Willover Property Limited

Abbeydale - Derby

Inspection report

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Date of inspection visit: 2 March 2015
Date of publication: 28/07/2015

Ratings

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

Overall summary

We inspected Abbeydale on 2 February 2015. The inspection was unannounced which means that we did not tell the provider before that we were coming to inspect the service. Abbeydale provides accommodation for persons who require nursing or personal care, treatment of disease, disorder or injury to people and diagnostic and screening services.

At our last inspection on 17 March 2014 the service was meeting the regulations we inspected with regard to consent to treatment and record-keeping.

On this inspection we found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 with regard to peoples' care and welfare. You can see what action we have told the provider to take at the back of the full version of this report.

A registered manager was in place. 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.

Summary of findings

Staff had received training on how to protect people who used the service from abuse or harm. They demonstrated they were aware of their role and responsibilities in keeping people as safe as possible.

We found people largely received their prescribed medication in a safe way by staff trained in medication administration.

Detailed risk assessments had not always been undertaken to inform staff of how to manage and minimise risks to people's health from happening.

Improvements in some aspects of caring for people with dementia were needed in terms of providing more stimulating activities and improving the environment.

The provider supported staff by an induction and some ongoing support, training and development. However, comprehensive training had not been provided to all staff.

The Mental Capacity Act (MCA) is legislation that protects people who may lack capacity to consent to their care and treatment. We found examples where the registered manager was following this legislation which informed us that people's capacity to consent to specific decisions had been assessed appropriately.

People who used the service had their dietary and nutritional needs assessed and planned for. People received a choice of what to eat and drink and staff supported them to maintain their health.

People who used the service and relatives told us they found staff to be caring, compassionate and respectful. Our observations largely found staff to be kind and attentive to people's individual needs.

People who used the service were, as far as possible, able to participate in discussions and decisions about the care and treatment provided.

People who used the service and their relatives had been to share information that was important to them about how they wished to have their needs met, though this process had not been fully completed.

The provider had internal quality and monitoring procedures in place. These needed to be strengthened to prove that necessary actions had been implemented.

The managers enabled staff to share their views about how the service was provided by way of staff meetings and supervision, although these opportunities had been infrequent.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not consistently safe.

Staff were aware of how to report concerns to relevant agencies.

The safeguarding authority and we had not been informed of situations of potential abuse to people which meant that monitoring action to prevent these situations had not been comprehensive.

Medication has not always been supplied as prescribed.

People had not always been supervised when there was a risk to their safety.

Staffing levels needed to be reviewed to ensure people's needs were always met.

Recruitment procedures designed to keep people safe were in place.

Is the service effective?

Requires improvement

The service was not consistently effective.

Risk assessments were not fully in place to protect people's health. Staff training neede expanding. Staff received some supervision to support them to provide care to people, though this was not frequently provided.

The provision of training required some improvement to ensure staff were provided with up to date skills and knowledge

Staff were not aware of the process of assessing people's mental capacity to ensure people were always empowered to choose how they wanted to live their lives.

Staff received some supervision to support them to provide care to people, though this was not frequently provided.

People and their relatives reported that care was available when needed.

People reported the food was of good standard though .

Some people had not been assisted to eat. Our observations showed that people who required assistance at meal times were not always provided with this.

Is the service caring?

Requires improvement

The service was caring.

People and their relatives said staff were kind and caring, treated them with dignity and respected their choices.

Summary of findings

Staff largely showed consideration for peoples' individual needs and provided care and support in a way that respected their individual wishes and preferences.

People and their relatives reported they were involved in planning for their care needs.

Is the service responsive?

Requires improvement 

The service was not consistently responsive.

Risk assessments of peoples' plans of care, needed to provide people with safe care, were not always in place for staff to follow.

Staff did not always have the most up-to-date information on people's needs as they had not read all of people's care plans.

People and their relatives told us that they had received care that met their needs.

Formal complaints had been investigated and a detailed response sent by management to these issues. Informal complaints had not been recorded and followed up in the same way so it could not be proved that action had been taken to resolve the issue.

Is the service well-led?

Requires improvement 

The service was not consistently well led.

Incidents involving people had not been reported to us so that we could consider whether we needed to inspect the service to ensure it was meeting its obligations to keep people safe.

Staff told us the registered manager provided good support to them and had a clear vision of how quality care was to be provided to people.

People told us that management listened and acted on their comments and concerns.

We found out systems had been audited to try to ensure the provision of a quality service, though these had not been fully assessed.

Abbeydale - Derby

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 took place on 2 and 3 March 2015 and was unannounced. The inspection team consisted of two inspectors for the first day and one inspector for the second day.

We also reviewed information we received since the last inspection including information we received from the safeguarding team from the local authority.

During our inspection we spoke with the registered manager, the registered provider, six people that used the service, five relatives, two qualified nurses, four care staff and one domestic worker. After the inspection visit, we undertook phone calls and spoke with three health professionals who worked with the service.

We observed how staff spoke with and supported people living at the service and we reviewed five people's care records. We reviewed other records relating to the care people received. This included the provider's audits on the quality and safety of people's care, staff training and recruitment records and medicine administration records.

Requires improvement

Is the service safe?

Our findings

People and relatives we spoke with told us they felt safe with staff that provided care. One person said: "If I was concerned about a member of staff I would speak to (a deputy manager) he wouldn't let anything happen to us." Another person said, "The managers here are pretty decent and easy to speak to."

We spoke with one person who preferred to stay in their room. They said they had falls before they came to the home and were not able to walk. They said staff had to use a hoist to transfer to the toilet and when they went to bed. They said they needed two staff to use the hoist. They said they felt safe when being transferred and had never fallen.

We saw staff being present in the main lounge observing people using the service and keeping them safe. They were alert to potential risks and took steps to ensure people's safety. For example, a person with risk of falling was persistently walking around. Staff encouraged the person to sit down. However, another person, with an identified risk of falling, got up and started to walk when there were no staff present in the lounge for 10 minutes. This was a risk to their safety.

We saw statements written by staff in a person's care plan describing an incident in August 2014 where the person may have been assaulted. We asked the manager why a safeguarding referral had not been made. She said this had been discussed and she felt it had been resolved and therefore did not need a safeguarding referral. As there was a possibility of abuse, this needed to be reported to the safeguarding authority and to us to monitor people's safety. The manager said she would follow this procedure in the future.

Each person had a range of risk assessments in their plans of care, including nutritional risk, serious health conditions, assistance with mobility, and bed rails. These issues identified the action needed to reduce the risk to the person. We found these interventions were not always in place. For example, the person assessed as needing a bed rail to stop them falling out of bed, there was no assessment as to whether they could climb over the rail and fall, or of any other measures that would be better to manage this risk. This did not keep this person safe.

The provider had safeguarding policies and procedures in place. These were designed to protect people from harm.

Staff we spoke with had a good understanding of their responsibilities and told us they would immediately raise any concerns with their line management. They told us that they were confident that the management team would then take action to report the concerns raised. If not, staff knew of relevant agencies to report their concerns to, although not all staff knew all of the relevant agencies, which could have delayed referrals to agencies and not kept people safe. The manager stated all staff would be appraised of this information.

People and relatives we talked with said they felt there were normally enough staff on duty to care for them. However, they said their call bells were not always answered quickly. One person said, "It has taken them up to 30 minutes for staff to come to help me to go to the toilet but it is normally five or 10 minutes wait." Another person we spoke said sometimes it felt as if there were not enough staff. They said this was not usually a problem, but it was occasionally frustrating.

Staff members told us that there generally enough staff on duty to meet people's needs though at times it could be short staffed and was very busy so was not enough time to spend with people or to provide activities. Staff reported there was a ratio of staff to the numbers of people accommodated in the home. The manager said this was not true as it depended on people's dependencies. We were supplied with an assessment of people's dependencies. However, there was no correlation between dependencies and staffing levels. We also observed two occasions where no staff were in the lounge. On one occasion a person, unsteady on their feet, had attempted to stand up. This situation did not protect their safety. The manager and provider stated they would review staffing levels to ensure people's needs were met at all times.

On the day of the inspection there were six care staff, which included an agency care staff that had been ordered before we had arrived at the service. This showed management had been proactive that day in trying to ensure proper safe staffing levels.

Staff told us they had followed various recruitment procedures such as completion of an application form, interview, and proper criminal checks had been taken up. We looked at four staff files and found recruitment processes, designed to keep people safe, had been followed.

Requires improvement

Is the service safe?

People told us they had received their medication when they were supposed to get it. We observed staff supplying medication to people. This was carried out properly with a drink supplied to make the medication easier to take. On one occasion a person dropped the tablet and a staff member picked up from the floor and gave it to him. The manager said this did not follow procedure as it was not hygienic or safe practice. She would follow this up with staff to ensure it did not occur in the future.

We checked medication supplies and found them to be securely kept but not always well managed. For example, we found that the person had not had one medication for five days because it had run out. The manager said this would be followed up with staff and a review of systems to ensure that staff ensured medication was delivered on time to the home to protect people's health. She said she would also follow this up with the pharmacist.

Requires improvement

Is the service effective?

Our findings

We found a number of examples where by people had not received effective care. Each person had a range of risk assessments in their plans of care, including nutritional risk, serious health conditions, assistance with mobility, and bed rails. These issues identified the action needed to reduce the risk to the person. We found these interventions were not always in place. For example, the person assessed as needing a bed rail to stop them falling out of bed, there was no assessment as to whether they could climb over the rail and fall, or of any other measures that would be better to manage this risk.

For a person who had a cancerous condition there was no recorded prognosis documented. Without this information the service could not organise appropriate support to assist the person to deal with this condition

A person had been assessed as having a risk of losing weight. There, there was a risk assessment in place which stated that if the person lost weight, this needed to be referred to involve the GP and dietician. The person lost 3.7 kg between November and December 2014 but this information had not been referred to health professionals. This meant there was a risk to the person's health.

We saw that a person For the person who had been discharged from the physiotherapy department and, there was information in the person's file that exercises should be encouraged to enable her to be more mobile. However, there was no evidence that staff had encouraged the person to follow this exercise programme

We asked staff members if they had read people's care plans. They said they had read approximately half of them, although they received information about peoples' needs on a daily basis through staff handovers. However, some staff stated that handover information was not always comprehensive as it did not provide them with all up-to-date information about people. The manager said this would be reviewed and discussed with the registered nurses. This meant that there was a risk that because staff were unaware of the care they should be providing, as detailed in the examples above, this was a risk to providing effective treatment to people. 's health and welfare. The manager said she would set up a system to ensure that staff read and followed all the care plans.

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

A system was in place to provide staff with training. We looked at the training matrix, which showed the training that staff had undertaken. We saw that staff had not always been provided with training in line with the provider's training programme to ensure they had effective skills to deliver care to people. For example, a large percentage of staff had not had training on issues such as fire, first aid, infection control, medication awareness and moving and handling techniques. Some staff had not had training on dementia and safeguarding people. The manager stated that staff were encouraged to take part in training but sometimes they did not volunteer to do so. If this was the case, they received a letter stating they needed to complete this training. The manager and provider said that if this reminder did not work then staff would potentially face disciplinary action.

The training matrix showed We did see evidence that courses had been arranged in 2015 for staff to receive this training, though it did not identify if all staff would receive this training. This meant some staff may not have the latest knowledge and skills in key topics needed to deliver effective care.

We saw records of staff supervision. This meant staff had an opportunity to discuss their roles and their training needs. However, we saw that some staff had not received supervision for up to 10 months. The manager stated she recognised this and would be ensuring staff would receive regular supervision in the future.

Each care record contained a mental capacity assessment document. In one care plan, the person's relatives and GP had contributed to the information about the person and the decision.

We also saw evidence of resuscitation documentation. On one file the person had been assessed as not having capacity. The person's relative had signed the care plan but had not signed the resuscitation form. The manager said this would be followed up.

People we talked with said they enjoyed the food at the home and there was enough to eat and drink. They said care staff came round every day and asked them what they

wanted. They said there was a choice of two main courses at lunchtime and they were asked to choose from the menu in the morning for that day. People said that there was plenty of food and it was of good quality.

People said they could have a cooked breakfast if they wanted one. We saw there were jugs of drinks available in the lounges and we saw staff provide people with hot warm drinks during our visit.

The cook showed us information displayed in the kitchen which indicated people's preferences and how food should be prepared to protect people's health, such as the texture of food needed. She said there was no person accommodated at the moment from a minority community but in the past a person from the Afro-Caribbean community had lived in the home. She had asked the person what they like to eat and made sure that the person's food preferences had been met to respect their choices.

We observed that people were relaxed and most staff were talking with them while helping people with their meals. We saw one person had specially adapted cutlery to help them to eat more effectively. This person struggled to use the cutlery to eat their main course and resorted to eating from their knife. After a while they seemed to get frustrated and pushed their plate to one side having eaten about a quarter of their meal. A nurse saw the person had finished eating and asked the person why they had eaten such a small amount. There was no discussion about their ability to use the cutlery and no one checked the person was eating once they had been served their lunch. The person was asked if they wanted a pudding and they said they did. Once they had their pudding served the person ate this with their spoon without a problem. It was not clear whether the person did not want their main course or whether it was a problem with their cutlery. This meant the person may not have been supplied with a proper amount of food.

We saw that the menu included a choice of meals. People also confirmed that if they did not like the food offered the cook would prepare something else for them.

This showed us that peoples' nutritional needs had largely been met.

Staff told us that daily handovers took place so that staff could update the next staff on shift about people's needs and if any changes in their care had been identified. Staff we spoke with told us the handover was a good source of information and helped them to meet people's needs. However, some staff stated that handover information was not always comprehensive as it did not provide them with all up-to-date information about people. The manager said this would be reviewed and discussed with the registered nurses.

CQC is required by law to monitor the operation of the Deprivation of Liberty safeguards (DoLS). This is a law that requires assessment and authorisation if a person likes mental capacity and needs to have their freedom restricted to keep them safe. We found evidence that people had been assessed regarding their capacity to make decisions. We had been informed previously of a number of people where there had been an application for Deprivation of Liberty Safeguards (DoLS), which had been authorised as people has been assessed as not having the capacity to make decisions for themselves.

We saw that staff explained to people what care they were intended to provide and asked their permission about this. A person told us that staff had made arrangements for their GP to visit because their leg was swollen. They said they were pleased the GP had been able to come and visit them at the home.

The manager stated that she was looking to make facilities more stimulating for people with dementia. We discussed having themed corridors such as seaside scenes, local history, and shops from the past so that people could identify with them. We saw signs around the home pointing people to facilities. Some bathroom doors had also been painted a different colour to identify them more easily to people. One bedroom door had photographs of a person and their pets earlier in their life to help them identify where their bedroom was. The manager said she would look towards doing this for other people. (it sounds like you are telling the manager what to do- maybe you need to condense this info and just state what was in place, the impact and the managers plans for improvement)

We spoke with a visiting healthcare professional who said they had visited the home over a number of years to assess people. There were examples of referrals and assessments undertaken by healthcare professionals who specialised in the assessment and treatment of people with dementia.

Requires improvement

Is the service effective?

We spoke with an optician who was testing one person's vision. He said he had been visiting the home for a number of years and in his view the standard of care was good. He said staff were always helpful and there were usually enough staff on duty to support people effectively.

Requires improvement

Is the service caring?

Our findings

Staff were aware of people's personalities. This was obvious from the way in which staff engaged with people in conversations during the day. For example, we heard staff talking with one person about their family.

Five people we talked with said all the staff were kind, caring and helpful. For example, one person said, “All the staff are very friendly. There is not one that I could criticise.” Another person said, “Staff try to help you all the time.”

Our observations showed that most interactions between staff and people were positive with no negative interactions. We found staff were calm and patient and explained things well, except for one situation where we found a staff member to be very directive in dealing with a person, telling the person to sit down four times in a row. The manager said this would be followed up with a staff member concerned.

One person’s relative said that the person could not find his way to the toilet from his bedroom. Staff immediately put some signs in place to direct him. This meant that he was able to retain his independence in this issue.

We spoke with one person who told me her son had looked at a number of places and had chosen Abbeydale because they thought it was friendly and the staff were pleasant. Another person we spoke with told us, “Staff are always pleasant.” They said, “It’s the same everywhere. There are a couple who can be a bit snappy but I don’t let them bother me.”

We spoke with staff about maintaining peoples privacy and dignity. They were able to give us examples of how they did this. For example, making sure doors were shut when they were supplying personal care, covering exposed areas when assisting to wash people, and always knocking before entering people's bedrooms.

People and their relatives told us staff protected privacy when supporting with personal care. They said staff always knocked on their bedroom doors before entering and checked with them about their needs and wishes.

We observed a carer sit next to a person who was eating their main course. The carer took the person’s fork out of their hand without speaking to them. The carer did not engage with the person. They did not make eye contact and did not speak to them throughout. In contrast another carer supporting another person spoke with them throughout offering encouragement and praise. This contrasted sharply with the other member of staff.

Five people we talked with said all the staff were kind, caring and helpful. For example, one person said, “all the staff are very friendly. There is not one that I could criticise” Another person said, “Staff try to help you all the time.”

We observed a lot of positive practice. For example; staff assisting a person to sit down at their pace. Staff sat down and chatted to a person. There were times where staff did not react to requests. For example, a person said she wanted a book from her bedroom. This was eventually supplied to her, but it took an hour to get the book.

We saw that most interactions between staff and people who used the service were caring and respectful. Staff informed people about the care they were about to provide and asked their permission.

People told us that staff offered them choices and were able to choose when they got up and when they went to bed. They said they chose the clothes they wanted to wear and whether they wanted to participate in activities.

One person’s relative said that the person could not find his way to the toilet from his bedroom. Staff immediately put some signs in place to direct him. This meant that he was able to retain his independence in this issue.

People and their relatives said they were involved in making decisions about their care. They told us they were aware of their plans of care and had input into their reviews.

People and their relatives told us staff protected privacy when supporting with personal care. They said staff always knocked on their bedroom doors before entering and checked with them about their needs and wishes.

People told us their friends and relatives could visit them at any time and staff always welcomed visitors.

Staff informed people about the care they were about to provide and asked their permission.

We spoke with one person who told me her son had looked at a number of places and had chosen Abbeydale because they thought it was friendly and the staff were pleasant. She had found this to be the case.

Requires improvement

Is the service caring?

We observed a staff member sit next to a person who was eating their main course. Staff then took the person's fork out of their hand without speaking to them, did not engage with the person by making eye contact or speaking with them. In contrast another carer supporting another person spoke with them throughout offering encouragement and praise. This contrasted sharply with other members of staff. The manager said this would be followed up as it was not acceptable practice.

We saw evidence that people's end of life wishes had been recorded in their plans of care. A relative confirmed that end of life wishes had been discussed with her for her relative who did not have capacity to choose arrangements for herself.

Requires improvement

Is the service responsive?

Our findings

We spoke with one person who was visiting a friend. They said they visited often. We asked them about their impressions of the home and the staff. They said, "The staff are pretty good here. ''Another person said, "If anyone gets ill they are taken into hospital quickly" and "People seem well cared for, the place is always clean and people always look smart."

We spoke with three relatives about the staff response if their relative had been ill or had a fall. All the relatives told us that the staff were excellent in quickly informing them of any incidents of concern.

We asked one person if they were able to choose whether they had a bath or a shower and they said they could. They said, "I have a bath every other day, I really enjoy my bath and staff are happy to help me."

People told us their friends and relatives could visit them at any time and staff always welcomed visitors.

A person told us that staff had made arrangements for their GP to visit because their leg was swollen. They said they were pleased the GP had been able to come and visit them at the home.

We asked one person if they were able to choose when they went to bed and they said they did and they chose when they wanted to get up in the morning.

People's records provided evidence that their needs were assessed prior to admission to the home. Each care record contained a summary page giving very brief information about the person's support needs, past medical history, communication issues and details of key contacts.

Some care plans contained little information about people's preferences for daily living and their past history. This would have been useful for staff to know and to use this information to provide care, conversation and stimulation for people. For example, what time people liked to get up and go to bed, their night time routines and what they liked to drink. The manager said this type of information would be available in the future as staff were in the process of obtaining this information from people and their relatives. We saw evidence that this was the case.

We saw evidence of reviews of the care plan with athe person using the service and their relative.

There was a specific risk assessment for a person who displayedwith behavioursdisplayed behaviours that could have offended some people. Staff were requested to supervise this person closely. This person did not have an advance care plan or any information in place as to whether he wanted to be resuscitated in the event of a health emergency. The manager said this would be followed up. This would ensure that a more responsive service could be provided.

People we talked with said there were activities for them to participate in which they enjoyed. This included singing and armchair keep fit. However, during the inspection we did not observe people engaged in any activities. The activities organisers shared activities between this service and the other service owned by the provider nearby.There was an activities program available which covered five days a week but this showed minimal activities on two of these days.

We received comments from staff that they needed to be more activities so that there was stimulation available to people every day. They suggested activities such as bingo, baking sessions, more craft sessions and more time to play games with people. Also, to have regular trips out for people who would enjoy this type of activity.

We did not see any provision of also discussed with the provider and manager the need for activities for people with dementia. They said they would look into this provision and to provide equipment such as tactile equipment and memory boxes for people with dementia. We did not see any artefacts to help stimulate people with dementia such as having tactile objects or memory boxes of valuable objects. The manager stated the home did have specialised aprons with objects with different textures on them, so that people could have this experience. However, this was not available when we inspected. We also discussed the activities organisers having specialist training on providing relevant activities to people.

This told us that people were not offered frequent stimulating activities. The manager said this provision was being reviewed at present with a view to ensuring the service offered people more activities that they enjoyed.

We spoke with three staff about people's preferences and needs. They were able to tell us about the people they were caring for and what they liked and disliked.

Requires improvement

Is the service responsive?

The people we talked with said they were not sure how to make a complaint. They said that if they had a complaint or concern they would speak to a carer but they would not know what to do if it was not addressed. There was a complaints procedure displayed in the front entrance of the home. The manager said people would be reminded of how to make a complaint.

We looked at details of complaints. We found evidence that concerns had been recorded and followed up. There was no complaints book for staff to record any concerns with the service. The manager agreed this would be useful to be able to keep track of people's feelings about the service and this would be provided to staff.

The complaints procedure showed that people could complain to management and included information about how to raise concerns with the ombudsman if necessary. However, it did not give details of the lead authority for investigating complaints. The manager said the procedure would be amended to include this and take out the reference to the Care Quality Commission investigating complaints, which is not a legal duty of the Commission.

Requires improvement

Is the service well-led?

Our findings

Three relatives told us that management were very approachable when they had raised any issues, which had been quickly responded to.

All the staff we spoke with said that the manager was very supportive and available to speak to with regard to any issues they had. One member of staff told us, "I know I can go to the manager if I have any concerns and it will be properly looked into." Staff also told us that the manager had a strong emphasis on ensuring that people's welfare and rights were protected and promoted. This was stressed to them in their induction when they started working and also in staff meetings and supervision they received.

We saw evidence that people and their relatives had been provided with a satisfaction questionnaire to give their views of the service. This had been analysed with actions in place to meet the issues raised.

We saw evidence of other audits. This included reviews of hygiene and infection control, health and safety, accidents, management audit of all systems such as care plans, safeguarding, staffing, training, a provider review, social activities and medication. Some audits did not appear to be in depth. For example, the medication audit in January 2015 assessing medication recording talked about the on going audit of charts, without assessing whether they proved people had received their medication. The analysis of accidents did not produce any learning points, for example, whether staffing levels were high enough to properly supervise people at risk and whether there was proper equipment in place. The manager said this issue would be followed up.

There was evidence that 'resident meetings' had been held. However they all say 14 month gap between meetings. The manager recognised this and said they would be held more frequently in the future. Meetings provided an opportunity for people and the relative to feedback comments or concerns to the management team.

We spoke with health professionals about how the management and staff work with them. They said this had been positive. Proper referrals had been made to them and action taken to provide proper care and treatment.

We saw evidence of incidents where some people living in the home had been injured. We did not see evidence that they had been reported to the local authority safeguarding authority, or to us. The provider has a legal duty to report such incidents to both CQC and the local authority. The manager stated that all such incidents would be reported properly in future.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People who use services were not provided with effective personal care because comprehensive risk assessments to protect their health and welfare were not in place and staff were not aware of all of people's assessed needs.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.