Hawkhurst House Limited

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

Summary of findings

Overall summary

This inspection took place on 25 and 26 October 2018 and was unannounced. Hawkhurst House is a purpose-built modern building and provides accommodation and nursing care for up to 85 people. The service also provides personal care and nursing care for people who rent or buy their accommodation within Hawkhurst House. There were 16 people living at Hawkhurst House during our inspection; of which all were receiving accommodation and nursing care. The service provides nursing care on the ground floor and supports adults living with dementia. The first floor was not operational and the second floor was used as staffing accommodation.

The service has a registered manager, who was present throughout the inspection. 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 and associated Regulations about how the service is run.

Hawkhurst House was first registered with CQC to provide regulated activities on 17 December 2017 and this is its first inspection.

Accidents and incidents were reported and responded to in most cases.

Staff knew how to keep people safe from abuse and neglect. The registered manager referred most incidents to the local safeguarding authority.

The provider had not kept CQC informed of all events that happened in the service as required by legislation.

Risks to people had not always been mitigated to protect people for harm. Prospective members of staff were living at the service without the relevant checks being completed. We have made a recommendation about the assessment of risk.

Audits and checks had not been fully effective in identifying and remedying shortfalls. The service had a Practice Development Manager in place working alongside the registered manager.

Care plans, risk assessments and guidance were in place to give staff knowledge about how to support people in an individual way.

The management of medicines was effective, people received their medicines safely and in a timely manner. Policies and procedures were in place for staff to follow ensuring safe storage and recording of medicines.

The safety of the premises was assured by regular checks on utilities and equipment. Fire safety had been addressed through training, fire drills and alarm testing. Maintenance had been carried out promptly when repairs were needed.

People had a choice of nutritious meals, snacks and drinks, and could choose where they would like to eat. Staff encouraged people to eat their meals and gave assistance to those that required it.

There were enough staff on duty that had received relevant training and supervision to help them carry out their roles effectively. Staff were observed putting their training into practice in a safe way. A dependency tool had been introduced to enable the registered manager to make sure that staffing levels remained adequate. Recruitment files contained all the required information about staff.

A range of professionals were involved in people's health care and individual plans of care were mostly in place if people had specific health needs like diabetes, catheters or pressure wounds. Some care plans required review to ensure they contained clear, detailed guidance for staff to follow.

Staff and registered manager worked within the principles of the Mental Capacity Act 2005 (MCA) which ensured people's rights and wishes were protected.

Staff treated people with kindness, compassion and respect. Staff took time to speak with the people they were supporting. We saw many positive interactions and people enjoyed talking to the staff. The staff on duty knew the people they were supporting and the choices they had made about their care and their lives.

Care plans were person-centred; they reflected people's individual preferences and gave staff an understanding of the person. A range of activities were on offer with specific sessions and groups designed for people living with dementia. Staff encouraged people to be involved and feel included in their environment. People's privacy and dignity was respected.

Complaints had been documented and recorded. People and relatives said they knew how to complain if necessary and that the registered manager was approachable.

We found a breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we have asked the provider to take 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.

Safeguarding processes had not always been followed to ensure people were kept safe.

Risk assessments were carried out to mitigate any risk to people's health.

The premises and equipment were properly maintained. People were protected from the risk of infection.

Accidents and incidents were recorded and analysed.

Is the service effective?

Good

The service was effective.

People or their relatives met with staff before moving to the service, to assess their needs.

New staff received an induction to their role and ongoing training to enhance their knowledge and skills.

Staff received regular supervision from their line manager, and a programme of annual appraisal was in place.

Staff were working within the principles of the Mental Capacity Act 2005.

People were supported to eat a balanced diet. People were encouraged to lead as healthier life as possible.

Staff referred people to other health professionals when their needs changed.

The service was purpose built and met people's needs.

Is the service caring?

Good

The service was caring.

People were treated with kindness and respect.

People were encouraged and supported to be involved in their care and support.

People were supported to be as independent as possible.

Is the service responsive?

Good

The service was responsive.

Each person had a care plan which contained details about people's choices and preferences. People had access to activities they enjoyed.

People received person centred care, that met their needs and were supported in a dignified way at the end of their lives.

Complaints were recorded and investigated.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider had not kept CQC informed of all events that happened in the service as required by legislation.

Staff completed checks and audits. These did not always identify shortfalls.

People were comfortable in the company of the management team.

People, relatives, staff and stakeholders were asked their views on the quality of the service.

The service worked with other agencies to deliver joined up care.

Hawkhurst 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 checked 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 25 and 26 October 2018 and was unannounced. On the first day, the inspection team consisted of two inspectors, a specialist advisor and an expert by experience. The specialist advisor was an experienced nurse and an expert by experience is a person who has personal experience of using similar services or caring for family members. On the second day, the inspection team consisted of one inspector and a specialist advisor.

Prior to the inspection, we looked at notifications about important events that had taken place at the service. Due to technical problems, the provider was not able to complete a 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 took this into account when we inspected the service and made the judgements in this report.

During the inspection we joined some people for lunch and attended a daily meeting with the head of each department. We spoke with 10 people and 11 relatives to gain their views about the quality of care provided. We also obtained feedback from a doctor that visited the service each week. The views from people, relatives and health care professionals is contained in detail in the main body of the report.

We spoke to the registered manager, deputy manager, practice development manager, two nurses, two senior care staff, one care staff, the administrator, chef, housekeeper and maintenance person. We also viewed several records including six care plans; the management of medicines; the recruitment files of five staff recently employed at the service; staff training records; health and safety records; complaints and compliments; accidents and incidents and quality monitoring audits.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Hawkhurst House. Comments included, "I feel safe because there are always plenty of people about" and "I feel safe living here." However, we found that the service was not always safely managed.

Risks to people had not been adequately assessed. We found not all risks to people were mitigated and people were potentially put at unnecessary risk of harm. At the time of inspection, we found that there were 12 members of staff living on the second floor and an additional two potential employees who had recently arrived from abroad. The two potential employees were currently undergoing pre-employment checks; however these had not been completed but they were still allowed to move into the staff accommodation at the service. No risk assessment or guidance had been put in place to minimise the risk to people and as a result, people were not suitably safeguarded from potential abuse or harm. We bought this to the attention of the provider, who assured us the two potential employees would not live at the service until the required checks had been completed and they were assured that they were not placing people at risk. We recommend that the registered provider ensures robust risk assessment processes are in place.

Other risks to people had been identified and assessed. There were individual guidelines in place to tell staff what action they should take to minimise the risks to people, for example if people were living with diabetes or were at increased risk of choking. Risk assessments were reviewed and updated as changes occurred so that staff were kept up to date. People were protected from the risk of financial abuse. There were clear systems in place and these were regularly audited.

Staff we spoke to had received training in safeguarding and keeping people safe. Staff demonstrated that they knew how to follow the provider's safeguarding policy. Staff knew about different types of abuse and their responsibilities to report any concerns to help make sure people were kept safe from harm. Staff also knew about the whistle blowing policy. This ensured staff were protected if they witnessed poor practice of another person employed at the service, and they needed to report it.

Staff were recruited safely. Checks had been completed to make sure people were honest, trustworthy and reliable. These checks included written references and an employment history, any employment gaps had been discussed. Disclosure and Barring Service (DBS) criminal records checks had been completed before staff began work at the service. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care services.

There were sufficient staff on duty to meet people's needs. The registered manager used a dependency tool to calculate how many staff were needed. People told us there were enough staff to meet their needs and that their call bells were usually answered in a reasonable time. Comments included, "I think there are enough staff I'm always told who my carer is for the day"; "The staff come quite quickly when I press the bell" and "When I push the bell they come as quickly as they can."

Medicines were given to people by registered nurses and trained care staff. Medicines competency checks

were carried out on new staff and existing staff's competency was assessed through a practical task, including direct observation. Other medicines, including those which were at higher risk of misuse and therefore needed closer monitoring were stored securely. Medicine Administration Records (MARS) contained a photograph of each person so that they could be easily identified. Information was available to staff giving out medicines if a person had an allergy to any prescribed medicines. Protocols were in place for people who were prescribed their medicines to be given 'as required' (PRN) and these were understood by staff. Staff recorded when patches for pain relief were applied to people's skin and when they were rotated to ensure they were regularly moved to maintain people's skin integrity.

The premises were well maintained. There were records to show that checks took place to help ensure the safety of people, staff and visitors. Procedures were in place for reporting repairs and records were kept of maintenance jobs, these were completed promptly after they had been reported. Records showed that portable electrical appliances and firefighting equipment were properly maintained and tested.

Records showed Health and Safety audits were completed and that these were reviewed by management to see if any action was required. These checks enabled people to live in a safe and suitably maintained environment. Staff told us everything was in working order.

People had a personal emergency evacuation plan (PEEP). A PEEP sets out specific physical and communication requirements that each person has, to ensure that they can be safely evacuated from the service in the event of a fire. The business continuity plan detailed the steps staff should take to keep people safe in the event of an emergency.

People and their relatives were satisfied with the cleanliness of the service. Cleaning staff followed a schedule and worked hard to ensure the service was clean. During the inspection we saw areas of the service where there were no residents living being cleaned such as the first floor. A resident of the day scheme had been introduced and this included the designated person having their room deep cleaned.

There was a housekeeping team who had oversight of all aspects of cleaning and laundry. Systems were in place for dealing with soiled laundry and sluice rooms were available throughout the service. During the inspection, a person had become unwell in the night and a deep clean of their bedroom was needed. By lunchtime, personal clothes and bed linen
had been replaced and soiled items had been washed and laundered. Infection control audits were carried out and staff had access to personal protect equipment such as disposable gloves and aprons to prevent any cross infection. All these actions helped to minimise the spread of any infection.

Staff made a record if an accident or incident occurred which included a description of what had occurred, any treatment given and who was informed such as the next of kin. The registered manager reviewed all significant events to see if there had been any common themes or patterns and that the appropriate action had been taken. Accidents and incidents were also discussed at daily meetings. There were systems and processes to make improvements when things had gone wrong. When people had fallen, an analysis was undertaken to identify if the person had fallen previously and when this had occurred a referral had been made to the falls clinic.

Good

Is the service effective?

Our findings

People told us they enjoyed their meals at Hawkhurst House. One person told us, "They will always cook something different if I don't like what's on the menu." A relative commented, "It's nice to be able to have lunch with my wife every day it brings some normality back into our lives."

People's needs were assessed using a comprehensive assessment tool before they moved to the service. This was also used to assess people before they moved back to the service, for example, following a stay in hospital. This supported the registered manager to make sure the service could meet people's needs and review if any additional staffing or training was required. This assessment was used to create the person's care plan. Where possible, people and their relatives were involved in planning their care delivery and were aware of risks to be monitored and managed.

New staff received an induction to the service. This included shadowing more experienced staff, completing training and the Care Certificate, along with getting to know people and the service. The induction was covered over a flexible period depending on the individual staff member.

Staff received ongoing support through regular updates, supervisions and annual appraisals. Staff continued to receive refreshers in mandatory training and were offered other additional training that was relevant to people they supported. For example, managing aggression; diet and nutrition; care planning; dignity and respect and equality and diversity. A spreadsheet contained details of what training had been completed and allowed the registered manager to identify who was due to complete or refresh training.

Staff completed regular assessments of people's ongoing needs using recognised tools. These included Waterlow assessments (to assess the risk of people developing pressure areas or skin breakdown) and a malnutrition universal screening tool to identify people at risk of losing weight. Specialist mattresses and cushions were used to help support people who were at risk of developing pressure areas. Where concerns were identified around how much people ate or drank, records were made. This enabled staff to track how much people ate and formed a starting point for dieticians to decide if fortified or food supplements were required.

We received positive feedback about the quality, nutritional value and choice of food served. One person told us, "The food is good and we get a choice. The chef comes to see us and asks if we liked the menu." The cook was passionate about their role and the quality of food they served to people. They were aware of individual dietary needs and how to cater for them, along with people's likes, dislikes and favourites. Another person told us, "I have very recently moved in and it has been an anxious time moving to somewhere different. I am not allowed to eat certain foods because of my diet needing to be gluten free but the chef here has been fantastic so far! This has really helped settle any nerves." We spoke to the chef about meeting people's specific dietary needs and he had sourced ingredients on the morning of the inspection from a local supermarket to ensure a person's needs were met.

The chef explained to us that they worked out the nutritional content of meals to enable to them to fortify

meals for those who needed it. To support people with diabetes, they offered some dishes in a slightly smaller portion so that they could have the same choice as others.

There were also detailed records about individuals dietary needs to support the kitchen staff to deliver a person centred approach. The cook told us that they spoke to each person daily to see what meals they would like and are always able to offer another choice of they don't want the main menu.

Staff monitored people's health and referred them to healthcare professionals when their needs changed. One person told us, "I sees the optician to sort my glasses when I need to." People's weight was monitored and when people lost weight they were referred to the dietician. People who had difficulty swallowing were referred to the Speech and Language Therapist (SALT) to be assessed. Staff followed the guidance from the health professionals, people had started to gain weight and people were eating and drinking safely.

Hawkhurst House was purpose built and met people's needs. The corridors and doorways were wide and the registered manager had considered best practice guidance for a dementia care setting. Although, only a small number of people suffered from dementia there was a vision for the service to become more specialised for people with these health needs. For example, there were handrails in corridors to aid mobility. Signage to toilets and lounge areas were easily visible and in written and pictorial forms. Peoples bedroom doors were painted in different colours to help people to more easily distinguish them. Each floor had a different colour scheme and this helped to aid people's awareness of their surroundings. Bedrooms were personalised with people's own possessions, photographs and pictures. There was a garden that people were able to access and spend time in. Toilets and bathrooms were clean and had hand towels and liquid soap for people, visitors and staff to use.

The service was operating within the principles of the Mental Capacity Act 2005 (MCA). The 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 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.

At this inspection we found that staff understood the principles of the MCA and people were offered choices throughout the inspection, like where they would like to spend their time and what they would like to drink. When important decisions needed to be made on people's behalf, best interest meetings had taken place with people who knew the person well.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

Good

Is the service caring?

Our findings

People and their relatives told us and indicated that they were happy with the care and support they received, from staff who were kind and caring. Comments included, "Staff always come and chat, they are all very nice" and "In general they are very good here, I don't mind it, it is actually quite good." A relative told us, "Looked after mum beautifully; can't speak highly enough of them."

Another relative was very complimentary about the care their loved one received at Hawkhurst House. Their loved one had suffered from severe anxiety and refused to be moved from their bed via a hoist at a previous care home. This meant the person had been bed bound for seven years. After a period of time spent gaining trust, care staff managed to encourage them to use a hoist and sit in a chair. Now the person regularly sits in the lounge and joins other people for dinner. On hearing the news that their loved one was out of bed for the first time in years, a relative said, "Wow! That's why I'm glad [loved one] is with you guys. That is absolutely amazing."

Another person moved to the service earlier in the year after a fall; had lost all confidence in walking and unable to weight bare safely. Their mobility improved whilst at the service and two months ago, they walked out of Hawkhurst House with the aid of a walking stick to live independently in their own home.
Staff knew about people's background, their preferences, likes and dislikes and their hopes and goals. During the inspection we observed many kind and caring interactions, where it was evident that staff knew the person well, and knew how they would respond. When people had to attend health care appointments, they were supported by staff that knew them well, and would be able to help health care professionals understand their communication needs.

Staff spent time with people to get to know them, and supporting them in a way they preferred. People felt they were treated with dignity and respect. Comments included, "Always nice and polite, if I want anything I get it straight way" and "I have asked for a female carer and they abide by that."

Staff told us at the time of the inspection that people who needed support were supported by their families or their care manager, and no one required any advocacy services. Information about advocates, self-advocacy groups and how to contact an advocate was held within the service, should people need it. An advocate is someone who supports a person to make sure their views are heard and their rights upheld to ensure that people had the support they needed.

Some people required additional support to communicate. Staff used some signs and symbols to assist people's understanding where possible. There were pictures displayed of the staff at the service, activities on offer and of the menu to reinforce people's understanding.

People's care plans and associated risk assessments were stored securely and locked away so that information was kept confidentially.

People told us that staff respected their privacy. They said, "Always knock every time" and "Knock and open

the door." When people were at the service they could choose whether they wanted to spend time in communal areas or time in the privacy of their bedroom. Staff described how they supported people with their personal care, whilst respecting their privacy and dignity. This included explaining to people what they were doing before they carried out each personal care task.

People told us they could have visitors when they wanted. People told us visitors were able to come at any reasonable time and they were always made to feel welcome; "Visitors can come when they like and always get offered tea and coffee" and "My wife comes every day, she is always welcomed. Some people had mobile phones, and there were computers and internet access so they could contact family and friends whenever they wanted to.

Good

Is the service responsive?

Our findings

Relative and/or Visitors told us staff were responsive when their relative's care needs changed. One visitor told us, "My wife has dementia and the transition period from home to here had been very difficult but we are getting there with the help and support of the staff." People told us they felt they received the support they needed and were happy. One person told us, "They have put extra padding in my hoist sling, they are trying to get an extension to my bed because I am so tall and they extended the television to angle it so I can watch it lying down in bed. They are excellent at meeting individual needs."

Each person had a care plan, which included details about their choices and preferences. There were details about what people liked to eat and drink, when they wanted to get up and go to bed and how they liked to receive their care. Health conditions were identified and care plans provided guidance for staff about how to support people and what to do to reduce identified risks. For example, where people required support to ensure good skin integrity there was specific guidance around how a person needed support to turn and their legs needing to be elevated on a pillow when in bed to reduce swelling, as well as to relieve and minimise friction against pressure areas.

Other care plans required further work to ensure there was clear, specific guidance for staff. For example, one person's care plan recorded an anxiety disorder. However, it did not give clear information about signs and symptoms they may display, or how to support them. It would be good practice to include this so staff have a clearer indication of support needs, however, staff we spoke with were clear about how best to support this person. This is an area for improvement.

Within people's care plans were life histories, guidance on communication and personal risk assessments. In addition, there was guidance describing how the staff should support the person with various needs, including what they could and could not do for themselves, what they needed help with and how to support them. Care plans contained information about people's wishes and preferences and guidance on people's likes and dislikes around food, drinks and activities.

Health plans detailed people's health care needs and involvement of any health professionals. Each person had a healthcare passport, this gave health professionals details on how to support a person in healthcare settings if needed, for example, if a person needed to stay in hospital. Care plans were regularly reviewed and reflected the care and support given to people during the inspection.

People were supported at the end of their lives. People were asked about their end of life wishes and these were recorded, some people had declined to discuss their wishes and this was respected. Staff received training in palliative care and nurses could support people with the administration of medicines to keep them comfortable. Staff made sure that medicines were available when people needed it. Staff liaised with the GP and other health professionals to ensure people's needs were met. One visitor commented, "The one thing that really impressed me was when we arrived someone had passed away and the quiet, discreet compassionate way they moved the person reassured me about their excellent end of life care."

People had review meetings to discuss their care and support. They invited care managers, family and staff. Where able, people were encouraged to be involved in the content of their care plan and where possible family or friends were asked to assist. Where people had been involved, and were able to, they had signed their care plan.

People told us they were supported to take part in a variety of activities including music therapy, physiotherapy, quizzes, bingo, singers and entertainers. People also told us how they enjoyed being taken to the local pub for Sunday lunch. During the inspection there was a classical singer, which people appeared to enjoy. Some people also enjoyed manicures and pedicures. An activities timetable for the week was displayed for people and their relatives to see. People were positive about the variety and frequency of activities. At the time of our inspection there was a vacancy for an activities co-ordinator.

The provider had a complaints policy and this was displayed within the service. People and relatives told us they knew how to complain. People told us, "If I needed to make a complaint I'd talk to the manager"; "I'd be happy to make a complaint if I needed to" and "The manager is very good, I wouldn't have any problem talking to them if I had a complaint." Complaints had been recorded and investigated in line with the provider's policy. Verbal complaints were recorded and dealt with immediately, to the person satisfaction.

Requires Improvement

Is the service well-led?

Our findings

People and relatives told us they thought the service was well led and the registered manager and the management team were approachable. One person told us, "I think it is well managed, the place chugs along" and "The manager is approachable but you have to pin them down." Relatives told us they were confident in approaching the management team, "The manager was just wonderful; we were in crisis with my mum. I was driving by on a Wednesday and saw the open sign and came in. She was here by Friday."

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of certain changes and important events that happen in the service. These are referred to as Statutory Notifications. This enables us to check that appropriate action had been taken. This is important so that we can check that people are being kept safe.

The registered manager had failed to inform us about all events. These included not notifying CQC of an allegation of abuse and not notifying CQC that police had been involved with an incident that had been reported to them about the service.

Failure to report notifiable events to CQC is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered manager was aware that they had to inform CQC of significant events and, had submitted other statutory notifications in a timely way.

Audits by the provider's quality team gave additional scrutiny and led to action plans for improvement. Names of people responsible for actions and timescales were added to any action plans for improvement. Accidents, incidents and complaints were reviewed by the registered manager and by staff at the provider's head office to check if any patterns were emerging. These were used for learning and improving the service. However, audits did not highlight the need for more robust risk assessments of potential members of staff living at the service. During the inspection, the provider implemented a risk assessment to ensure potential employees were of suitable character to be living at the service.

There were systems and processes to help care staff to be clear about their responsibilities. This included two senior care leads who led each shift. Arrangements had also been made for a senior member of staff to be on call during out of office hours to give advice and assistance to care staff should it be needed. One member of staff told us, "I'm clear about the role and I can always ask if I'm not sure."

Regular team meetings were held, giving staff the opportunity to share information and discuss concerns. The registered manager attended regional manager meetings, where best practice and updates were shared. The registered manager shared this information with the staff team. Accidents and incidents were also discussed at team meetings to help identify any emerging trends. One member of staff told us, "We have staff meeting each month. Every day the lead carer does the 11 to 11 meeting. You voice any issues here. In staff meetings we're given the opportunity to raise concerns. The managers are good at making sure

we are all on the same page, for example night and day shifts. We used to have defined line between day and night staff. At the last meeting we talked about it because we're 24 hour, one team together. Day and night don't see each other so often so it's nice to get the opportunity to discuss things. We can talk about things that we don't talk about in the handovers. One staff member starts at 6am, and works in the day, so that's a link between night and day."

The registered manager, senior staff and practice development manager completed a range of checks and audits on the service. Regular health and safety and infection control audits were completed and any actions that were identified were completed and signed off. Regular checks on medicines were completed and the registered manager sampled and checked people's care plans to ensure they contained the necessary level of detail.

The registered manager and staff worked in partnership and liaised with a range of professionals and other organisations when people's needs changed. There was a range of policies and procedures for staff to refer to for advice and support. Policies were up to date and staff knew how to access them. Links with the local community had been forged, with visits from the local primary schools had been planned.

Resident and relative's meetings were held and discussed topics such as menus, activities and upcoming events. Relatives told us, "I am often asked how I feel things are being done and if there is anything I feel could be changed"; "yes we have meetings and I am asked what my views are and I have filled out a questionnaire" and "I do feel listened to and I do feel a part of the home in so far as they really do value out input and views and we often see our little ideas such as new signs and different choice of soft drinks being implemented."

People who lived in the service and their relatives had been invited to complete questionnaires about the quality of the service and to make suggestions about how the service could be improved. Action had been taken to act upon any feedback that had been received.

This was the first inspection of this service under its new registration therefore there was no previous rating to display.

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 Personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered manager had failed to inform us of some events, such as an allegation of abuse. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.