Mrs Jean Miles

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

Summary of findings

Overall summary

The inspection took place on 8 November 2017 and was unannounced. When we completed our previous inspection on 21 January 2016 the service was rated as good overall. This is the first time the service has been rated Requires Improvement.

Hillingdon House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Some of the people living in the home were living with dementia. At the time of our inspection 21 people were using the service. Hillingdon House accommodates people in one main building and a separate building which they call the 'Annexe' and which we will refer to as the 'Annexe' throughout the report. In the main building there is a communal lounge, a dining area, and a garden area that people can access. There is also a communal lounge and a small dining area in the 'Annexe' and seven bedrooms.

The service had a registered manager 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.

Risks to people's health and wellbeing were not always assessed and managed. They were not always assisted to move safely. The night time arrangements to respond to emergencies had not been assessed and to ensure that there were adequate staff. The provider hadn't always considered the rights and wellbeing of their staff when deploying them at night time. There were not always enough staff available to meet people's needs during the day. This meant that people were left at risk of harm at times. When accidents were reviewed the provider had not considered the time they happened and whether the staffing levels could have impacted on them.

Staff did not always recognise some incidents as potentially harmful situations. These had not been shared with the responsible external agencies to ensure that people were safeguarded against harm. The risks associated with medicines were not always managed to ensure that people received them as prescribed. The management systems which were in place to monitor the quality of the home were not always effective in highlighting and addressing errors. We were not notified of all of the changes in the home that we require as part of the registration so that we can monitor how it is managed.

People's dignity and privacy were not always upheld and this had an impact on their independence. They did not always have enough interesting and stimulating activities to engage them.

People's capacity to make their own decisions was assessed to ensure that they were able to do so. This meant that people were supported to have choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People had a

choice of good quality food; including specialist meals when required. The provider had developed working relationships with other healthcare professional to ensure that people's health and wellbeing were monitored and managed.

Staff understood people's preferences for care and their care plans were up to date and reflected their current needs. Staff received training to do their jobs, including induction training. They felt supported through staff meetings and supervisions. They had caring relationships with people and their families who were always welcomed.

Safe recruitment procedures were followed to ensure that staff were safe to work with people. The provider's previous rating was displayed in the home as required.

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.

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 consistently safe.

People were not always protected from risk because the systems in place to assess it and reduce it were not always effective. Staff did not recognise all safeguarding concerns to protect people from harm. There were not always adequate numbers of staff deployed to meet people's needs in a timely manner. The learning from mistakes was not always sufficient to make the changes required. Infection control was managed to ensure people were protected. Safe recruitment procedures were followed.

Is the service effective?

Good

The service was effective

Staff received training to do their jobs effectively. People were asked to consent to their care and if they were unable to then decisions were made in their best interest. The environment met people's needs. Good relationships with other organisations ensured that people had their healthcare needs met. People had a choice of good quality food.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's dignity and privacy was not always upheld and this impacted on their independence. They had caring relationships with staff and their relatives were welcomed.

Is the service responsive?

Requires Improvement

The service was not consistently effective.

People were not provided with enough stimulating activities. Staff understood people's preferences and delivered care in line with them. Care plans were up to date and regularly reviewed, including plans about end of life care. There was a complaints procedure in place and people and their relatives understood how to use it.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Audits and quality improvement measures were not always effective in improving the service. Notifications were not always made. The rights and wellbeing of staff were not always managed. There were meetings with staff and people to receive their feedback.

Hillingdon 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.

Hillingdon House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Some of the people living in the home were living with dementia. At the time of our inspection 21 people were using the service. Hillingdon House can accommodate 15 people in one main building and 7 people in a separate building which they call the 'Annexe' and which we will refer to as the 'Annexe' throughout the report. In the main building there is a communal lounge, a dining area, and a garden area that people can access. There is also a communal lounge and a small dining area in the 'Annexe' and seven bedrooms.

This inspection site visit took place on 8 November 2017 and was unannounced. The inspection visit was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The inspection was informed by feedback we had received from whistle-blowers, information from the local authority and notifications the provider had sent to us about significant events at the service. We used this to formulate our inspection plan.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We observed the care and support that people received in the communal areas. We spoke with eight people about the care they received and also to five people's relatives to gain their feedback. We also spoke with the registered manager, the deputy registered manager, a senior member of care staff and three care staff. In addition we spoke with the kitchen registered manager and one visiting health professional.

We looked at the care records for five people. We did this to check that the care they received matched the information in their records. We also looked at records relating to the management of the service, including quality checks and staff recruitment files.

Requires Improvement

Is the service safe?

Our findings

There were not always enough staff deployed to keep people safe from harm. People slept in two separate buildings; seven people slept in the 'Annexe' with one member of staff on duty. There was one member of staff on duty in the main building with the remaining people. When we reviewed records we saw that a number of accidents and falls had occurred at night. We spoke with staff who explained that a second member of staff would be requested to assist through radio handsets. The registered manager confirmed that this was correct. This meant that there would be periods of time during the night when there were no staff in one of the buildings. There was no risk assessment in place to consider the safety of this arrangement.

We talked to staff and looked at some records for people who lived in the 'Annexe'. Two of the people required two staff to assist them to move using equipment; this meant that if they required assistance during the night the other building was empty. In addition, two people were able to mobilise independently and both were living with dementia. The provider had not assessed the risk of harm to these people if they did mobilise when the building did not have any staff in it. In addition, we saw that there was a small kitchen with a kettle which they could access. One relative we spoke with said, "I did not know there was a kitchenette in the 'Annexe' with a kettle. My relative wouldn't be safe if they came in here alone". This was also not risk assessed and no management plans put in place. This demonstrated to us that risks to people's safety were not fully considered to protect them from harm.

We saw that people had personal plans in place which detailed how they should be assisted to leave the building in an emergency. All of the people who lived in the 'Annexe' required the assistance of one or two members of staff. The front door was kept locked for people's safety and staff confirmed that people who lived there would not be able to open it. Therefore, when staff were in the other building assisting in emergency situations it would mean that people would not be able to vacate the building; for example in a fire.

There were not always enough staff to meet their needs in a timely way. One person said, "There are not really enough staff because I often have to wait to go upstairs or to the toilet because the staff are busy". Another person told us, "I do have to wait sometimes but there are so many people here that need help that it's understandable because the staff can only help us one at a time. I do get a bit concerned sometimes about waiting to go to the toilet". When we spoke with staff they described how they planned their time to meet people's needs and this included five people who required two care staff to support them. In the mornings there were three staff available to meet people's needs and we saw that when they asked for assistance staff were able to provide it. Between 15:00 and 18:00 there were only two staff available. We saw that this meant that when they supported people who required two staff to assist them then there were no staff to support the other people in the communal area. This meant that there were not always enough staff to meet people's needs during certain periods of the day.

Staff we spoke with described the arrangements in place for night staff to assist people to get up in the morning. When we spoke with people they told us that they got up early and that it was night staff that

mostly assisted them. One member of staff we spoke with said, "When we come in at seven am there are two people left to get up in the 'Annexe'; five are already up. The night staff from the main building goes across to help the other night staff to get them up. There will be six or seven people up at 7am in the main building which leaves two care staff to get two or three people up". Another member of staff said, "The night staff get fourteen people up between them before they leave at eight. That arrangement is in place because it would be too difficult to get people up with three staff". One person we spoke with told us, "I choose to get up when I want I suppose; as long as it fits in with when everyone else is coming across from the 'Annexe'. We saw that this deployment of staffing was confirmed in records that we reviewed. This demonstrated to us that there was not always enough staff available to offer support to people.

We spoke with the registered manager about the staffing arrangements. They told us that they would review night time arrangements but that they felt that there were enough staff to meet people's needs and preferences in the morning and throughout the day. When we asked if staffing was planned using a dependency tool they told us they did not use one at the moment. A dependency tool assists in planning staffing levels around each person's needs. This showed us that they were not regularly reviewing staffing levels in line with people's changing needs.

This is a breach of Regulation 18 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

Risks to people's safety when they were being supported to move were not always assessed or managed in a safe way. We saw that one person was assisted to move from their wheelchair using an armchair to lean on; this was used to support their weight. In order for them to sit down we saw they had to turn around while holding the armchair, as they did this we observed they were unsteady. There was no risk assessment for this and as the armchair was the incorrect height and not secured the person was placed at risk of falling.

We saw people being supported to move using a handling belt on three occasions. A handling belt is designed to assist transfers because the member of staff uses handholds which provide a more secure grip and can prevents injuries caused by holding of limbs. The Health and Safety Executive guidance states for moving and handling in care homes that, 'Handling belts to assist residents who can support their own weight, e.g. to help them stand up. They should not be used for lifting'. We saw that on each of the three occasions the person was lifted by the belt and was not supporting their own weight. In addition when staff described to us who they used the belts with and how they used them they described this as lifting the person. When we reviewed records we saw that one person had previously fallen to the floor. Staff had recorded the actions they had taken; this said, 'lifted with standing belt'. This meant that the equipment was not used in line with current guidance and put people at risk of harm.

The environment was cluttered during mealtimes which increased the risk to people falling. One person told us, "There is always a lot of equipment in here which has to keep being moved, but there is no-where else to keep it". We saw that the tables were close to each other and that there was little space between chairs. The room also contained people's wheelchairs and walking frames around the tables. We saw that people could not get through the spaces and had to ask staff to assist them to safely get through the room; although they could usually mobilise independently.

Medicines were not always managed to reduce the risks associated with them. We saw that one person was given some soluble medicines at lunchtime. The member of staff who administered them did not wait to ensure that the person took them. We observed that the medicine sat on a table beside them until we alerted staff at four o'clock which was three hours later. The member of staff said, "I will destroy that because they will be due their next administration soon and there must be a gap of four hours between

each". This meant that the person did not receive their medicine as prescribed. We saw that this medicine had been signed as given on the medicine administration record (MAR). This is not in line with National Institute for Health and Care excellence (NICE) 'Managing medicines in care homes' guidance. This states that care home staff must record medicines administration as soon as possible and ensure that they make the record only when the resident has taken their prescribed medicine.

Some people took medicines which were prescribed 'as required', or PRN. We saw that two people were prescribed a medicine which they could take if they were anxious during personal care to calm them. There was a plan in place for each person to describe this. When we reviewed their MAR we saw that they had taken it every day. This was not in line with the plan nor best practice guidelines which states that if PRN medicine is given regularly then a referral to the prescriber should be considered for a medicines review, as their treatment may need to be altered (Managing medicines in care homes published March 2014 by NICE).
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We reviewed the stock of medicine against the records. Although staff were recording a daily stock take when we checked some of the amounts recorded were incorrect. This meant that we could not be sure that people had the medicines they were prescribed.

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

People's safety was not always fully considered because safeguarding procedures were not always followed. When we spoke with staff they were able to describe what action they would take if they saw something that they considered to be abuse. They were able to give us examples and these included staff behaviour towards people who lived at the home or potential abuse from families. However, when we reviewed records we saw that there had been an incident between two people who lived in the home earlier in the year. This had resulted in a physical altercation between the two people and both had received injuries. When we spoke with staff about this incident they did not recognise it as a safeguarding concern which should have been reported to the safeguarding authority. We looked at records and spoke with the registered manager and saw that this incident had not been reported as required. This demonstrated to us that although there was a safeguarding procedure in place and staff received training they did not always put it into practise to protect people.

The analysis of when things go wrong was reviewed and action taken to reduce the risk to people. For example, a back door was secured to prevent people who would be at risk if they were out on their own leaving the building unsupervised. We had also previously received complaints from whistleblowing that not all staff had police checks before they started work at the home. We had discussed the process that the provider used to recruit and train new staff. The provider told us that they had ensured that these staff did not work unsupervised during their training period. However, in light of these complaints they decided to change how they recruited new staff.

Safe recruitment procedures were in place to ensure that new staff were suitable to work with people. One member of staff we spoke with told us, "They took references before I started and I also had a new police check. It was all in place and then I started my induction training". When we reviewed records we saw that they had all of the correct checks in place.

Staff understood their responsibilities in relation to infection control and hygiene. One member of staff said, "We have had training in it and we are provided with the protective equipment we need". We saw that staff used gloves and aprons when supporting people and different coloured aprons when they went into the

kitchen. We spoke with the registered manager about actions they took after an infection control audit. We saw that they had revised the cleaning schedule and put additional hand washing areas in the building. We observed that the building was clean and odour free and we saw staff cleaning throughout the day. We also saw the provider had been rated a four star by the food standards agency. We spoke with the registered manager and they told us that they had completed some observations of staff in the kitchen and provided training in hand washing to meet the recommendations in the rating. The food standards agency is responsible for protecting public health in relation to food.

Good

Is the service effective?

Our findings

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 or 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. When we spoke with staff they understood about people's capacity to make their own decisions. They told us that they had received training in MCA and DoLs and records we reviewed evidenced this. We heard them asking people for consent before delivering care. When people did not have capacity to make their own decisions we saw that they were made in their best interest with professional advice and in discussion with important people; for example, people's families. We saw that some DoLS authorisations had been granted to legally restrict some people's liberty to maintain their safety and that further applications had been made. There were no conditions on the DolS for the provider to follow.

We saw that assessments were written and delivered in line with current legislation For example; one person was prescribed a medicine which for a condition which needed to be monitored. The dose of the medicines needed to be adapted in line with the monitoring. We saw that this was assessed and there was a plan in line with NICE guidance. The monitoring was completed in partnership with health professionals and information was passed between the two teams to ensure that the person's needs were met. When we asked staff they were able to explain this and what the current dose should be. Records demonstrated that staff followed the plan and communicated any concerns with health professionals. This demonstrated to us that staff had developed effective partnerships across other teams.

The development of these partnerships assisted the staff to ensure that people's healthcare needs were met. One healthcare professional we spoke with said, "We have worked together and the person we support has all of the equipment they need to manage their condition and staff follow the plans that are put in place". People told us that they had regular check-up appointments; for example, with opticians and chiropodists. They also told us that when they were unwell they saw a doctor without delay. We reviewed records and saw that people had assessments by health professionals when their needs changed. We saw advice from language therapists about specialist diets which could reduce the risk of people choking. At mealtimes we saw that this advice was followed.

People had good meals and were always offered a choice. One person said, ""I love the food and often have seconds. I wasn't cooking properly at home so this is great". Another person said, "I can't remember not liking a plate of food here. It's always very tasty and edible and I don't think I have ever left any". We saw that when people needed assistance to eat this was provided in a respectful, kind manner. People told us

and we saw that there were regular snacks throughout the day. One person said, "They are always coming around with drinks and biscuits". People were weighed regularly to monitor their health and to ensure they were having enough to eat and drink. When they lost weight referrals were made to healthcare professionals. This meant that the provider ensured that people had enough to eat and drink and maintained a balanced diet.

Staff were provided with training and support. One member of staff told us, "The training is brilliant. We do practical things with the training registered manager like moving people safely and also go through workbooks together". Another member of staff told us, "I have been trained in administering medicines and also been observed to check I am doing it correctly. The night staff also have this training in case someone requires pain management during the night". Another member of staff described their induction. They said, "When I first started I shadowed another member of staff. I have worked in care before but every home is different and it is important to get to know people.

The home environment met people's needs. One relative we spoke with said, "We chose here because it is homely and small and we knew our relative wouldn't be comfortable in a more clinical environment". People had decorated their own rooms, including family photographs and ornaments. We saw that people had access to the garden and some people were supported to have a cigarette in an adapted area.

Requires Improvement

Is the service caring?

Our findings

People's dignity, privacy and independence was not always respected and promoted. We spoke with one person who told us, "I can't go to my room when I choose. I have a downstairs room by the door and the staff use it during the day. They let district nurses and other people use it to see patients so I just stay here". The person was sat in the communal lounge. We spoke with staff about this and they confirmed it was correct. One member of staff said, "Yes, when the nurses come they do sometimes see people in that person's room". This meant that the person's personal space and their privacy was not respected.

The arrangements for people to spend the day in the main building impacted on their independence and choice. One person told us, "I cannot go back to my room in the day because it is next door and it's locked so someone would need to come with me". Another person said, "I like my room; it is very comfortable but I spend most of my time in the lounge". A third person said, "The staff are nice but we all have to sit around here all day long". We observed that most people sat in a communal area around the sides of the room and some people spent time in the dining area. Only one person spent time in their room and that was because they were cared for in bed because of their health. This meant that people's independence and dignity were not fully respected and upheld.

This is a breach of Regulation 10 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

People told us that the staff were kind and patient; but often too busy to be able to spend time with them. One person said, "The staff are very nice and helpful" and another person said, "The staff are very patient as I cannot move very quickly". A third person said, ""The staff are generally very nice and I feel quite well looked after. I just wish I didn't have to sit here like this all day". We saw that when staff did have time to spend with people they were considerate and respectful. They knew people well and could talk with them about things they had done and families. There were times during the day when staff had time to spend with people; for example, painting their nails. At other times of the day the staff were more task focussed and people had little interaction. We saw that a lot of people slept or looked disengaged during the day.

We saw and relatives told us that they were made to feel welcome. One relative we spoke with said, "The staff are very caring and considerate and they always make us feel very welcome when we come". We saw that when relatives did visit they were greeted warmly and updated on the person's wellbeing.

Requires Improvement

Is the service responsive?

Our findings

People did not always have enough opportunities to pursue interests and hobbies. One person told us, "The activities are okay but are very limited and only happen sometimes". Another person we spoke with said, "I am very bored most of the time as many people in here go to sleep all day and I have to sit here". When we spoke with people they said that there were games of bingo sometimes; but that activities were not every day. We saw that a game of bingo did take place but also that a lot of people did sleep in chairs during the day. People also told us that they did not have the opportunity to pursue their spiritual beliefs. One person we spoke with said, "I used to go to church at home and there used to be someone come from the local church here but they haven't been for a long time". When we spoke with staff they confirmed that activities for people had not always been in place recently and that they tried to do things with them when they had available time. The registered manager told us that they recognised that there had been less organised activities for people. They said, "We have recruited a new member of staff to focus on activities and they will start soon".

Staff knew people well and could describe their likes and dislikes. One person said, ""The staff are very kind and seem to understand me very well. It is good now because we have a meeting every month with my family. It means we can discuss things early before they become a problem". A relative we spoke with said, "Before our relative moved in we met with the registered manager. We discussed their needs and the registered manager seemed confident that they will be able to support them. We were encouraged to bring things from home so that their room is more personal. They have settled in well". Another relative said, "The staff are lovely. I speak with them most days and they always let me know if anything has happened or if my relative is unwell".

We saw that staff understood how to meet people's preferences; for example, sitting near friends and having personal belongings nearby. Staff knew what was in people's care plans and we saw that they were updated to reflect people's changing needs. When people were receiving care at the end of their life we saw there was a plan in place which described how they wanted to be supported. We saw that there was a plan in place for one person who was on end of life care. It had been completed with the person's relatives and with healthcare professional to ensure that they had pain management medicines available.

People and their relatives knew how to raise any concerns or complaints that they had. One relative told us, "We have discussed any concerns with the registered manager. We were able to talk to them and they were very supportive of our needs". People we spoke with told us that they would not want to complain because they could speak with staff if anything was bothering them. The provider had a procedure in place to deal with complaints and we saw that they had not received any. The registered manager told us that they had kept a record of concerns raised and the actions they took to resolve them; for example, they were considering how to improve the laundry service by changing how they labelled people's belongings.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in place The registered manager had not notified us of all of the important events that occurred in the service in line with their registration. We saw that two DoLS had been approved and we had not been notified of this. We were also aware of one safeguarding incident which we had not been notified of. This meant that we had been unable to check whether the provider had taken appropriate action.

This is a breach of Care Quality Commission (Registration) Regulations 2009: Regulation 18

The rights and wellbeing of staff were not always considered to ensure that they could deliver safe, effective care to people. We saw that there was an arrangement for one member of staff to work a late / sleep in arrangement to support people in the 'Annexe'. When we spoke with the registered manager about this they said, "They are paid an hourly rate so if people need them they are available; but if they have nothing to do then they can sleep". When we asked how long the member of staff slept for on average they were unable to tell us. We asked staff about the arrangement and they told us that the member of staff did not usually sleep at all. If the member of staff did not sleep this meant they were working a fourteen hour shift. We saw that one member of staff did this shift on two consecutive days which would mean that they only had ten hours rest time before starting work again. This is against the Working Time Regulations 1998 which states that, 'An adult worker is entitled to a rest period of not less than eleven consecutive hours in each 24-hour period during which he works for his employer'. This demonstrated to us that the provider had not considered the regulations in place to ensure that a night worker who was alone in a building had enough sleep and rest to perform their role effectively.

The audits and reviews which were were completed to drive quality improvement were not always effective. We reviewed the medicines audit which stated that the counting and recording of stock of medicines was not always correct and that staff seemed to be writing down the previous quantity without checking that it was correct. When we checked medicines we found the same errors. Therefore, although the audit had highlighted the error the action taken to follow up with staff had not amended the errors. We also reviewed the analysis of accidents and saw that they also did not include any incidents of behaviour which could cause harm to people; although, we did see records which stated that this occurred in people's personal plans.

Some quality improvement systems had not been implemented. When we discussed the staffing levels and how they were deployed with the registered manager they told us that they had not used a tool to assist them to continually assess people's dependency. This would assist them to consider the staffing levels in line with people's needs; for example, when someone's mobility reduced and they required two staff to assist them to move. The registered manager told us that they would implement a tool to review staffing levels.

The provider demonstrated that they worked in partnership with other agencies effectively. After our last inspection the provider had an external infection control review which highlighted action points required to

meet standards. We saw that these were met and that the subsequent review demonstrated improvement. When we reviewed these actions with the registered manager we saw that they had been sustained. They demonstrated that they made similar improvements after food hygiene assessments and fire risk assessments also.

There was a registered manager in place and they were known by the people who lived at the home. One person told us, "I know the owner and the registered manager. They are friendly". We saw that the registered manager knew people well and spoke with them about how they were. There were meetings for people who lived at the home and changes were made in response to their feedback; for example, planning menus.

There were also regular staff meetings and staff told us they felt supported by the registered manager. One member of staff said, "If I ever need any support I can go to the registered manager, the deputy or the owner and they will do something". The registered manager told us that they held meetings at different times over a few days to ensure that they spoke with all staff. We saw records which evidenced this. Staff understood whistleblowing and told us that they felt confident that they would be listened to and that action would be taken. Whistle blowing is the procedure for raising concerns about poor practice.

The provider had displayed their rating in the home in line with our requirements. They had a website but the registered manager informed us that it was not up to date and they were in the process of closing it down. They understood that they would need to display their rating on any new website.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents We did not receive all of the notifications required in line with registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way for people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always sufficient staff deployed to meet people's needs