to make adjustments to ensure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard (AIS). The AIS is a framework put in place from August 2016 making it a legal requirement for all providers of NHS and publicly funded care to ensure people with a disability or sensory loss can access and understand information they are given. The provider had made improvements to the Wi-Fi access to enable people to speak with their relatives via video calling.

People received care at the time they needed it. The management team had implemented a daily planner for the staff team, this identified the care and support needs for each person which enabled the staff team to be more effectively deployed to meet the needs of the people across the home.

People's had a choice of activities they could access. The provider had employed two full time activities co-ordinators. Facilitated activities were available on a Monday to Friday and all people living at the home had the opportunity to spend time with the activities co-ordinator on a 1:1 basis each week doing an activity of their choosing. One person told us "[Name of activities co-ordinator] sits and chats with me sometimes." A family member told us that their relative "Gets quite a lot of one to one's and the activities have improved." Another relative told us "[Name of activities co-ordinator] is great. Very patient with [relative]." During our inspection we observed the activity coordinators engaging positively with people during a group activity.

People's spiritual and faith needs were considered. Various faith leaders visited on a regular basis.

People had the opportunity to see a holistic therapist for a hand and foot massage, Indian head massage, manicure or reiki once a week including weekends. Treatments were adapted to people's needs, wants and abilities. We saw, and people told us that they had time with the therapist on a one to one basis receiving a treatment of their choosing once a week. This enhanced people's care experience. The provider had

recognised the value of offering this support and had increased the therapists time at the home to four days a week.

People received personalised support at the end of their lives. The provider was passionate about ensuring people were supported at the end of their life to have a comfortable, dignified and pain free death. We saw that the registered manager, provider and qualified nurses were in regular communication with the GP to ensure that end of life medications were prescribed to enable prompt administration should people's symptoms change or their condition deteriorate. The provider had supported three members of staff to attend the gold standards framework training on end of life care.

The provider ensured that families could spend time with their loved ones at the end of their life. One staff member told us, "Visitors are welcome anytime and can sleep overnight when people are end of life, we get a recliner chair and blankets for them." The provider told us that if people do not have the support of family members they will ensure that the person has one to one support so they are not alone and will facilitate extra staff to be available to ensure this takes place. Staff told us that the management team often provide support to people at the end of their life outside of their usual working hours.

People had the opportunity to discuss with staff what it meant to be at the end of life and make their preferences known in an advanced care plan, such as remaining in the home or receiving care in a hospital and we saw that advance care plans were in place. Advance care planning is the term used to describe the conversation between people, their families and carers and those looking after them about their future wishes and priorities for care.

People and their relatives we spoke to told us they would have no hesitation raising a concern and felt confident it would be dealt with. The provider had a complaints policy and displayed the complaints procedure in the reception area of the home. There was no record of any complaints being received by people that lived at the home, relatives or visitors in the last 12 months. The registered manager and provider told us that they encouraged people to speak with them if they had any concerns to ensure they were promptly resolved. One staff member told us "We have very few complaints, I think this is because we are open and transparent."

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in June 2016 'well-led' was rated as good. At this inspection we found that the service had deteriorated and there were areas that required improvement.

The provider did not have an effective system in place to formally assess and monitor the service to improve the quality and safety of the services provided in carrying on of the regulated activity. Whilst the registered manager had undertaken audits of the care plans and controlled drugs they had not monitored the quality of the service through other audits, such as training, supervision, Medication administration record, recruitment, accident and incident reporting and environmental checks to identify where improvements were required. For example, the provider was not aware that there had been gaps in the fire checks, recruitment checks or training until this was brought to their attention by the local authority and had failed to address maintenance and décor issues in a timely way.

The provider was unable to evidence how it continuously learns, improves, innovates and ensures sustainability. In the absence of thorough quality assurance systems, they were unable to formally evaluate learning from current performance to shape and improve the provision. The provider did not make best use of information technology systems to effectively monitor and improve the quality of care. Staff told us that suggestions they made were not always listened to with one staff member telling us "The management won't change if you suggest things."

There were no systems in place to ensure that staff received appropriate supervision and feedback on their performance. The provider did not prioritise supervisions and appraisals for their staff team and did not review clinical competencies for the clinical nursing staff. The provider and registered manager could not be assured that staff were practising safely and effectively and that people were receiving safe care. Staff did not receive formal feedback on their performance to enable them to improve their practise, to celebrate success or innovation, or have the opportunity to discuss their development needs.

The provider did not have an effective system in place to formally assess and monitor the service to improve the quality and safety of the services provided in the carrying on of the regulated activity. This is a breach of Regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Providers have a legal responsibility to ensure that notifications such as incidents of neglect, incidents involving the police and deaths are reported to CQC. The providers safeguarding policy states the provider must notify the CQC without delay incidents of abuse, and allegations of abuse, as well as any incident reported to the police. The provider had not always consistently submitted the legally required notifications.

The registered manager was aware of the day to day culture in the home. We could not be assured that the management team were always open and transparent in their communication with us. For example, we witnessed a staff member being challenged for sharing information with us during the inspection.

The provider and registered manager held meetings with nurses and senior carers at different intervals, which gave them the opportunity to address any areas of practice that required improvement. For example, not using mobile phones during working hours, requesting attendance to courses and improving the quality of daily reports. However, there were inconsistencies in meetings with other staff members. One staff member told us that "There are 3-4 team meetings a year." Another staff member told us they are "Once a year." We saw that the meetings for nurses and senior carers occurred regularly whereas meetings for other team members were infrequent.

People told us they knew who the management team were and that they had a visible presence in the home. One person told us "There are two [ladies] in the office, they are in charge. They are always around. They seem to get on well with staff. They speak to me sometimes." A relative told us "I see the manager when we come." Staff told us the management team had an open-door policy and they could speak to them about any concerns. One staff member told us, "[provider] calls at the weekends to check everything is ok." And a professional told us "We all work as a team and get good feedback."

The management team were committed to ensuring that people's emotional and wellbeing needs were being met and that they received excellent end of life care. They had taken the time to get to know each person living at the home. The provider was proud of having a consistent staff team, only using staff from an agency as a last resort. Staff told us that the registered manager would often step in to cover nursing shifts due to sickness or absence to promote continuity of care for the people living at the home. The provider had achieved a Silver "Investors in People" award. Investors in People is a standard for people management, offering accreditation to organisations that adhere to the Investors in People Standard.

People we spoke with were aware of resident's meetings. We saw that residents' meetings had taken place and that a newsletter was available in the reception area for people and visitors to the home which referred to an upcoming residents meeting and stated, "All relatives and friends welcome." Residents meetings recorded feedback from people about their experiences of the home and recorded any recommendations for the management team to action. For example, the provider had introduced a cinema night once and week and had co-ordinated for two volunteers and two students to spend time befriending people.

The provider worked alongside the clinical commissioning team and the local authority commissioning team to share information and to identify whether they would be able to support someone's needs. The provider shared information and assessments with other relevant agencies for the benefit of people who live at the home. We spoke with visiting health and social care professionals during our inspection who fedback that the provider had engaged with them and shared information to inform their assessment of need.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the location where a rating has been given. This is so that people, visitors and those seeking information about the provider can be informed of our judgments. We found the provider had displayed their last report which included their rating at the location.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems for monitoring and improving the service were not consistently effective. Regulation 17 (1).